Fair and transparent pricing for NHS services

A consultation on proposals to formally object to the pricing methodology

Shelford Group Response to "Fair and transparent pricing for NHS services", December 2012

Personal Details

Organisation(s) represented: Shelford Group

The Shelford Group comprises ten leading NHS multi-specialty academic healthcare organisations. Members include:

- Sir Andrew Cash OBE, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
- Dr Karen Castille OBE, Interim Chief Executive, Cambridge University Hospitals NHS Foundation Trust
- Mark Davies, Chief Executive, Imperial College Healthcare NHS Trust
- Mike Deegan CBE, Chief Executive, Central Manchester University Hospitals NHS Foundation Trust
- Sir Robert Naylor, Chief Executive, University College Hospital NHS Foundation Trust
- Sir Leonard R Fenwick CBE, Chief Executive, Newcastle upon Tyne Hospitals NHS Foundation Trust
- Sir Ron Kerr CBE, Chief Executive, Guy's and St Thomas' NHS Foundation Trust
- Sir Jonathan Michael, Chief Executive, Oxford University Hospitals NHS Trust
- Dame Julie Moore, Chief Executive, University Hospitals Birmingham NHS Foundation Trust
- Tim Smart, Chief Executive, King's College London NHS Foundation Trust

This consultation response was contributed to by University Hospitals Birmingham NHS Foundation Trust and University College Hospital NHS Foundation Trust, on behalf of the Shelford Group.

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, proceed to Question 2** ☐**No**

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

The Shelford Group agrees that existing providers should have the opportunity to comment and, where appropriate, challenge the tariff construction methodology and/or pricing. Given the proposed methodology, it is considered important that the denominator is not distorted by providers with unrepresentative tariff portfolios.

Although some Shelford Group members believe that including unaffected providers will not have a material impact on whether a threshold is reached or not, there is concern that it would dilute the % objectors such that the threshold for challenge may not be met by a substantial number of affected providers.

Questions 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?

☐**Yes** ☒**No**

If no, please suggest an alternative source.

The Shelford Group agrees that it is essential that the data used to calculate an objection threshold is based upon the services for which the objection relates. Doing otherwise would penalise small or specialist Trusts e.g. specialist cancer, paediatric, orthopaedic, women's hospitals etc. and will also make it mathematically impossible for providers of specialist services to reach the required threshold to trigger the actions laid out in the DH proposals.

In addition, it would also disadvantage large specialised teaching hospitals with a high local price:PbR ratio due to their significant component of highly specialist work, which is more likely to be outside the scope of tariff and with a significant proportion of income from other sources e.g. Education, Training and R&D activities, where some element of cross subsidisation still exists.

The Shelford Group recognises that this will introduce an element of complexity around definitions – however, HRG-level and specialty-level information is readily available and should be used.

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

☐ Yes ☐ No

If yes, please give details and reasons.

This should depend upon the service provided. In general, the policy is too blunt an instrument and setting thresholds for tariff challenges at organisation only level runs counter to the ethos of developing a more granular tariff to better reflect clinical case complexity.
In addition, the proposed policy leaves no opportunity for comment and challenge by related expert groups who may have a significant contribution to make e.g. Royal Colleges.

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

☐ Yes ☒ No

If not, what figure would you propose, and why?

The Shelford Group agrees that this is set too high and the result would be that the net would be cast too wide in event of punitive tariff and could cause widespread financial instability.

It is important if a substantial minority of providers object to a particular area of the tariff for this to trigger the actions laid out in the proposals. However, 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.

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

☐ Yes ☒ No

If not, what figure would you propose, and why?

The Shelford Group agrees that this is also set too high and the result would be that the net would be cast too wide in event of punitive tariff and could cause widespread financial instability. It is important if a substantial minority of providers object to a particular area of the tariff for this to trigger the actions laid out in the proposals.

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

☐ **Yes** ☒ **No**

If not, how should their share of supply be calculated?

The Shelford Group agrees that this methodology is inherently unfair and that it is essential that the data used to calculate an objection threshold is based upon the services for which the objection relates:

o Providers with a significant cohort of specialised services, which by their very nature have been difficult to encompass within national tariffs and so remain either outside the scope of PbR or are named exclusions, would be disadvantaged by this approach.

o 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.

o This leaves no room for challenges rated to high cost/low volume procedures and could have the perverse incentive of stifling innovative clinical practice.

The DH has proposed a single definition of supply citing complexity and administrative burden, however, there are many data sources e.g. HES activity, SUS-PbR or current reference costs collection data that are readily available for all existing Providers and Commissioners.

These data sets, within a large database, can easily be grouped at: Treatment Function Code, HRG sub-chapter level or even procedure level to determine market share by organisation and hence proportional voting rights.

Hence, an alternative methodology would not seem to be an overly burdensome calculation and should be relatively quickly ascertained without recourse to any additional data collection; this could be calculated in advance and held centrally or at the time of a specific query. Indeed a database of national market share at a granular level would be useful information for Monitor to retain for wider business purpose.

It must be recognised that for some services within PbR, a relatively small number of organisations account for a large proportion of the activity undertaken nationally e.g. 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.

It is important to note that such services identified above could be classed as 'commissioner requested services' or 'protected services' under the proposed 'Continuity of services' and Monitor Licence conditions, and as such it is imperative that providers, with their own expert understanding of the costs of provision can be actively engaged in the process of constructing relevant tariffs. This should be by reference to specific services and cannot operate only at an organisational bottom line basis.

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?

☐ Yes ☐ No

If not, on what basis should they be weighted?

As with Question 3, the Shelford Group agrees that weighting based upon income received from the relevant area of tariff services is appropriate, although note that this should not be based upon total tariff income. This would seem to be inequitable and would penalise small or specialist Trusts e.g. specialist cancer, paediatric, orthopaedic, women's hospitals etc. In addition, it would also disadvantage large specialised teaching hospitals with a high local price:PbR ratio.

Providers with a large tariff income base derived from e.g. general medicine and general surgery should not have a greater weight in the decision as to whether to appeal the price setting methodology for a particular service than providers with a different case-mix (including that particular service).

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?

☐ Yes ☒ No

If not, what percentage should be set, and why?

The Shelford Group agrees that this is set too high and the result would be that the net would be cast too wide in event of punitive tariff and could cause widespread financial instability. The materiality of the query and challenge needs to be taken into account i.e. what is the net effect for each provider and for the NHS as a whole?

The Shelford Group also agrees that it is important that if a substantial minority of providers object to a particular area of the tariff, this should trigger the actions laid out in the proposals.

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

☒ Yes ☐ No

If so, please provide details of the evidence.

The proposal as draft is likely to impact upon not only providers of specialised services but would also potentially impact upon the funding of patient care within the following groups: maternity services, gender reassignment, chronic disease and/or disability as their voices could easily be lost within proposals outlined. Some Shelford Group members would be able to demonstrate evidence for this, and for more information, please contact the Secretariat.

Other general points to note include:

- It would be more logical, and simpler, to have one threshold based solely upon share of supply – otherwise there is the possibility of a number of commissioners / providers triggering the threshold despite only having a very small proportion of supply between them, whilst a smaller number of commissioners / providers with a large proportion of supply (but just under the proposed threshold) would not meet the threshold.

- It will be important to clarify what constitutes an objection. For example, what data or evidence is required – and the timescale for rectification – including whether it will be retrospectively applied.

- Those lodging an appeal should not have to bear all of the costs of an unsuccessful appeal. In order to encourage input from commissioners and providers it is important not to disincentivise using the process laid out in the DH proposals.