Foundation Trust Network

ENSURING FAIR AND TRANSPARENT PRICING FOR NHS SERVICES
RESPONSE FROM THE FOUNDATION TRUST NETWORK

The Foundation Trust Network (FTN) is the membership organisation for the NHS acute hospitals and community, mental health and ambulance services that treat patients and service users in the NHS. The FTN helps those NHS trusts deliver high quality, patient focussed, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. The FTN has over 210 members – more than 90% of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 630,000 staff.

General comments

Pricing overview

1. We agree that the process detailed in the consultation is a back-stop and should be the end point of a much wider planned consultative process on pricing, suitable for the new regulated industry in health.

2. Provider engagement with pricing is critical and consultative machinery needs to be established, which should continue to include the sense-check and road test proposals as now, but widened to include consideration of the general settlement.

3. We look forward to discussions with the DH, NHS Commissioning Board and Monitor on what these processes should look like and are pleased that there appears to be support in principle for such an approach. The overall process should be clearly agreed in a timely manner, and at least a year in advance.

4. It is critically important that this process is got right - this is an objective we all share. There needs to be a transparent way of ensuring that costs are reflected appropriately in the tariff. On that point, the interaction with other tariff levers will be critical. There are currently levers in place which distort price relationship with costs, for example the 30% marginal rate for non-elective admissions and the readmissions policy, and the two year delay in reference costs being reflected. Costs often move in a non-linear way, and yet prices are set as if they are linear.

This consultation

5. The FTN carried out a survey of its members on the headline questions in the consultation – the objection threshold and the denominator. We received feedback from 73 member organisations and report on the results below. Our response also incorporates qualitative comments from the survey, which highlight important issues to be addressed in the next stages of the process; and also direct member responses to the consultation questions.

Thresholds

6. On the threshold question as applied to providers, while there was the most support for a 51% threshold (28/72 respondents, 39%), there is support for a figure in the 20-30% range too (49% of responses supported a threshold at around this level). Therefore we consider that at the very least a threshold significantly lower than 51% would be a reasonable figure for alerting potential problems with the method and this lower threshold could usefully prompt an action short of full referral. Such a dual approach to thresholds would support better sensitivity and responsiveness to risk in the system, of which it is essential the DH and the agencies reporting to it are aware.

7. In respect of the actual threshold figures, it is difficult to be absolute in terms of what threshold is appropriate until the level and significance of changes is known. We report on our sector feedback below so that the DH can take an informed view of provider opinion, but it is important that the determining threshold is subject to a consultative review process after a reasonable period, conducted in light of emerging experience and the impact of the chosen course on the system.

8. Furthermore, we consider there is a role for the FTN, as the trade association for public providers, in alerting the DH and others to any emerging difficulties in a responsible way, irrespective of the chosen threshold, and for these to be considered, given the likelihood that a global threshold is likely to be insufficiently nuanced and could potentially mask issues that might be affecting particular local health economies.

9. It would be useful to consider the provider threshold in conjunction with the share of supply threshold to quantify robustly the impact on the system and the necessity of review. We should welcome further discussions on this point.

Baseline

10. Given that a reasonable threshold for objecting to the methodology could well vary for each service, there was wide support for a more granular approach to the calculation - there is an overall sector view that a whole tariff denominator was inappropriate, with 75% supporting a service-specific approach (47/63). One in five supported an all-tariff approach.

Other headline points

11. A further check on whether the method is operating effectively will be the inter-action with the requirement for local price adjustments – perhaps if higher than expected or in particular specialties. If these are widespread then clearly the methodology will require investigation.

12. We should like to have clarification on the expected costs of the new process, particularly whether there is a risk of building in a disincentive to object? Will costs be borne by those who lodged an objection and saw it rejected and how might the costs be apportioned reasonably?

13. It will also be important to make it clear what constitutes an objection – for example, what data or evidence is required – and the timescale for remedy, including whether it will be retrospectively applied.

Questions

Question 1: Do you agree that providers of services in the tariff in operation at the time at which Monitor consults on the next tariff should count towards the thresholds?

Yes.

All providers of services subject to tariff should be able to object and count towards meeting the thresholds. We hope that mental health and community services will be included in tariff at the earliest practical opportunity and included in the calculation at the next available point following.

On the point of how off-tariff services are approached, members were concerned that many healthcare services were currently out of scope of this process, including many specialist services, some acute, as well as mental health and community services. It is important that there are mechanisms to support fair price determination and a means of provider appeal in these areas of provision.

It will be important also to capture somehow in the process the position of those trusts who have agreed off-tariff arrangements for services where tariff is available because of inadequate tariff reimbursement to date. Those off-tariff arrangements will be de-facto a rejection of the current methodology, but do not appear to be accommodated in the equation proposed.

The consultation question immediately brings out the importance of adopting the correct denominator for the calculation, as members felt strongly that only those organisations that undertake activity in the area that is being challenged should count towards the thresholds, at a service level.

Question 2: If yes, do you agree that this should include any such providers who are exempt from the requirement to hold a licence?

Yes. The ability to object to pricing methodology should be open to all providers of relevant NHS services.

However it is important that there is the capacity for providers to object to aspects of the tariff that might not apply to all providers of tariff services, an example currently being the 30% marginal rate for non-elective admissions, which applies to incumbent NHS public providers. If unaffected providers were included in the denomination they would dilute the percentage of objectors such that the threshold for challenge may not be met by a substantial number of affected providers.

This illustrates that

a) The issue is more complex than a straightforward answer to the question posed;

b) As stated above, there is a need for consultative mechanisms on the financial settlement as a whole.

Question 3: Do you agree that the data used to calculate an objection threshold should be based on total tariff income, as reported in financial accounts?

The data presented in annual accounts is reasonable for an all tariff calculation, but while there was some support for total tariff income to be used as the basis for the calculation, others felt that a more service-specific approach was necessary. The case is illustrated by specialist services in particular, but the point is a generally applicable one. This might well need a more granular approach to the calculation. We discuss this below.

Question 4: Are there any other providers who should count towards the threshold?

We agree that all organisations providing NHS funded services should count towards the threshold.

We note the proposed policy leaves no place for comment and challenge by related expert groups who may have a significant contribution to make e.g. Royal Colleges and other Clinical groups.

Question 5: Do you agree that the objection percentage threshold should be set at 51% for commissioners?

It is essential that there are measures in place to ensure that the NHS Commissioning Board (which will hold a substantial proportion of the NHS commissioning budget) cannot automatically trigger a threshold acting alone, as this would be an inappropriate use of purchasing power within the NHS market.

We agree with the approach in the consultation that there should be parity of thresholds applicable to all parties.

Question 6: Do you agree that the objection percentage threshold should be set at 51% for providers?

As reported above, a significant proportion of respondents felt that 51% was too high to be the sole trigger point for a review. We note that under the model proposed, 49% of providers could have a significant and material financial issue which would not count as a relevant challenge - this would quickly cause a national problem for the NHS.

The full distribution of responses to the question on suitable thresholds for objecting is as follows:

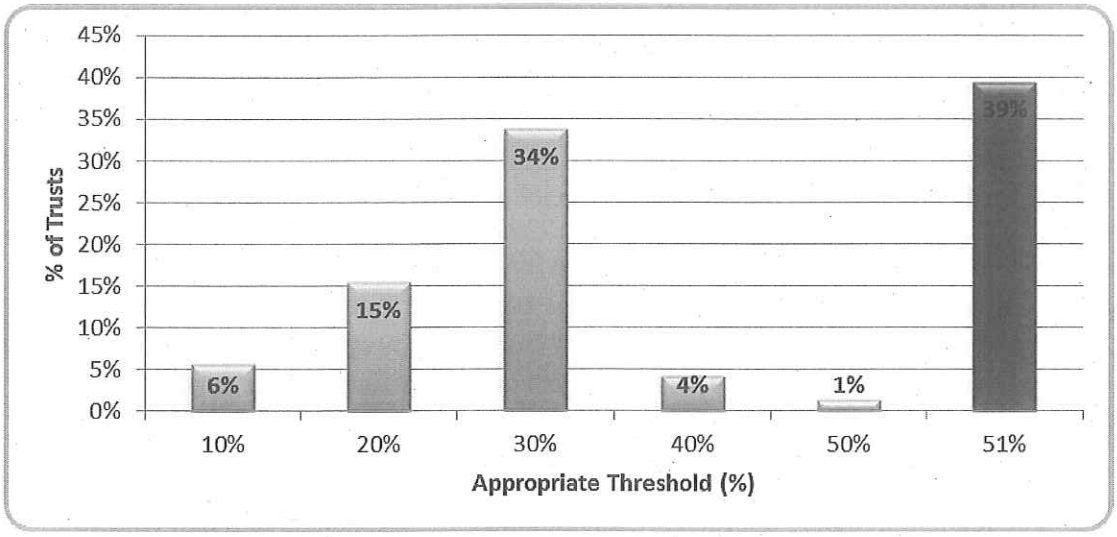

Table 1: *FTN survey of members showing indicative support for a reasonable threshold to lodge an objection to pricing methodology (n=72).*

Elaborating on the dual approach we outlined above where an objection in the 20-30% range could signify a significant issue with the methodology, we consider that if there is a greater than 25% objection to the pricing methodology, then a rationale for not pursuing a review should be published. As one of our members reported:

> *"I would suggest that if a third of organisations object on reasonable grounds then the pricing method must by definition be questionable".*

Again linking to the question of the denominator, it is likely the acceptability of the threshold will depend on the methodology and its impact on a particular service. The larger the service, the smaller the significant number becomes – for example in maternity services, it is likely that it would require a large number of providers to object to reach 30%, but if a more granular approach was adopted then a threshold over 50% would be reasonable for an objection to be pursued.

Question 7: Do you agree that a provider's share of supply should be calculated across all tariff?

No.

As stated throughout, there is overwhelming support for the denominator to be determined on more of a service level, applicable to both the provider threshold and the share of supply threshold, so including in the calculation those organisations that provide the service in question. Three out of every four respondents supported this approach (47/63).

> *"A crude threshold percentage of trusts is technically irrelevant unless applied at a specialty or HRG level".*

This will introduce an element of complexity around definitions – however, our members felt that HRG-level and specialty-level information is readily available and should be used.

For some services within tariff, a relatively small number of organisations account for a large proportion of the activity undertaken nationally, for example, Chronic Renal Dialysis and sensible discussions on relevant tariffs for such very specific services could be ignored using a voting share methodology distorted by large volumes of general medical and general surgical activity nationally. This effect would be even more marked for more highly specialised or very low volume tertiary services.

> *"A high proportion of objections to tariff methodology are likely to be service specific i.e. within a speciality and as such the voice of a majority provider of a particular service, could be effectively relegated to a minority vote under this "bottom line" calculation".*
>
> *"This leaves no room for challenges rated to high cost/low volume procedures and could have the perverse incentive of stifling innovative clinical practice".*

Question 8: Do you agree that providers should be weighted based on income from tariff services delivered, as stated in the previous year's financial accounts and minus any local area adjustments?

Local area adjustments, should they be widespread, could be an indication of problems with the methodology so shouldn't be discounted from consideration, but it is appropriate to exclude these for the basis of the calculation.

A weighted approach as described appears reasonable, but given that all the issues presented in the consultation are inter-related, to re-iterate our view it is important that this weighting is derived on the back of a more granular, service-specific calculation.

Question 9: Do you agree that the share of supply percentage threshold should be set at the same figure as for the objection percentage thresholds, i.e. 51% of the total supply?

As noted above, there should be consistency and parity in the thresholds that trigger a review, though the 51% threshold should be reconsidered in light of the sector views reported above.

Question 10: Do you have any evidence that the proposals in this document will impact adversely or unfairly on any protected groups?

No, we agree with the view outlined in the consultation.

How to Respond

Please return your responses, no later than **21 December 2012.**

e-mail pricing.consultation@dh.gsi.gov.uk with the subject 'Pricing Consultation'

post

Pricing Consultation
Department of Health
Room 229
Richmond House
79 Whitehall
London
SWIA 2NS