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2015/16 National Tariff Payment System

Engagement Workshops

GOV.UK/monitor
england.nhs.uk

Leeds, 30 July 2014
London, 31 July 2014

Introduction and schedule for the workshop

Workshops were held in Leeds and London on 30 and 31 July, 2014 to engage commissioners and providers of acute NHS funded-health care on the proposed changes to the National Tariff 2015/16. Over 60 people attended each session.

This record gives an overview of the slides presented, together with summaries of feedback captured through plenary discussion and from the table posters which were used to capture the discussion.

Responses to the engagement documents and comments on draft national prices are due by **midday on Friday 15 August**

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Overview of the proposals for 2015/16

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What is this session about?

- The process for setting the 2015/16 national tariff
- Key themes for 2015/16
- The principles for decision-making
- Our engagement documents and the proposals they set out
- How you can get involved

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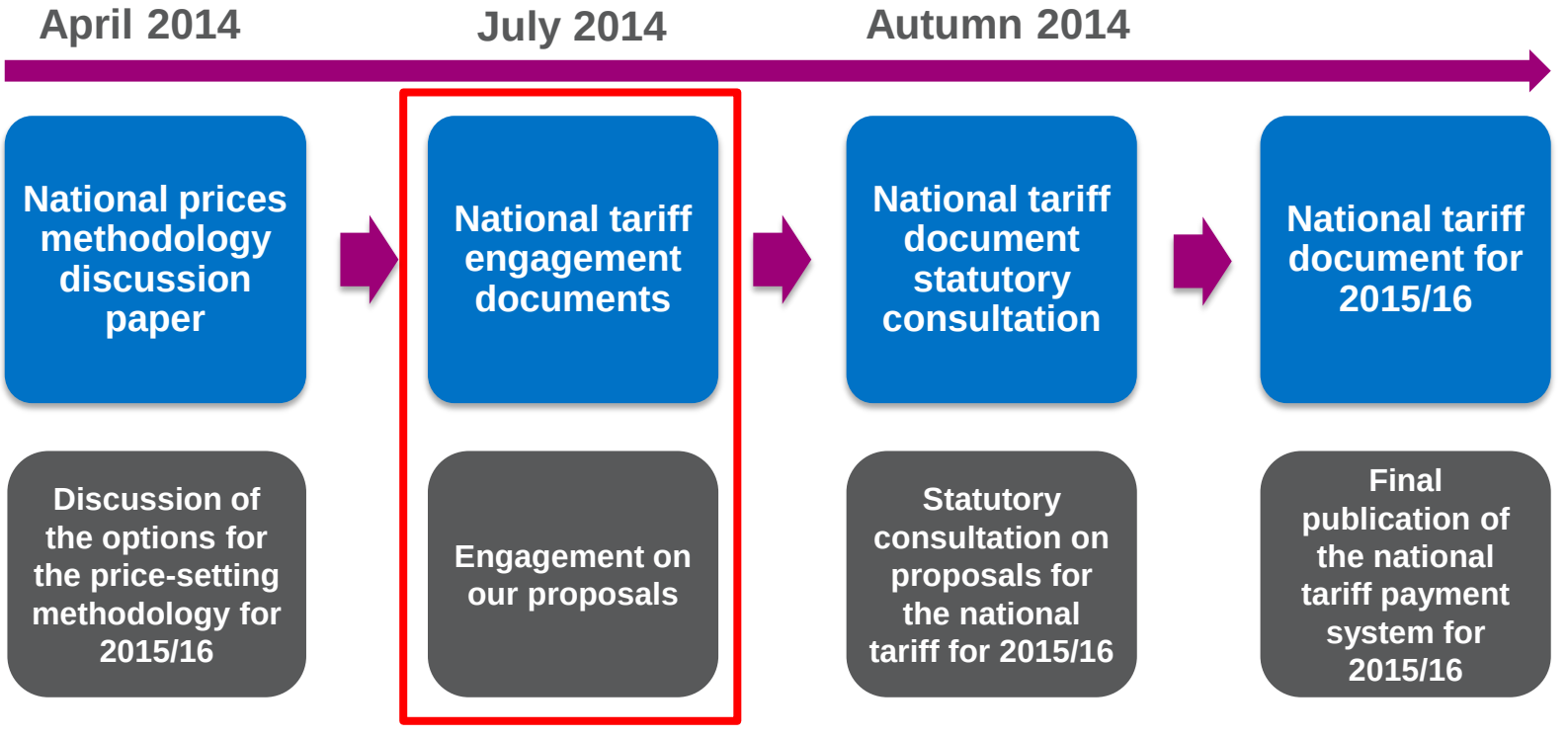
Overview of the process for 2015/16



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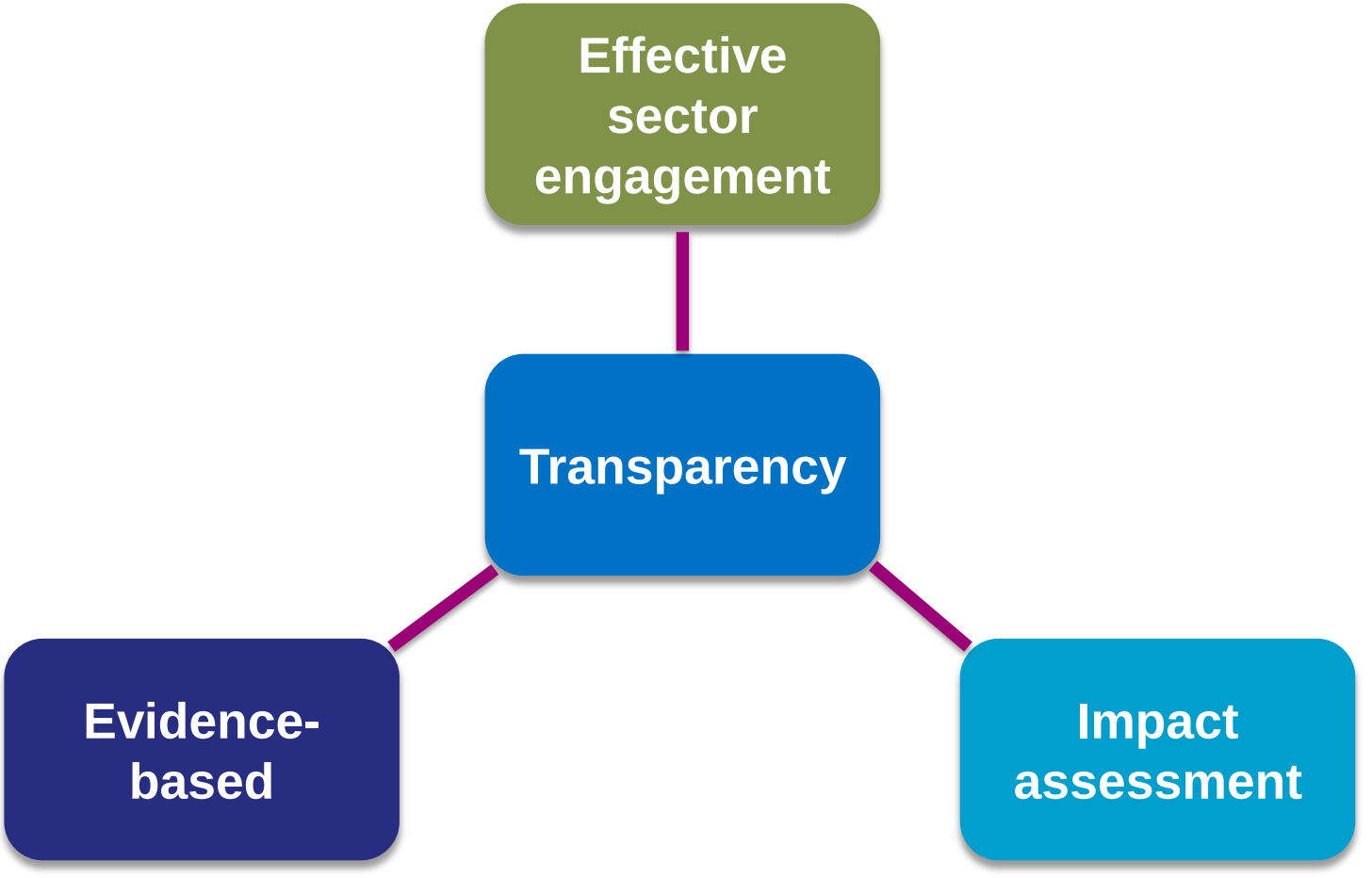
Key themes for 2015/16

Maintaining financial discipline while promoting high quality care in tough conditions

Encouraging transition to new payment designs at pace and scale

Strengthening the 'building blocks' of the national tariff

Principles for developing proposals



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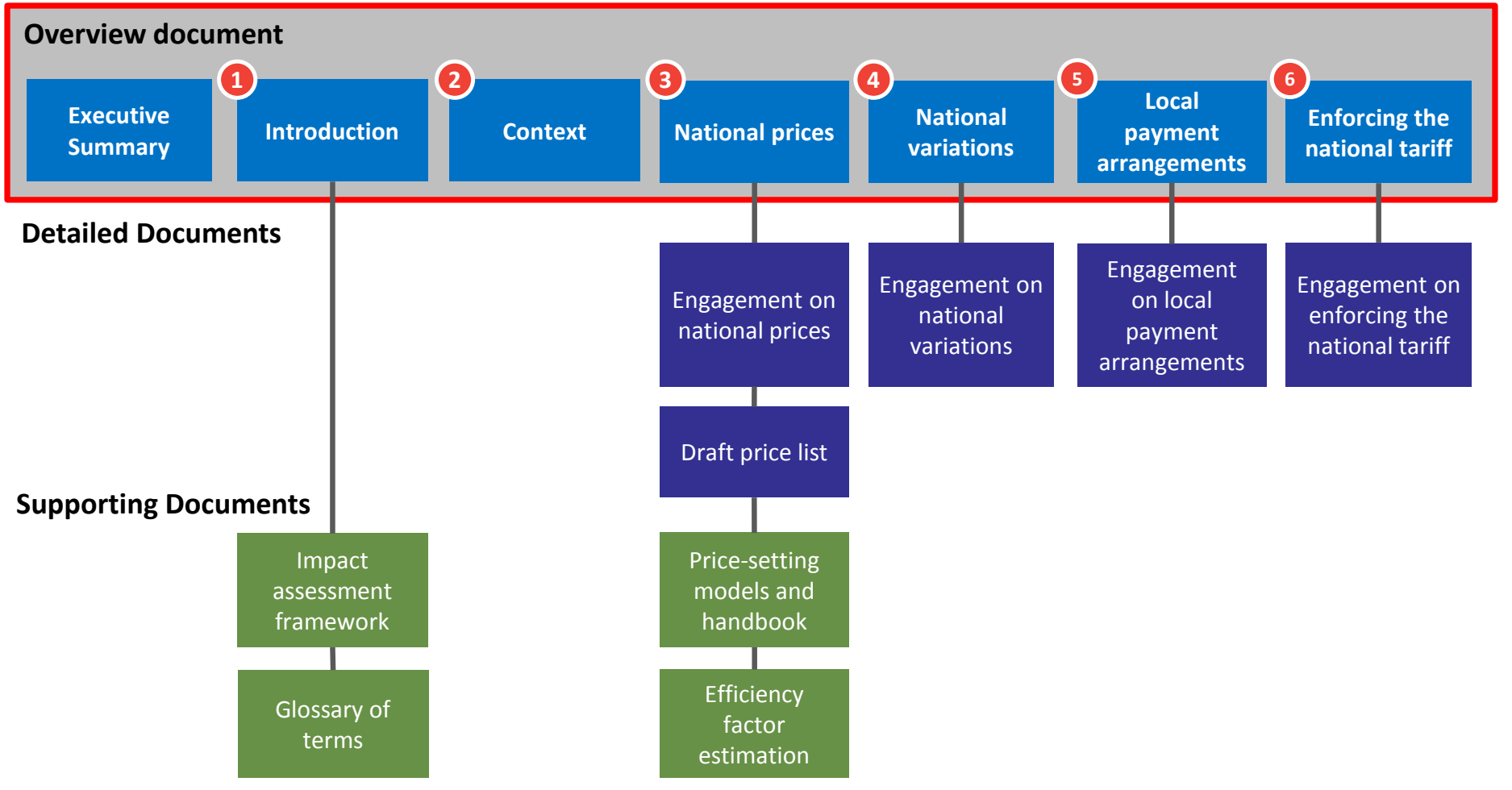
What is in the engagement documents?



Proposals for national currencies

- Move to 2011/12 HRG design (plus adjustments already in 2014/15)
- New national prices for 4 HRGs
- New heart failure best practice tariff + higher thresholds for 4 BPTs
- Update factors for assigning maternity pathways
- Update high-cost drugs and devices list

Proposals for price-setting model

- Modelling national prices from 2011/12 reference costs
- Comprehensive data cleaning rules
- Thorough quality-assurance and manual adjustments process
- Updating the short stay emergency tariff bands and eligibility
- Seeking views on the appropriate cost base for calculating prices

Proposals for cost adjustments to calculate national prices

Index costs to tariff year using factors from previous national tariffs

Retain last year's approach to cost uplift factors, introduce consultative process for service development uplift

Single efficiency factor approach, proposed within range of 3 – 5%

Engage on policy options for addressing 'additional actions' that constitute tariff leakage

Proposals for national variations

Remove the transitional arrangements for:

- **maternity pathway**
- **unbundled diagnostic imaging in outpatients**
- **chemotherapy delivery and external beam radiotherapy**

Retain the marginal rate rule and 30-day readmission rule while reviewing long-term reform of payment arrangements for urgent and emergency care

Retain market forces factor and specialist top-ups while reviewing long-term cost drivers. Consider appropriateness of top-ups in light of currency/cost base changes for 2015/16

Proposals for local payment arrangements

Guidance on mental health – rules and principles, cluster-based reporting

Supporting innovation by providing examples of payment designs

Retain rule on having regard to cost adjustment factors, engage on strengthening the guidance

Two options for promoting value in acute services without national prices

Proposed guidance for reporting requirements

- Submitting local modifications by 30 September 2015
- Including plans to address structural issues in local modifications
- Publishing on Monitor's website decisions on local modifications
- Identifying how benefits will be measured for local variations
- Identifying costs incurred due to service change for local variations

Questions for group discussion on efficiency factors

Group	Interest	Question
A	I am interested in the methodology used and modelling assumptions made when estimating the efficiency factor	What are the key things to consider when using historical data to inform a decision about an efficiency factor that is applied to a future year?
B	I am interested in the judgements that need to be made to set the specific efficiency factor from the range provided by the models	For an averagely efficient provider, what catch-up rate is reasonable in 1 year?
C	I am only interested in what the final number is	How should we consider the impact of the efficiency factor on providers and commissioners to get to a value that is in the best interest of patients?
All		What would be the impact on your organisation of an efficiency factor of: 3%, 4%, 5%?

Summary of feedback on efficiency factors

- Efficiency will only come from major structural change - efficiency gains can't be made forever. Where is the evidence for what is really deliverable?
- How can the tariff encourage different models and management at a local level? (This approach is not encouraging a system wide and collaborative response.)
- A single efficiency factor is a mistake – there is huge divergence in pressures (7 day working, nursing ratios etc) – it is difficult to develop a single answer for all circumstances. Suggest a dynamic efficiency factor which recognises individual cost pressures.
- Are we talking provider efficiency or efficiency for patients? How are patients involved in deciding this?
- It is a shared problem, not just acute; there is a risk of pushing them further into deficit.
- This is leading to movement away from PbR agreements.
- Historical data may not be the most accurate data source especially if it 2-3 years old. Need to take into account demographic trends.
- Efficiency factors based on individual providers (cost index). Low index score providers have less opportunities.
- These efficiency factors (particularly 5%) will lead to trusts being in deficit, reducing patient choice and working against collaboration. Broad consensus that 3% is realistic although many are planning on 4% (given the caveats above).

Promoting value in acute services without national prices

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What is the issue?

Payment for acute services without national prices has increased much faster than payment for those with national prices

Not looking at just prescribed services – there are a range of acute services outside national prices (eg non-consultant led outpatients)

NHS England considering longer-term changes to the way it commissions acute service without national prices

Lack of good costing and benchmarking data, and bias towards continuing with existing arrangements

We have identified 2 options to address the issue

Option 1 – strengthened guidance

Reiterate that local prices must comply with rules and principles in the national tariff (including reflecting efficient costs)

Set out expectation that providers would demonstrate efficient costs of service through improved transparency

Potentially change the NHS Standard Contract to strengthen provisions for commissioners to control reimbursement levels

Option 2 – rules

New rule or change an existing local price-setting rule to limit the growth in the price paid for acute services without national prices by reference to past trends. For example:

Introducing a marginal rate for services with established activity information flows, or indexation of block contract prices to a base year with marginal prices for volume adjustments

Introducing service level revenue caps (eg for each commissioner) across multiple providers, with payment based on a provider's share of total activity, with in-year monitoring

We are also interested in views on alternative solutions that would achieve the same aim

Potential additional requirements

We are considering 2 potential requirements which could be introduced in addition to either option. They are:

Full disclosure by providers of activity and cost data relating to the services in question

Provider service transformation plans that must be agreed with commissioners to secure greater efficiency for non-tariff services

Points of clarification on promoting value in acute services

- Q: What's behind the upward trend (average price, total quantum)?
- A: Overall spend is rising and the proportion going into these services is taking a bigger share (how much is driven by activity and how much by prices agreed?)
- Comment: Local prices are usually in response to a commissioner wanting lower than the national tariff (eg changing models of care such as nurse led clinics).
- Response: We do have some analysis – point well made.
- Q: Can we have some numbers to characterise this problem? And what about policy? Eg the country wants more transplants which are not nationally priced.
- Comment: Activity outside national tariff arose for a reason (eg specialist services prices can rise due to nature of activity). See next slide for supporting detail.
- Q: Do we know these services are not promoting value or is it simply difficult to account for them? Maybe they are good value.
- A: Good point; it may be that more work needs to be done to understand these issues. Maybe those without national tariffs are delivering value locally.

Supporting statistics on tariff expenditure

Annual growth in expenditure (2007/8 – 2011/12):

- National prices (PbR tariff) **+4.5%** per annum
- Local prices (non-tariff) **+8.4%** per annum

Expenditure split for 2012/13:

- National prices (PbR tariff) ~ **£30bn**
- Local prices (non-tariff) ~ **£12bn**

Summary of feedback on promoting value

Questions for groups:

- What should our response be to the upward trend in payment for acute services without national prices?
- How well would each of the options achieve the policy goal of promoting value for patients? Take into account payments for services without national prices, and accelerating convergence to prices that reflect the most efficient costs. Is there a better alternative?
- What issues would need to be considered in implementing each option?

Feedback:

- Increase in total quantum of cost is not an issue per se (driven by more local prices for redesigned services such as ambulatory care).
- Quantum of non-tariff services is increasing because the tariff has changed and more activity is now outside (eg unbundling of diagnostics, the increase in the categories for high cost drug and device exclusion).
- Need for clarity on why this is an issue (is it simply untidy?) Need to separate activity and pricing. For instance is it due to:
  - growth of activity in existing locally priced services?
  - activity moved from national prices to local prices?
  - an increase in unit price of existing locally priced services?
- The contract already has the levers to control the provider so the commissioner has the control
- If anything we should strengthen guidance to support local price setting to ensure value. This includes clarification of expected level of transparency/granularity in costings and expectations on reasonable margins that should be negotiated.
- 'Value for patients' needs definition if we are to improve it.

Local payment design examples

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What are we trying to achieve?

We want to encourage transition to new payment designs

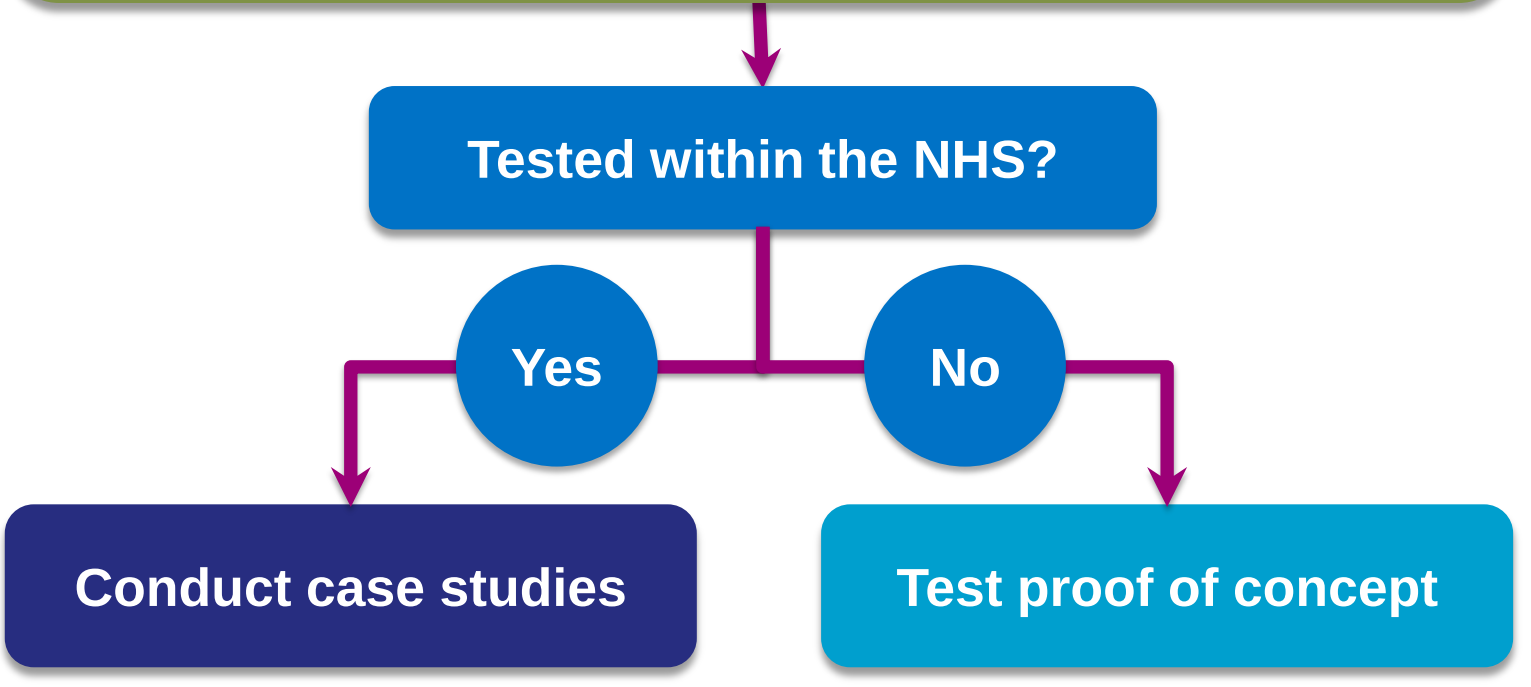
Transition should be in a considered and systematic way

For 2015/16 we want to encourage local adoption of promising payment approaches

The approach will be evaluated and considered for national roll-out in future years

What are local payment design examples?

Payment arrangements that deliver:
- **better outcomes for patients**
- **more efficient resource use**
- **appropriate risk allocation**



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The payment examples we are considering

Approaches that support integrated care:

- capitation payment
- disease-specific per person, per year payment
- needs assessment and care co-ordination
- risk sharing mechanisms
- personal health budgets

Approaches that support the reform of urgent and emergency care following review by Sir Bruce Keogh

Approaches that support opportunities in planned care:

- integrated outpatient tariff
- marginal rate for elective care

Mental health-specific approaches:

- bilateral risk-sharing with outcomes
- liaison psychiatry
- secure and forensic services pathway
- IAPT outcome-based payment

Points of clarification on local payment design examples

- Comment: With dementia liaison psychiatry is essential for unlocking care pathways. Seems it should be central and a large group.
- Response: This is actually a small numbers of patients but we do recognise the high cost.
- Comment: What about community services?
- Response: Aware there are lots of block contracts; we are working on that to describe currencies for community services (maybe we should have an example).
- Comment: There is the danger of making a complicated set of rules even more complicated. Have to design it locally, being told how to do it is irrelevant. Don't want to be told how to do integrated care. Do want local health economies to generate and then share examples but not to have them mandated.

Questions and summary of responses for group discussion

Questions	Responses
Is it helpful to make local payment design examples available?	• Yes, although context is important and they need to be specific and detailed • Marginal elective care tariff is unhelpful. It hasn't worked for emergency where there are current capacity issues at most trusts. The cost of understanding additional activity over the plan is often at a premium (eg weekend working).
Do the proposed payment examples cover the right combination of services?	• Any examples of delayed discharge or step-down/intermediate care tariffs to reimburse providers for patients still in their beds who don't need to be • GP services • Ambulatory care • More community activity • Children's services
What information would you require for the payment examples to be useful to you?	• Pathway definition • Shared information with pilot trust KPIs • Clear definitions about what is included in how outcomes can be measured • Website of examples would be useful • Who has tried the examples – can we talk to them?
What support would your local health economy require in order to be able to implement 1 (or more) of the proposed payment examples?	• Providers need support systems to capture this data in patient admin systems, not separate databases • Levers for influencing GP behaviour • Support in collecting and evaluating the data needed to be able to track payments/impact • Guidance useful but must be clearly trialled first

Group discussion: your key issues for 2015/16

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Key issues and questions for 2015/16

Key issue	Questions for groups to consider
Tariff leakage	• What forms of leakage are not in the best interest of patients? • When is it appropriate to adjust national prices for leakage?
Transitional arrangements	• What do you expect to be the impact of the proposed removal of the transitional arrangements? • How can we ensure appropriate risk sharing between commissioners and providers (specifically for this proposal)?
Maternity Pathway	• What are the current constraints to applying the maternity pathway payment in the best interests of patients? • What support can NHS England and Monitor offer at operational level to support application of the pathway payment? • What do you expect to be the impact of adding factors for allocating the pathways?
Cost uplifts	• Is a disaggregated approach materially better than a simple one (eg RPI)? • What types of information should be considered (and can you provide) when setting the service development uplift?
Best practice tariffs (BPT) and incentives	• For the proposed new BPT for heart failure, what are the costs and benefits of basing it on information submitted to the auditor including care practices? • What information should be considered (and can you provide) when deciding whether to move to higher thresholds for existing BPTs?
Local payment arrangements (LPAs)	• What do commissioners and providers need to ensure that LPAs are implemented in the best interest of patients? • How should we encourage the sharing of best practice LPAs?
Modelling national prices	• What principles should guide any manual adjustments we make to modelled prices? • What adjustments need to be made to reference costs to ensure that national prices only reflect efficient costs of providing services?
Specialist top-ups	• How do specialist top-ups currently affect your organisation? • What should guide future changes to specialist top-ups?

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Questions for groups

What forms of leakage are not in the best interest of patients?

When is it appropriate to adjust national prices for leakage?

Feedback

- It is important to get a clear definition and supporting evidence for leakage as well as guidance (there seems to be an implication that it is not benefitting patients). There are numerous dynamics conflating the issue which need to be unpicked.
- Leakage is the wrong term. The efficiency target is too onerous on providers – leakage is the only way to ensure they survive.
- The policy to control leakage is inappropriate if we do not understand the elements of it properly.
- All trusts should not be penalised for what only some do.
- Don’t lose the capability for CCGs and providers to work together to fix local problems with a bit flexible financing.

Questions for groups

What do you expect to be the impact of the proposed removal of the transitional arrangements?
How can we ensure appropriate risk sharing between commissioners and providers (specifically for this proposal)?

Feedback

- Have all trusts implemented equally?
- Maternity dataset is not there yet
- Benchmarking for diagnostics rates would be really helpful
- Clearer guidance needed on unmatched SUS data; there is currently an unclear logic for matching etc

Questions for groups

What are the current constraints to applying the maternity pathway payment in the best interests of patients?

What support can NHS England and Monitor offer at operational level to support application of the pathway payment?

What do you expect to be the impact of adding factors for allocating the pathways?

Feedback

- Unforeseen consequences, difficulties with data, resource intensity of P2P contracts, CCGs being double charged.
- All agree that the system has been introduced without essential IT backup (recording of info, national database) and there are major information problems. Full post-implementation review needed.
- Transparency over whether the standard pathway covers cost of some patients developing pregnancy related factors.
- Resource issues of providers contracting with other providers (debt collection etc).
- Need pragmatism – agree case mix % at start of year based on audit and use for whole year.
- Changes to criteria are ok but real issues are bigger (pathway clarity, consistency of criteria, inter-provider charging).
- Where new factors are introduced, we should be able to amend the level of care for patients part way through.
- Better if charge CCG per attendance but number of attendances capped?

Questions for groups

Is a disaggregated approach materially better than a simple one (eg RPI)?

What types of information should consider (and can you provide) when setting the service development uplift?

Feedback

- Yes, disaggregated approach better than simple (too simplistic for NHS) and could be extended to reflect the different cost inputs/services.
- Real need for transparency on how this is made up particularly for service development – commissioners and providers will use this to negotiate on any other local investments (eg 7 day working).
- Is there any national overview on potential efficiencies on CNST as this is soaking up significant resources?
- Need granularity.
- Need to retrospectively review; eg was last year's uplift sufficient and does it match changes in cost reported in provider's accounts?
- Last year's uplift did not get anywhere near to covering the real cost of Francis, next phase of 7 day working (as trusts have not been able to implement in a big bang), NICE, safer staffing.

Questions for groups

For the proposed new BPT for heart failure what are the costs and benefits of basing it on information submitted to the auditor including care practices?

What information should be considered (and can you provide) when deciding whether to move to higher thresholds for existing BPTs?

Feedback

- Publicise future direction of travel and forthcoming BPTs well in advance to give time to achieve (eg new heart failure BPT)
- Need to incentivise transition to BPT, not penalise providers
- Phased changes are best solutions for providers and trusts

KEY ISSUES – Local Payment Arrangements (LPAs)

Questions for groups

What do commissioners and providers need to ensure that LPAs are implemented in the best interest of patients?

How should we encourage the sharing of best practice LPAs?

Feedback

- Don't agree with the underlying assumption that price drives service value
- Patient value needs defining – get patients to define what outcomes they want
- KPIs needed to drive quality of care, build evaluation into the process – after action review
- Overall take a longer term approach to LPAs

KEY ISSUES – Modeling National Prices

Questions for groups

What principles should guide any manual adjustments we make to modelled prices?

What adjustments need to be made to reference costs to ensure that national prices only reflect efficient costs of providing services?

Feedback

- If complex is cheaper than non-complex, fix price at same for both
- Significant changes (year on year) may require averaging
- Concentrate on common HRGs only
- Comparison to PLICs output (in time)
- Check CQC rating – may exclude data
- Are reference costs a waste of time?

KEY ISSUES – Specialist Top-ups

Questions for groups

How do specialist top-ups currently affect your organisation?

What should guide future changes to specialist top-ups?

Feedback

- Need to move away from ‘one size fits all’ for providers; specialist top-ups too crude to reflect differences
- Link between specialist services and top-ups is causing problems
- Phase the changes to top-ups to ensure sustainability

Enforcing the national tariff

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Ideas for enforcing the national tariff - key points from talk*

- 2014/15 is the first year with a legal basis for enforcing the national tariff
- 2014/15 through to 2015/16 – keen not to go straight to enforcement but rather would want to understand issues to do with compliance (eg difficulties you're facing, why people may not be following the national tariff)
- 3 part strategy:
  - pragmatic short term improvements in transparency
  - series of step changes in use and quality of data
  - clean sheet redesign of how we do enforcement to drive out some of the unintended consequences from payment by results (perverse incentives need to be addressed with the sector)

* Slides were not used for this talk

Ideas for enforcing the national tariff

Question for groups

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

Feedback

- Find out what others have done and publish local variations
- If there isn't compliance, work out why; ensure rules are consistent and clear before publication
- Simplify process for local variations and modifications
- Ensuring all parts of the system comply equally
- Reintroduce the code of conduct that used to exist under PbR
- Ensure information sources in place before look at service change
- Safe haven for information sharing – doesn't breach confidentiality/commercial confidence
- Needs an independent arbiter
- Simplify tariff document (used to be 1, now there are several)
- Clarify consequences if a local agreement is deemed non-compliant
- Conduct random audits
- Need consistency of approach across all sectors; eg system resilience funding appears to encourage CCGs to pay outside tariff arrangements

Ideas for enforcing the national tariff

The remaining slides are from the group discussions that took place at both the Leeds and London Events.

Ideas for enforcing the national tariff

Discussions from the Leeds Event

Efficiency factor – group A

What are the key things to consider when using historical data to inform a decision about an efficiency factor that is applied to a future year?

- RPI - Basket of cost
- Efficiency = Cost OR Volume
- Is historical data an accurate source?
  - Individual based efficiency target per provider.
    - + Per Req Costs Index?
    - + Better Care indicator eg. Daycase rate.?
- How old the data is
- Trend in demand (current + future)

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

- Deficit - Deficit - Deficit
- Impact on Provider's ability to maintain SLAs
- 3% May be more acceptable to most Providers based on Planning assumptions

Efficiency factor – group B

For an averagely efficient provider, what catch-up rate is reasonable in one year?

CATCH UP IS ALREADY IMPLICIT IN TARIFF BY IT BEING AN AVERAGE

CAN'T BE ADDITIONAL TARGET IN TARIFF ON TOP OF THE SECTOR WIDE EFFICIENCY

WIDER EFFICIENCY DEBATE:

- THERE IS A FLOOR IN TERMS OF EFFICIENT COSTS VS QUALITY - CONSTRAINTS WITHIN NHS
  - ↳ STAFF
  - ↳ BUREAUCRACY
- REF COSTS BASIS VS FT REQUIREMENT TO MAKE SURPLUS

What would be the impact on your organisation of an efficiency factor of:

- **3%**
- **4%**
- **5%**

+ ALL PROVIDERS

- PRIVATE PROVIDER MAY HAVE TO CONSIDER WITHDRAWING FROM NHS WORK
  - ↳ WHERE DOES THE WORK GO?
- IMPACT ON REQUIRED INVESTMENT
- 5% NOT POSSIBLE WITHIN CURRENT SYSTEM
  + POLITICS
    - PATIENT CHOICE
    - KEEPING LOCAL SERVICES
    - MANDATED SERVICES
- 5% REQUIRES STRUCTURAL CHANGE - NOT POSSIBLE IN A YEAR
- 4% CHALLENGING - EASIER SAVINGS ALREADY MADE
- IMPACT OF CONTRACTUAL OBLIGATIONS + EXTRA COST - HAVE WE GOT PRIORITIES RIGHT? E.G KPIS / SUS REPORTING

• sudden cash inflows from e.g. Winter payments is not spent well/on structural reform.

Efficiency factor – group C

How should we consider the impact of the efficiency factor on providers and commissioners to get to a value that is in the best interest of patients?

- Downward pressure of EF drives providers → leakage
- Small, efficient providers ~~have~~ in independent sector can't find more efficiency
- Risk of more complex cases driven from independent to NHS providers
- Providers can't achieve more efficiency without structural, systemic change, beyond their individual control BUT
- Payment system needs to incentivise cooperation across types of service provider (eg. acute + community).
- Losing income doesn't always equate with losing cost for provider eg. if activity moves to community care
- Commissioners need to 'pump prime' providers to make efficiency gains but have no money for it.
- Pace of loss with E.F. doesn't allow time for structural change TIME
- Joint provider/commissioner structural solution essential for patients.

What would be the impact on your organisation of an efficiency factor of:

- **3%** — gives providers who achieve better than 3% opportunity may to spend extra efficiency gain on restructuring.
- **4%**
- **5%** → (panic) among acutes; could drive perverse behaviour e.g. a provider could cut 15 services
  - providers would 'cherry pick' if they could
  - MUST be detrimental to quality for patients. + choice

- Tariff doesn't put same financial pressure on other types of provider — MH, community etc. — as on acutes

The other types they don't have the same transparency.

- How can commissioners measure quality etc. unless it is activity + quality data measured.

- Many provides monitoring PbR but under block arrangements

Efficiency factor – group C

How should we consider the impact of the efficiency factor on providers and commissioners to get to a value that is in the best interest of patients?

- Which organisation (provides. or commissioners) can bare the impact of the efficiencies
- Should efficiencies be across acute / mental health + other?.
- Time in which to get there is difficult for providers - medium term change now as opposed to small scale cuts.
- Needs to provide a sustainable service - how to define this?
- Enforcing standardisation to drive efficiencies
- Provider + commissioner joint statement on efficiency?
- Pushing to local agreements + moving away from PbR.
- Depends on how acutes are performing to see who can deal with efficiencies

What would be the impact on your organisation of an efficiency factor of:

- **3%** Net 1.5%
- **4%** — CCGs planned for this.
- **5%**

- Depends on planning of Trusts + CCGs - If plans are showing a worse case then providers will be 'better off'
- Shifting problem between CCGs + providers.
- 4% in line with what has been signalled for planning
- Top slicing for those in need?
- Provides - planned for 4% but is this achievable?
- Which body has the best chance of delivery?
  - not a short term solution.
- Wider issues with cuts to social care...

1) HOW SHOULD WE CONSIDER THE IMPACT OF THE EFFICIENCY FACTOR ON PROVIDERS AND COMMISSIONERS TO GET A VALUE THAT IS IN THE BEST INTEREST OF PATIENTS?

- There are some services where you can't expect to make yr on yr savings without fundamentally Δ service design.
- Recognition that done all relatively easy stuff to deliver efficiencies - need to design incentives for commissioners / providers to collaborate or provider - providers collaboration to deliver efficiency.
- Still trying to identify services which are more efficient to deliver in comm'y.
- Conflicting pressures / messages
  - competition vs collaboration
  - integration (BCF)
- Tariffs should encourage best practice / service change
- Issues about how risk is shared across org^ns - not as simple as risk transfer.
- Service specifications are not helping / constraining ability to deliver efficiency
- Impact on different types of providers → small providers + market management.

2) WHAT WOULD BE THE IMPACT ON YOUR ORGANISATION OF AN EFFICIENCY FACTOR OF: 3% 4% 5%

- interested in the net figure, especially cost of service developments.
- If too high, leakage will ↑.

Efficiency factor – group C

How should we consider the impact of the efficiency factor on providers and commissioners to get to a value that is in the best interest of patients?

- If efficiency factor is set too high, will Trusts try to find ways around it?
- How can providers keep delivering efficiency
- Small providers can't compete so withdraw from market → reduced choice.
- For large providers they may not be able to withdraw.
- With all national drivers eg Francis + IF RTT + Stoll does this fit with efficiency factor

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

- Need to know what the uplift will be.
- If 5%, providers will not be able to afford to do what they need to do
- Might not be able to reduce further
- Need to stop inappropriate referrals or have a tariff that enables providers to triage or treat in a different way – eg telemedicine

(+)

- IS providers – have different complexities. No provider wishes to reduce quality
- Can't outsource if not economic for IS provider
- Need discussion about quality ie can →

① Can we afford all procedures to be carried out within 18 weeks? (c. 90%)

- However patient has the right to treatment within 18 weeks under the NHS Constitution
- Are there more opportunities to move elective → day cases or day cases → outpatient eg foot procedures (mine.) So could introduce new BPT
- Most Trust already have v. high CIPs + already made efficiencies year on year

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② In theory efficiency factor should reduce as providers are having to become more efficient + there is a limit to efficiency

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↑ CIP + efficiency vs national drivers in terms of staffing

→ Trusts in deficit
→ IS withdrawing
→ Patient choice reduced + quality will suffer

(−)

Problem :- ↑ CIP + efficiency vs natural drives on staffing + 18 week etc, quickly

↳ ↑ costs in deficit

↳ IS providers withdrawing

↳ patient choice + quality suffers

Solution :- Need to stop inappropriate referrals or have a tariff to enable triage

+

find alternative commissioning arrangements eg telemedicine where F to F is not required

+

pathway redesign

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

Is this a question more about volume rather than price? - prices currently being deflated annually

Set more national prices – critical care etc.

National price negotiations (with drug companies) for high cost drugs/devices

More National currencies?

↳ leading to more mandated tariffs

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

Mandate use of National deflator – already being done anyway?

Marginal payment not an effective solution in many cases, but in some areas/services may be possible

What issues would need to be considered in implementing each option?

See above

Transitional relief for new currencies/tariffs

Transparency in local prices

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

- upward trend in spend ≠ unexpected. Activity increases, HCD expansion.
- need to agree specific areas for review - have to be realistic what is do-able.
- Accuracy of costing models
- Are there more services ripe for transferring to national prices eg critical care?
- Tools for benchmarking costs + service delivery.

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

Option 1: reasonable but not clear how 3rd pt would work. - clarification of how contract would facilitate this. Normally contract reinforces national tariff rules so would expect clarification would come via national tariff guidance.

Alternative

- focus on currency development for specific agreed areas, involve stakeholders in benchmarking costs / prices. Need structured multi-year programme. Need a wide range of participants.

What issues would need to be considered in implementing each option?

→ blocks of services need to be considered differently eg high cost Drugs vs Critical Care

→ reliability of activity data currently, currencies and potential for counting changes/ accuracy.

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

* Why is there no tariff?
* Need to move to tariff?
  - Info/activity issues
  - Difficulty in identifying data definitions
* Look towards buckets of services?
* Some areas could be 'easier' to standardise e.g. critical care - old use critical care network datasets
* Need to identify know impacts on the trend e.g. transfer of TCS from PCTs to providers
* The feeling is that net efficiency on tariffs is also applied to local tariffs so why the upward trend?

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative? IS THIS SOMETHING NHSE SHOULD BE INVOLVING THEMSELVES IN?

① More guidance required to enforce

→ Feel that if providers & CCGs have agreed ~~to~~ a activity the isn't value for patients achieved??

③ Other options
* Cap e.g. 10% of activity can be non PbR
* Use networks e.g. critical care to set tariffs with agreed local variations

② Change the rules
- ↳ Transformational plan
- ↳ Need shadow timeframe
- ↳ What's the impact of marginal rate over threshold or capped overall & irrespective of activity growth

What issues would need to be considered in implementing each option?

* Really need more clarity/validation of ~~to~~ what is driving NHSE's concern.

1) WHAT SHOULD OUR RESPONSE BE TO THE UPWARD TREND IN PAYMENT FOR ACUTE SERVICES WITHOUT NATIONAL PRICES?

— EMPHASISE RULES + PRINCIPLES Commissioners + providers should follow to agree non-tariff services + payment: strategic guidance

- Is upward trend a good thing? Does it prevent acute admissions etc.
- Sometimes submitting reasons for Local Tariff hinders the implementation time we must until next contracting round.

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2. HOW WELL WOULD EACH OPTION ACHIEVE THE POLICY GOAL OF ~~ACHIEVING~~ PROMOTING VALUE FOR PATIENTS FROM PAYMENTS FOR SERVICES WITHOUT NATIONAL PRICES AND ACCELERATING CONVERGENCE TO PRICES THAT REFLECT MOST EFFICIENT COSTS? IS THERE A BETTER ALTERNATIVE?

- Need to ensure whatever guidance comes out is not open to interpretation
- Need to have rules that are clear and not complicated.
- Marginal rate would be better approach as opposed to cap.
-

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3. WHAT ISSUES WOULD NEED TO BE CONSIDERED IN IMPLEMENTING EACH OPTION?

- needs to promote innovation
- need to unpick these services to understand activity and cost of delivery
- Need to ensure activity is captured.
- Need to evaluate providers to engage in either option ie pump prime / invest to save.

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

- Historical / Volume
- changes in pathways / new pathways
- Use of resources, costs from ≃ 4yrs ago.
- Complexity going up?

- Giving options + tools is good.
- Pathway pricing
- Strengthen guidance

- Need to understand + support.
- Two views - do nothing - local commissioners will have the overview
  - do more work around why this is occurring
- Has this gone up due to an increase in reporting?
- Better understanding of blocks - activity behind this?
- Is this NHSE spend rather than CCG?

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

- Option 2 risks limiting spend on non tariff activity + therefore constrains innovation
- Local agreements allow flexibility in PbR / pathways
- Option 1 is more beneficial for providers + commissioners
- Option 2 - rigid?
- Option 1 - strengthen advice / non mandatory guidance + transparency so agreements which are of value can be shared.

Option 1 - allows for variations (local) better pathway for patients

What issues would need to be considered in implementing each option?

Option 1 - Need to get people engaged - a lot of work.

Option 2 - Stifling innovation
- Another imposed efficiency
- How do you monitor this.
- Acute non tariff? - some would count it as community
- Difficult to enforce
- How can this be calculated (% of total?)
- Implies that there can be a national tariff

Promoting value in acute services without national prices

DO WE UNDERSTAND WHAT'S CAUSING IT?
IMPACT OF NEW TECHNOLOGIES?

What should our response be to the upward trend in payment for acute services without national prices?

EVIDENCE OF TARIFF INCREASE?
CONTRADICTION BETWEEN NEW MODELS OF SERVICE DELIVERY AND MICRO-MANAGEMENT?
WHAT IS COST BASE FOR THESE TARIFFS?
FIXED COSTS v VARIABLE COSTS - SIZE OF ORGANISATION
DIFFERENT METHODOLOGIES BETWEEN PROVIDERS - RULES?

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

/ HISTORICAL
, COMPLETE REVIEW OF COSTS?
OPTION 1 WOULD RAISE COSTS - POTENTIALLY START CHARGING WHERE NOT PREVIOUSLY
OPTION 2 RESTRICTS ABILITY TO SET LOCAL TARIFFS - INCREASE ADMIN

OPTION 1 FAVOURED

OPTION 2 NOT VIABLE IN SHORT TERM

What issues would need to be considered in implementing each option?

SEE ABOVE!

CONSISTENCY
RISK IN FULL DISCLOSURE OF COSTS (OPTION 3)
IN ABILITY TO MAKE A CONTRIBUTION
HUGE PIECES OF WORK!

OUTLIERS? WHICH TRUSTS TO USE FOR SETTINGS COSTS?
SPECIALIST v DGH?

Local payment design examples

Is it helpful to make local payment design examples available?

Yes - practical + real examples useful
- lessons learned - good or bad
- don't have to adopt but good to see others work
- diff population groups identified is good
- information requirements & frail elderly / children etc. or wider pops:

Do the proposed payment examples cover the right mix of services?

- Should integrated care + urgent care be separate?
- Primary care? Poss not as part of this work.
- Pathway based tariffs - need to be careful not to cross-cut payments

What information would you require for the payment examples to be useful to you?

- Prescriptive is better (based on maternity work)
- Worked examples
- Info systems to support if required - information flows
- Modular payment system?
- Use of local variation / modification
- List of what is included / excluded

Numbers of examples?
- more than one as some things will not work where others do.
- options.

Risk sharing

Modelling could be done at a local level.

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

- Guidance - clear + concise. / detail.
- Toolkits
- If standard then guidance.
- I.G. - guidance
- Aligned between NHSE, Monitor + the TDA.
- Trialling of schemes + guidance

Local payment design examples

Is it helpful to make local payment design examples available?

Do the proposed payment examples cover the right mix of services?

What information would you require for the payment examples to be useful to you?

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

IS IT HELPFUL TO PROVIDE EXAMPLES?

- Integration agenda is key
- Disease-specific less of an issue. Co-morbidity is a greater issue - better example
- Examples generally useful

ARE THESE THE RIGHT EXAMPLES?

- Examples of payments for outcomes
- More BPTs → they incentivise BPT examples even if not mandated
- Marginal rate example not favoured
- Example of payment to incentivise movement of activity with example of payment to move to.

WHAT INFO ON THE EXAMPLES DO YOU NEED?

- Who should be charged for parts of a pathway
- Rules should be established
- How these examples benefit the sector and patients

WHAT SUPPORT TO IMPLEMENT?

- Financial support to set up

Local payment design examples

Is it helpful to make local payment design examples available?

Yes

Do the proposed payment examples cover the right mix of services?

- Condition based / Pathway specific
- Tariff linked to pathway
- marginal rate for elective ??
- Cross organisational linkage of data makes it more complex
- Capitation payment → Too much competition, not likely to work

What information would you require for the payment examples to be useful to you?

- worked examples
- clarity
- when it is not appropriate

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

- Clear guidance / definitions
- Information systems / data collection ensure linked up from the start
- Who is it done for
- Time scales for implementation are appropriate

* DO NOT AGREE WITH MARGINAL RATES FOR ELECTIVE CARE
(no patient benefit to this payment model)

Local payment design examples

Is it helpful to make local payment design examples available?

- YES - WOULD BE HELPFUL TO HAVE: A LONGER ~~PERIOD~~ LEAD IN TIME
- PRACTICALITY OF IMPLEMENTING CHANGES IN TIMESCALES : SIGHT OF 5 YEAR PRIORITIES / DIRECTION OF TRAVEL.
  - TIMESCALES
  - SYSTEM CHANGES
  - INFORMATION REQUIREMENTS
- THE MORE DETAIL BEHIND THE PAYMENT DESIGNS THE BETTER

Do the proposed payment examples cover the right mix of services?

Pathway Payments - Can work where patient stays with one provider for a considerable amount of time (CF / Paed Diabetes) NOT MPP

Capitation payments - Flexibility for prime provider to determine service model.

* ~~Risk~~ Development of Assessment tariffs

What information would you require for the payment examples to be useful to you?

- Evaluation of the new payment designs -
- Share experiences with pilot sites
- Impact on other providers - NHS + Non NHS
- Understand how Providers can manage the bureaucracy that new payment models introduce
- Demonstrate benefits to patients

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

Information Systems

Feedback on successes / failures + Context of implementation

Reduce bureaucracy

Local payment design examples

Is it helpful to make local payment design examples available?

- Always helpful to have local examples that can be tested.
- Publicise link to existing examples that may already been submitted.

Do the proposed payment examples cover the right mix of services?

- Signposting to which are more likely to come into tariff docs in future.
- Need to be fully tested before included in tariff.
- Rules of implementation to be clearly defined.

What information would you require for the payment examples to be useful to you?

- Outcome based measures.
- Best practice for patients.
- Robust monitoring frameworks.
- Consideration of data/information requirements and potential administrative burden.

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

- Needs to be a whole system approach i.e. linkages with primary care and implications.
- Recognition that these can be implemented through shadow format rather than mandatory.

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

- Information first + in place before follow on with service change
- Safe haven for information sharing
- Modernise non-elective tariff to reflect current practice KPI's etc.

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

- feels less rigid this year, allowing more scope for flexibility, but need clear, consistently interpreted rules.
- Clarity about where have flexibility
- Concise documents, written is an easily digestable form. 13/14 + 14/15 guidance feels more cumbersome than previously.
- FAQs were helpful - reinstate please helps consistency.
- If submit local variations, + then change in year, do we need to re-submit? Template feel to onerous + no feedback how being used, so for busy people feels too much.
- NHS England sending messages that don't necessarily need to follow rules e.g. system resilience funding can pay for things that normally we would argue is within tariff.
- Providers ability to record all elements of BPIs. Bureaucracy of multiple databases adds to complexity / bureaucracy
- Need to understand where variance from expected is valid - need to be sensitive about how enforcement works + ask questions.

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

- rules clear + tested
  - so no need for development of work arounds.
- simplification of the process for local modifications & local variations
- transparency in language used to allow comparisons between providers
- How do EOY agreements fit in?
- How do we address the issue of financial stability
- Risk pool
- Reconcile parts NTPS with real world 'deals'.

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

1. Threat of audit! Checking that tariff is applied Crandomly.
2. Publishing what other people have done – transparency.
3. Timely guidance and all in one go to ensure people are all working to the same
4. Monitor deadlines – quite new to some Trusts – awareness
5. Clear on responsibilities / accountability
6. Clarity between local variation and modification

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

- Mandatory Audits?
- Reintroduce a Code of Conduct?

Topic: LEAKAGE

Q1 WHEN IS IT APPROPRIATE TO ADJUST PRICES FOR LEAKAGE?

* REVERSE LEAKAGE
* THIS IS VERY MUCH DEPENDENT ON THE DEFINITION OF LEAKAGE AND THE EVIDENCE BASE BEHIND THIS.
* UNLESS ITS PROVEN AND EVIDENCE BASED AS TO WHAT 'LEAKAGE' IS, IT IS NOT APPROPRIATE TO ADJUST PRICES FOR THIS.
- LOCAL APPROACHES TO ADDRESSING THIS AND UNDERSTANDING EACH OF THE ISSUES RATHER THAN A NATIONAL DIRECTIVE.
- TAKE INTO CONSIDERATION THE CHANGES IN THE COMMISSIONING LANDSCAPE.

Q2 WHAT FORMS OF LEAKAGE ARE NOT IN THE INTEREST OF PATIENTS?

- LINK TO Q1, THIS IS DEPENDENT ON THE DEFINITION OF 'LEAKAGE'.

Topic: LEAKAGE

Q1 WHEN IS IT APPROPRIATE TO ADJUST PRICES FOR LEAKAGE?

- Risk in national adjustment as it would penalise all.
- Nationally not appropriate?
- Winter pressures / additional 7day money
- Paying a premium for capacity.
- Providers who are not being given leakage would say this is anti-competetive.
- Would not want to adjust for providers where there is a fixed component which is not in ref costs yet

Q2 WHAT FORMS OF LEAKAGE ARE NOT IN THE INTEREST OF PATIENTS?

- Premiums due to late additional funding?
- Building fenced 'winter planning' monies into allocations?
- Leakage should be transparent - one provider benefits + not another currently.
- Cherry picking low level activity? Leaving more expensive procedures with a certain provider? - Is this in the best interest?
- Propping up inefficient services
  - ↳ providers not utilising their efficiency savings appropriately
  - ↳ Should CCGs be 'strong' and not continue to prop up these hops
- Are any forms of leakage in the interests of pts?
- Should NHSE/Monitor say CCGs cannot do this?
- STHAs used to fill deficits.

Definition = what is "leakage."

Topic: LEAKAGE

Q1 WHEN IS IT APPROPRIATE TO ADJUST PRICES FOR LEAKAGE?

Can't adjust until tariff is right - ~~because the original tariffs~~
Providers have to meet the efficiency.
CCGs can't bail out providers
$ is reference cost information robust enough.

Q2 WHAT FORMS OF LEAKAGE ARE NOT IN THE INTEREST OF PATIENTS?

- Leakage tends to be non-recurrent short term
  Not = long term interest of Pts.
- Need a transparent equitable system
- Vast majority of income from commissioned services. So no.
- More national currencies with no national price to national tariffs.

Topic: LEAKAGE

Q1 When is it appropriate to adjust prices for leakage?

No.... but

* Mixed views, based on Provider / Commissioner setting!

Q2 What forms of leakage are not in the interest of patients?

1. Some coding changes....
2.

* agree definitions of "leakage"!
* Consider guidance around reference cost calculation?

LEAKAGE

When is it appropriate to adjust prices for leakage?

(? NON-RECURRENT)

- WHEN DEMAND REQUIRES EXTRA-ORDINARY COSTS / PRESSURES ON A PROVIDER WHICH WITHOUT ADDITIONAL INVESTMENT WOULDN'T / COULDN'T DO THE WORK. E.G. RTT DELIVERY
- TO RECOGNISE INNOVATION E.G. ADDITIONAL SKILL MIX / WAYS OF WORKING IN A+E

What forms of leakage are not in the interest of patients?

- 'REWARDING' PROVIDERS FOR 'POOR' PERFORMANCE / POOR EFFICIENCY

TRANSITION ARRANGEMENTS

WHAT DO YOU EXPECT TO BE THE IMPACT OF THE PROPOSED REMOVAL OF THE TRANSITIONAL ARRANGEMENTS?

Which ones - Not clear

- Chemotherapy – unknown impact on Cancer services for some Trusts - ie ~~SCE~~ Cancer.

- Diagnostic Imaging – Impact on Outpatient Pathway? Contradictory
  - ~~Clearly~~ 3 diff aspects.

- Maternity
  - Higher Risk
  - ISN not Developed and Mandated.
  -

HOW CAN WE ENSURE APPROPRIATE RISK SHARING BETWEEN COMMISSIONERS AND PROVIDERS? (SPECIFICALLY FOR THIS PROPOSAL)

- Local Variation ~~threshold~~ Endorsed.
- Benchmarking of Providers.
- Dataset Mandated before tariff + currency

Topic: BEST PRACTICE TARIFFS

Q1 FOR THE PROPOSED NEW BPT FOR HEART FAILURE, WHAT ARE THE COSTS AND BENEFITS OF BASING IT ON INFORMATION SUBMITTED TO THE AUDITOR INCLUDING EEI CARE PRACTICES?

- PROVIDERS NEED TIME TO UNDERSTAND THE PROPOSED CHANGE, IMPLEMENT APPROPRIATE SYSTEMS/PROCESSES
- MULTI YEARS THRESHOLD (PROGRESSIVELY TOWARD THE DESIRE LEVELS) FOR BOTH DATA SUBMISSION AND CLINICAL INPUT

Q2 WHAT INFORMATION SHOULD BE CONSIDERED, (AND YOU CAN PROVIDE) WHEN DECIDING WHETHER TO MOVE TO HIGHER THRESHOLDS FOR EXISTING BPTs?

- NEED TO BE NATIONALLY EXISTENCE
- A NUMBER OF HRG'S WITH LOS ≤ 1DAY SHOULD HAVE OPPSD TARIFF TO ENCOURAGE PROVIDERS TO ADAPT INNOVATIVE IDEAS.

Topic: BEST PRACTICE TARIFFS (BPT)

Q1 FOR THE PROPOSED NEW BPT FOR HEART FAILURE WHAT ARE THE COSTS AND BENEFITS OF BASING IT ON INFORMATION SUBMITTED TO THE AUDIT OR INCLUDING CARE PRACTICES?

1. NEED TO BASELINE QUALITY OF SUBMISSION
2. A DEADLINE FOR FULL DATA SUBMISSION IN ORDER TO SET CRITERIA FOR BPT.
3. NEED TO CONSIDER ADMIN BURDEN/COSTS

Q2 WHAT INFORMATION SHOULD BE CONSIDERED (AND YOU CAN PROVIDE) WHEN DECIDING WHETHER TO MOVE TO HIGHER THRESHOLDS FOR EXISTING BPTs?

1. DC/OP - Incentivise for efficiency - look at trends for past few years?
2. Require tolerances
3. Baseline where providers are. Share with providers so they can assess where they are.
4. Endoscopy - JAG process an issue?
5. Leave the Hip + Knee as is. Too early to suggest changes?

Topic: COST UPLIFTS

Q1 IS THE CURRENT DISAGGREGATED APPROACH MATERIALLY BETTER THAN A SIMPLE APPROACH? (RPI-X)

POSITIVE

- Helps for contract negotiation (SLA)
- Benchmarking information.
- Feels fair and transparent.
- Helpful for providers to set CIP & measure against.

NEGATIVE

- Difficult when dealing across different sectors (acute/community)

⇒ Consistency across all providers; true alignment is required

⇒ staffing levels ⇒ is this in service specs ⇒ is this in service developments/mandates? If not, need to be.

Q2 WHAT TYPE OF INFORMATION SHOULD WE CONSIDER (AND YOU CAN PROVIDE) TO SET THE SERVICE DEVELOPMENT UPLIFT?

- Do the figures/calculations need to be more transparent?
  ↳ yes, to assist contract negotiations. Methodology helps.
- Joint responsibility for info sharing.
- As much info as possible to provide a challenge.
- Timescales – all very last minute & wrap time of year.

£70s costs

* Did 14/15 uplift inc. Francis & Keogh? Testing & audit back with providers to understand if sufficient resource.

Post evaluation → point @ which this is undertaken

Topic: COST UPLIFTS

Q1

IS THE CURRENT DISAGGREGATED APPROACH MATERIALLY BETTER THAN A SIMPLE APPROACH? (RPI - X)

- YES, MORE GRANULAR ~~GRANULAR~~ IF THIS WAS BY DIFFERENT SECTORS. (DIFFERENT UPLIFTS FOR DIFFERENT CARE SETTINGS)

~~COST OF LIVING~~

Q2

WHAT TYPE OF INFORMATION SHOULD WE CONSIDER (AND YOU CAN PROVIDE) TO SET THE SERVICE DEVELOPMENT UPLIFT?

- PROVIDERS BASELINE - ALL DIFFERENT STARTING POINTS
- SEVEN DAY WORKING
- DO SERVICE DEVS NEED TO BE BUILT INTO GENERAL UPLIFT? (DIFFERENTIATE BETWEEN NATIONALLY MANDATED AND LOCALLY AGREED INNOVATION)
- MORE EVIDENCE ON UNDERLYING COSTS
- IMPACT ASSESSMENT AGAINST PROPOSED UPLIFT.
- SERVICE DEVELOPMENT @ A LOCAL LEVEL

Topic: MATERNITY

Q1 WHAT DO YOU EXPECT TO BE THE IMPACT OF ADDING FACTORS FOR ALLOCATING THE PATHWAYS?

OVERALL £ NEUTRAL
CHANGE % SPLIT OF ACTIVITY INTO EACH
HIGHER ACTIVITY INTO MORE INTENSIVE
INTERPRETATION OF CONDITION AND RECORDING
STANDARD MANDATED DATASET NEEDED
EFFECT OF CHANGE IN PRICES
OTHER ISSUES - CROSS CHARGING OF SERVICES

Q2 WHAT ARE THE CURRENT CONSTRAINTS OF IMPLEMENTING THE PATHWAY AND WHAT CAN WE DO TO IMPROVE THE SITUATION?

- FOETAL MEDICINE PART OF TARIFF
- MANDATED DATASET (APRIL) - VALIDATION
- TRANSPARENCY

REF COST 11-12 → REVISED PRICES BY PATHWAY ?

RECORDING OF DATA ?
FOR 14-15 REF COST SUBMISSION

Topic: MATERNITY

Q1 WHAT DO YOU EXPECT TO BE THE IMPACT OF ADDING FACTORS FOR ALLOCATING THE PATHWAYS?

- Local recording may not mirror national requirements. – National data collection
- ~~Ad~~ Must be well documented and be able to follow what has changed.
- Training requirement for midwives, etc
- Ability to model impacts at an earlier date
- What information has been utilised to inform this?
- Complexity of patient may become more apparent.
  - Not just measure at first assessment

Understanding change in coding

Q2 WHAT ARE THE CURRENT CONSTRAINTS OF IMPLEMENTING THE PATHWAY AND WHAT CAN WE DO TO IMPROVE THE SITUATION?

- Problems of inter-provider payments
- IG issues
- Assuming that sub-contracts will 'balance out' is not viable.
  - Have mandatory prices to aid discussion

→ ~~In~~ Even harder with IS providers?

- Start again!
- Get the maternity dataset (like SUS) up and running
- Is there even enough money?
- Alternatives in guidance.

Ideas for enforcing the national tariff

Discussions from the London Event

Efficiency factor – group A

What are the key things to consider when using historical data to inform a decision about an efficiency factor that is applied to a future year?

2) – growth ~~in~~ activity
   – Economic growth
   – Health budget
4) – Size of hospital influences possibility of achieving efficiency
   · Monitor: scale, case mix already taken into account
5) – Financial position of trusts – if ~~[illegible]~~ more ~~[illegible]~~ go into deficit, delay in use of costs makes deficit easier to happen
3) – Is efficiency well defined? Is patients view taken into account?
1) – Tariff is not the only way to foster efficiency
   → e.g.: too many tests detract from patient experience; waiting times not factored into efficiency computation
6) – Were previous efficiency factors assessed post implementation.

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

The higher the higher the probability of being in deficit.

* FRONTIER ELEMENT SHIFT (TECH ADVANCES)
* CATCH UP FACTOR

OVERALL COST OF THE SYSTEM GOING DOWN?

SPLIT BY HOSPITAL TYPE?

Efficiency factor – group B

NATIONAL DATA
LOCAL CONSISTENT

For an averagely efficient provider, what catch-up rate is reasonable in one year?

PROVIDER VIEW G/DP COMMISSIONER VIEW G/DP

(4) LOWER END OF RANGE BUT SUBJECT TO RECOGNITION OF COST PRESSURES

Dynamic

(3) FACTORS FOR CONSIDERATION
* OLD ESTATE
* PFI
* RECONFIGURATION POSSIBILITIES / SERVICE RATIONALISATIONS

COMMISSIONER ALLOCATIONS FIXED 2 YEARS

WHAT IS AN AVERAGELY EFFICIENT PROVIDER? (Pay) (Nurses) REF COST 100 HOPE

— CONTROLLABLE COSTS

BUILD UP OF COSTS — SERVICE DEVELOPMENTS (COST OF UNDERSTATED)

QUALITY AGENDA
→ 7 DAY WORKING
→ CONSULTANT LED SERVICES
→ NURSE STAFFING

CUMULATIVE SAVINGS ACHIEVED OVER LAST NUMBER OF YEARS — LESS ABLE TO MAKE SIGNIFICANT SAVINGS

TIMING OF COST SAVINGS — MORE THAN 1 YEAR — PUMP PRIMING INVESTMENT TO SAVE?

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

2% → 4%

3%

HONEST CONVERSATION ABOUT WHAT IS ACHIEVEABLE??

(2) + Definition of Efficiency — Avoidable costs going down?

(1) Good level of evidence about the issues

But

Efficiency factor – group B

For an averagely efficient provider, what catch-up rate is reasonable in one year? (Less Efficient Catching up with most efficient)

- Can be driven by quality of data capturing & reporting.
- Should consider troubled LHE & Providers in distress to understand issues & determine capability.
- Some Providers feel they cannot be any more efficient
- Some Providers require invest to save to become more efficient.
  - ↳ Also other forms of support & Resources.
- Concerns around addnl 1% applied due to the anticipated 2015/16 Yr ahead.
  - ↳ Not evidence based unlike 2.4%
- Consider Impact on Pts of Efficiency

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

- ~~Distinction~~ required of Essential vs Non-Essential Services Distinction
- Impact on Pt & Pt choice.
- May cherry-pick services (not provide the non-(RS)).
  - ↳ De-commission.
- Commissioners will pay less for services.
- Commercial Providers: cannot enforce this on them.
- Whats the trade-off / Safeguard offered by Commissioners to support Providers @ 5%
- 5%: Provider Deficits possible
- 3%: Commissioner Deficits

- removing local services in acute settings.
- more work on prevention & health promotion
- square the pump priming

Efficiency factor – group C

How should we consider the impact of the efficiency factor on providers and commissioners to get to a value that is in the best interest of patients?

As more things are prescribed how is efficiency achieved e.g. ratio of nurses to patients
running out of easy options
Engagement across all services
Risk of decision makers that do not have to clinically enable to achieve things like.
Double impact of efficiency & penalties.
HOW commissioners use ways to 'remove' money from secondary care. Cumulative effect of used currently.

May use CQUINs late & local incentives to improve efficiency.

~~Better~~ Different ways of dealing with DNAs.

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

↑ in PDC paid by monitor for all above.

Pressure on some providers that are in difficulty may lead to safety problems in some providers for all above.

Efficiency factor – group C

How should we consider the impact of the efficiency factor on providers and commissioners to get to a value that is in the best interest of patients?

- CUMULATIVE EFFECT OF CIPs
- HOW WE DELIVER
- REFERENCE COST COLLECTION 'IN-BUILDS' INEFFICIENCES (CAN PRICES BE 'TARGETS')
- RE-VISIT/CONSISTENCY OF REF COST DATA

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

- BALANCE BETWEEN COMMISSIONER & PROVIDER BOTTOM LINES.
- PROVIDERS DON'T HAVE MUCH FLEXIBILITY SINCE PAY TAKES UP C. 70% OF COSTS.
- PROCUREMENT EFFICIENCIES ARE DIFFICULT DUE TO INDIVIDUAL OPINION OF CLINICIANS (IN BEST INTEREST OF PT)
- EFFICIENCY DRIVE CAN LEAD TO SHORT-TERMISM
- POWER OF CLINICIANS SIGNIFICANT ISSUE.
- EASIER FOR INDEPENDENT SECTOR TO GET CIPs? ACCOUNTABILITY

Efficiency factor – group C

How should we consider the impact of the efficiency factor on providers and commissioners to get to a value that is in the best interest of patients?

Lack of alignment : QIPP Activity Reduction vs Efficiency Factor price reductions

Where's the flexibility to provide the investment to make service redesign happen?

Extreme financial pressures inhibit rather than promote collaborative working

What would be the impact on your organisation of an efficiency factor of:

- 3%
- 4%
- 5%

Is this the right question?

Shouldn't the focus be on finding ways that support health economies working collaboratively together?

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

WHAT'S DRIVING THE TREND? LEAKAGE / SERVICE DEVELOPMENT

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

CONSISTENCY - PROVISION + COMMISSIONING OF SERVICES

GOOD / CONSISTENT INFORMATION / COSTINGS

What issues would need to be considered in implementing each option?

IDENTIFYING BEST PRACTICE

DISSEMINATING INFORMATION / GETTING ENGAGEMENT

COMMERCIAL SENSITIVITY

WORKING THROUGH INTERPRETATION DIFFERENCES

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

Where's the problem?? This is a good thing?
eg. more ambulatory care, local ways of using nurse led services etc. etc.

Priority should be on the transformation of emergency care.

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

Commissioners already have all the levers they need to get Providers to conform where they need them to.

Making sharing of patient level data easier would help understanding and control

BPT can work well eg. Paediatric diabetes

What issues would need to be considered in implementing each option?

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

- Growth in highly Specialised Services
- Innovation to reduce Cost
-

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

- Rules based doesn't work. Its about Engagement
- Don't want to add to admin burden and Rule Lucey
-

What issues would need to be considered in implementing each option?

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

+ Strong focus coders at assessments – may be reason for ↑ in non tariff activity.

Develop currency + Tariff for some services.

Guidance that parties have the same local prices for different providers commissioners

Guidance of what is a local currency + local price needs to be simplified.

How they are reviewing Data to Monitor + NHS England to understand the trend. Better data dictionary of things. Tariff not keeping up with pace of change.

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

Option 1: Consistency of coding + setting prices for
– Simplify guidance is important.

Option 2: Marginal rate :. may stifle innovation as clinical practice may change

OK

What issues would need to be considered in implementing each option?

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

DO SOME MORE RESEARCH

TEST AGAINST NATIONAL POLICIES (E.G. FEWER CONSULTANT APPTS) AND LOCAL INNOVATIONS AT COMMISSIONER REQUEST.

HOW MUCH OF THIS IS DRUG COSTS?

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

MORE RULES + MORE GUIDANCE MAY STIFLE INNOVATION.

NO EVIDENCE THAT THESE SERVICES AREN'T EFFICIENT.

LEAVE ROOM FOR LOCAL AGREEMENT

USE REF COSTS TO WIDEN SCOPE OF N.T.
EG CRITICAL CARE / SCBU / NURSE APPTS.

What issues would need to be considered in implementing each option?

- NEED TO INVEST IN DATA! COLLECTION ∴ COSTS TO BE COVERED.
- IMPACT ASSESSMENT
- NEED FOR BENCHMARKS FOR CCG's

Promoting value in acute services without national prices

What should our response be to the upward trend in payment for acute services without national prices?

How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? Is there a better alternative?

What issues would need to be considered in implementing each option?

Local Payment Design Examples

Is it helpful to make local payment design examples available?

YES, examples of what's be successful.

Do the proposed payment examples cover the right mix of services?

Remove!!!

Marginal rate on elective.

↳ Running high occupancy.

↳ Extra lists (costs).

Community Care should be in the list.

What information would you require for the payment examples to be useful to you?

Be clear about activity capture & outcomes.

Commitment from different organisations to engage.

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

Focused support e.g Trust with specialised services.

~~Answer process.~~

COST CONTAINMENT → CIPP EXAMPLES

OPERATIONAL + CLINICAL SERVICE REDESIGN PATHWAYS Should come first and the drive the COSTS / PRICING MECHANISMS

YES

Local payment design examples

Is it helpful to make local payment design examples available?

* INTEGRATED CARE — SERVICES TOO VARIED . . CENTRAL GUIDANCE MAY BE UNHELPFUL

MARGINAL RATE FOR ELECTIVE CARE → Problem/BENEFIT FOR PROVIDER ?

Context Sensitive

PRIME CONTRACTOR

↳ MATERNITY

GUIDANCE → RULES

No MANDATING

Do the proposed payment examples cover the right mix of services?

Priorities

DETAILED Rules

→ Good STARTING point — WHICH EXAMPLES ARE MISSING?

BUT LOCAL CHOICE

- COMMUNITY SERVICES
- WHOLE SYSTEM PERSPECTIVE
- Local Authorities + GP PRACTICES * ACUTE PROVIDERS

What information would you require for the payment examples to be useful to you?

Context

Outpatient Attenders → Different WAYS OF TREATING PATIENTS → NEW ACTIVITIES → CLASSIFICATION

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

NEW activities

— CONTEXT — Problem Definition

— GOOD STAKEHOLDER RELATIONS IN THE HEALTH ECONOMY

— DEVELOPING PLANS Coding / DATA CAPTURE

→ EVIDENCE — Information

RISK MANAGEMENT

SCATTER GUN ∪ FOCUS

Local payment design examples

Is it helpful to make local payment design examples available?

- Yes ✓
- Create library of schemes + services for easy reference.

Do the proposed payment examples cover the right mix of services?

- Community Services
- Outcomes.

What information would you require for payment examples to be useful to you?

Shared learning
Experience of other implementors

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

Underwriting
Permission — to take the risk and to fail

Local payment design examples

Is it helpful to make local payment design examples available?

YES - BUT WILL THE EXAMPLES BE COMPREHENSIVE ENOUGH TO BE IMPLEMENTED LOCALLY? (SPECS, TARIFFS etc)

Do the proposed payment examples cover the right mix of services? COMMUNITY SERVICES

- SPECIFICALLY. THE STUFF THAT SUPPORTS INTEGRATED CARE.
- WORK WITH COUNCILS ON SOCIAL CARE AS WELL
- PLANNED CARE SHOULD BE EXCLUDED. (CONFLICT WITH OTHER POLICIES)

What information would you require for the payment examples to be useful to you?

- DETAILED SERVICE SPECIFICATIONS (+ CONTRIBUTIONS FROM EACH PROVIDER)
- EVIDENCE OF SUCCESS
- INFORMATION SYSTEMS THAT COLLECT THE RIGHT DATA.
- RISK SHARE RECOMMENDATIONS

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

- IM+T
- SERVICE REDESIGN / PEOPLE
- ALIGNMENT OF INCENTIVES ACROSS SOCIAL/PRIMARY/ACUTE CARE.
- CLEARER INFORMATION GOVERNANCE re PATIENT IDENTIFIERS.

Local payment design examples

Is it helpful to make local payment design examples available?

YES - Quality Assurance + joint case study (provider + commissioner with pat rep where possible) is important so can be certain they are 'good' examples.

Provides a framework for developing local payment designs.

Do the proposed payment examples cover the right mix of services?

They are not for specific areas - Could ~~provide~~ apply the principles to lots of other areas.

NO GP Ambulance + 111 + CPs are missing

Ambulatory assessments.

What information would you require for the payment examples to be useful to you?

Quality Assurance, what other models were assessed?

Evidence behind them

Benchmarking

A specific website + forum for people to access design examples

Business models - executable excel file for example.

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

Flexibility - no formal applications

Streamline the bureaucracy.

Local payment design examples

Is it helpful to make local payment design examples available?

Yes

V.
→ Not keen on marginal tariff (for elective inpatients)

Integrated outpatients tariff → not a good ideas
↳ Does not take into account complexity
↳ Complex patients in acute (↑ FU's) → easier cases in community

There is a need to ~~inter~~ have incentive in outpatients but not this approach

Do the proposed payment examples cover the right mix of services?

- GP services not covered. → (linked to IC services)
- Children services

Concern over capitation approach
↳ Commissioner might not be taking full ownership passed to private providers

What information would you require for the payment examples to be useful to you?

- Pathway (definition of what is in / out)
- Shared learning
- KPIs on delivery (DATA)
  ↳ Info system that works
    ↳ costing
    ↳ data collection.

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

- IT support (sector based database)
- Info on ease of implementation.

Local payment design examples

Is it helpful to make local payment design examples available?

Yes - as long as examples - rather than dictate

Need them as in current format tariff as mechanism to integrate + reform of services

Will need evaluation - important to make sure that encouraging the right things

Do the proposed payment examples cover the right mix of services?

Community a currency area. That needs real work.

GP with special interests how do their services fit as far as currency design + payment.

Framework for managed care of older people would be useful. CHENMED

What information would you require for the payment examples to be useful to you?

Worked examples with evaluation + context — open ended +ves + -ves

practical how to guides

information flows.

Concern about - cap per marg' rate per element

how to control referrals received — is it correct to be penalised for patients sent to you by GPs/comm^ts - what will it achieve.

determining excess copy is difficult.

What support would your local health economy require in order to be able to implement one (or more) of the proposed payment examples?

Information flows — ensuring information systems are in place first

Info governance - sharing patient info is a key enabler to making lots of things work better

ideas - one stop shop service

* Other streams of income → R+D → Private patients → Non recurrent
→ Education

Historical Efficiency Assumptions v Achieved Efficiency Assumptions

Topic: LEAKAGE

Q1 WHAT FORMS OF LEAKAGE ARE NOT IN THE BEST INTEREST OF PATIENTS?

* Definition of Leakage
  - → Good Leakage?
  - → Bad Leakage? — upcoding – coding improvement
* Intellectual problem macro economics of services
  + Does it matter?
* Are we measuring the right things?
* Base National Tariff not sophisticated enough
* Casemix Issues → Higher mix, more complicated activity

CCGs
Service restrictions
→ IFRs

Q2 WHEN IS IT APPROPRIATE TO ADJUST NATIONAL PRICES FOR LEAKAGE?

Unmanaged Cost Cutting — foregoing investment, reducing staffing rotas

Timing Issues
ST v LT.

Example
Evidence of upcoding → Enforcement action

Topic: LEAKAGE

Q1 WHAT FORMS OF LEAKAGE ARE NOT IN THE BEST INTEREST OF PATIENTS?

* WINTER PRESSURE FUNDING.
  ↳ & ADDITIONAL STAFFING AT PREMIUM

Q2 WHEN IS IT APPROPRIATE TO ADJUST NATIONAL PRICES FOR LEAKAGE?

NO

Topic: MATERNITY PATHWAY

Q1 WHAT ARE THE CURRENT CONSTRAINTS TO APPLYING THE MATERNITY PATHWAY PAYMENT IN THE BEST INTEREST OF PATIENTS?

- Data Collection
- Data Validation
- Inter Provider Data
- Control of attendance / inappop. visits / scans
- Payments ≠ the Joint Spec NHSE/CCG
-

Q2 WHAT SUPPORT CAN NHS ENGLAND & MONITOR OFFER AT OPERATIONAL LEVEL TO SUPPORT APPLICATION OF THE PATHWAY PAYMENT?

→ Systems / IT — Investment
→ Guidance at P2P & transf.
→ Transparency in complexity of delivery / Pathway costing and Coding.
→ Guidance on likely rates of deselection

Topic: MATERNITY PATHWAY

Q1 WHAT ARE THE CURRENT CONSTRAINTS TO APPLYING THE MATERNITY PATHWAY PAYMENT IN THE BEST INTEREST OF PATIENTS?

1. INFORMATION
   - about patients – capturing complications etc.
     - not having reliable lead provider status.
   - sharing between organisations – info. governance
     - paper-based data collection
2. RESOURCE IMPLICATIONS FOR RECHARGES
   - providers become "commissioners"
   - data validation
   - query resolution between providers
3. AMBIGUOUS CLEAR DEFINITIONS OF FACTORS. - difficulty to assign intensity levels
4. BAD DEBT BETWEEN PROVIDERS – financial risk of unpaid invoices where lead provider status queried.

Q2 WHAT SUPPORT CAN NHS ENGLAND & MONITOR OFFER AT OPERATIONAL LEVEL TO SUPPORT APPLICATION OF THE PATHWAY PAYMENT?

1. WORK WITH HSCIC (+ IT Suppliers) TO ENSURE INFO. SYSTEMS ARE AVAILABLE - OPERATIONAL.
2. FUNDING AVAILABLE (or reflected through tariff) TO IMPLEMENT SYSTEMS FOR DATA CAPTURE
3. INFORMATION GOVERNANCE ARRANGEMENTS IN PLACE SO COMMISSIONERS PROVIDERS CAN SEE RELEVANT INFO ABOUT PATIENTS TO VALIDATE PATHWAY PAYMENTS.
4. CLEAR DEFINITIONS OF FACTORS
5. NATIONAL DATABASE OF LEAD PROVIDER STATUS
6. POST IMPLEMENTATION REVIEW
   - what has been cost benefit against providers/commissioners?
   - How have unnecessary interventions been reduced / patient care improved?
   - what lessons have been learnt to apply to future pathway models?

Topic: COST UPLIFTS

Q1 IS A DISAGGREGATED UPLIFT FACTOR MATERIALLY BETTER THAN A SIMPLE ONE (e.g. RPI)?

Too complex for one - NHS CNST

NHS inflation is ahead of RPI

We all understand our cost categories so disaggregation is helpful

Service development cost - Francis
- Consultant led care
- 7 day services

} under estimated in tariff uplift

New Equipment costs / New service Development - should uplift be added? ← strong policy push for innovation / R&D monies stifling innovation

Tailored uplift based on portfolio of service versus one rate for all

Q2 WHAT TYPE OF INFORMATION SHOULD WE CONSIDER (AND YOU CAN PROVIDE) TO INFORM SETTING THE SERVICE DEVELOPMENT UPLIFT?

More honesty on what is really required. Investment required is not reflected as the uplift provided.

NICE increases not in tariff are these to be in service development.

It is not just the mandate. Also 7 day working is being implemented in phases. Some Trusts better understanding of cost base.

Have a look backward to last year to see if there is FYE needed.

Topic: COST UPLIFTS

Q1 IS A DISAGGREGATED APPROACH MATERIALLY BETTER THAN A SIMPL ONE (e.g RPI)? / CENTRALLY FOCUSES EXPERTISE

Q JUST REDUCED EFFICIENCY? FLEXIBILITY NOT NECESSARILY HELPFUL. | AVOID DISTRACTION LOCALLY.

A OR PROTECTS PROV + OR COMPLIS BY HAVING TRANSPARENT FIGURE.

COMP TO RPI WHAT HAS INFLATION RUN AT.

SIMPLE - WILL STILL B EFF. (IENCIES WIPING IT OUT
v
MORE PRECISE

BUDGET. IS THE BUDGET.

TRANSPARENCY RE LEAKAGE SPECIFIC 2 ALL SECTOR?

Q2 WHAT TYPES OF INFORMATION SHOULD WE CONSIDER (AND YOU CAN PROVIDE) WHEN SETTING THE SERVICE DEVELOPMENT UPLIFT?

AFC INFLATION

SAFER STAFFING

STAFF SCARCITY — TEMP / BANK / INTERIM.

SERVICE DEVEL

DEMAND.

MFF REVIEW (SPORADICALLY)

Honest Discussion
→ Demand Management
→ Opps working

→ After Action Review → Did the Local Payments Arrangements work?

+ Testing Assumptions +

→ Reassessment Appropriately Dur

Topic: LOCAL PAYMENT ARRANGEMENTS (LPAs)

"Gaming Behaviour"

Q1 WHAT DO COMMISSIONERS & PROVIDERS NEED TO DO TO ENSURE THAT LPAs ARE IMPLEMENTED IN THE BEST INTEREST OF PATIENTS?

Wider Economy Context
↳ Resource Shortage
Provider Stability
↓ Affordability

* Definition – What are the best interests of patients?
  * + Outcomes
  * + Financial Efficiency
  * + Patient Experience / Perception
  * + Readmissions
  * + Right Appropriate Clinical Setting

* Prioritisation of Commissioning Intentions Balancing Priorities

* Affordability
  ↳ Rationing
  ↳ Trade Offs

* Commissioners
  Providers
  Patients
  → Alignments of views (Prices ↑ Prices ↓)
  → Expectations
  → Sponsorship – Distinct set of outcomes

* Cross Subsidisation Issues
Tariff v Local Prices

* Implementing the LPAs – Clinically Driven Access to the Team / Function Working → Evidence Based. → Access to Appropriate Data for Decision Making

Q2 HOW SHOULD WE ENCOURAGE THE SHARING OF BEST PRACTICE USE OF LPAs?

* Training / Piloting – Acceptance of Risks

* Local Pricing Variations / Modifications – Published Nationally on Website
  → Signposting of Relevant Sources of Information to help Easier Access
  → Key Words Search

Enforcement Team

Topic: LOCAL PAYMENT ARRANGEMENTS (LPAs)

Q1 WHAT DO COMMISSIONERS & PROVIDERS NEED TO DO TO ENSURE THAT LPAs ARE IMPLEMENTED IN THE BEST INTEREST OF PATIENTS?

- the price isn't the bit that is in patent interests
- incentives / sanctions aren't just about ££
- Common understanding
- price must not be the only factor in local arrangements
- prices can only go so far before price affects services - how do we ensure minimum svc levels
- engagement with clinicians - maybe some guidance on what good consultation looks like
- Clear KPI's - Value to patients

Q2 HOW SHOULD WE ENCOURAGE THE SHARING OF BEST PRACTICE USE OF LPAs?

- all local payments are submitted along with the local prices (what currencies - what information can be shared)
- build evaluation into the process
- a longer term approach to LPA's

SPECIALIST TOP-UPS

1. HOW DO SPECIALIST TOP-UPS CURRENTLY AFFECT YOUR ORGANISATION?

Link between specialist services rules + TOP UPS - is causing probs

Activity for Rheumatology - has significant impact.

Docs seem to help with services specifications,

Data quality initiatives to improve coding for eligible procedures

2. WHAT SHOULD GUIDE FUTURE CHANGES TO SPECIALIST TOP-UPS?

1) Phasing changes to top-ups - to ensure sustainable.

2) Perhaps more granularity in HRGs, rather than top-up - but TOP-ups are

3) [illegible]

SPECIALIST TOP-UP

1. HOW DO SPECIALIST TOP-UPS CURRENTLY AFFECT YOUR ORGANISATION?

1) - 28 to 32% NS revenue (small specialist Trust)
   - small % (acute treatment centre - digestive diseases)
   - CCG - much specialist care went to NHS England.
2) - Criteria for eligible providers ill defined in certain areas - focussed on provider characteristics rather than service organization and quality.
   - Really sick patients do not get sufficiently high top-ups - providers dealing with very sick patients affected (not enough granularity of the system)
   - CCG: not always eligible providers are that different from non eligible providers - the former get more money for essentially the same service
3) E.g.: Why does mostly everyone get specialist Top Ups for Trauma & Orthopaedics?! Why?

2. WHAT SHOULD GUIDE FUTURE CHANGES TO SPECIALIST TOP-UPS?

1) Some specialities are under/over subdivided - granularity should be improved
4) Phasing over of changes that may compromise stability
1) Focus on patients, make sure money follows patient
3) Rethink criteria for ~~becoming/staying~~ eligible providers
   - Some care pathway may have providers/services that would not be eligible for receiving top-up payments.

Topic: MODELLING NATIONAL PRICES

Q1 WHAT PRINCIPLES SHOULD GUIDE ANY MANUAL ADJUSTMENTS WE MAKE TO MODELLED PRICES?

- if complex cheaper than non-complex → fix price at same for both.
- Significant changes (year on year) - may require averaging.
- Comparism to PLICS output (in time)
- Concentrate on common HRG's only
- check CQC rating - may exclude data.

Q2 WHAT ADJUSTMENTS NEED TO BE MADE TO REFERENCE COSTS TO ENSURE THAT NATIONAL PRICES ONLY REFLECT EFFICIENT COSTS OF PROVIDING SERVICES?

- IS reference costs a waste of time ?

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff ?

- CLARITY
- SET OF RULES & FEEDBACK.
- MONITOR NON-ACTIVITY PAYMENTS (NON RECURRENT FUNDING)
- CLEAR STATEMENT WHY.

Thinking about the proposals & ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules & principles in the national tariff?

- More open discussions without fear of repercussions if local idea Fail.
- Equal spread & Notice of when information is required / Requested.
- Asking 'non NHS' providers.
- Understanding on why we are being Compliant and why the info provided is useful and what is it used for. (provide)
- Earlier deadlines, allowing more notice for commissioning contracts.
- Greater Flexibility on deadlines.
- Cross border issues, greater clarity of Treatment of Welsh, Scottish, NI CCG's treatment

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

Plain + clear definitions

Structure: avoid unnecessary duplication / repetitions with slightly different words

Splitting up in Annexes etc + different documents not helpful.

Unreasonable to expect people to remember what was published last year. Need to highlight New but re-state the old.

Not stifle innovation: having sufficient clear guidance about what 'innovation' becomes non-compliance.

Clear messages in the engagement + consultation exercises.

Simple guide to PDR type of document would be helpful

Make templates simpler

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

1. LISTEN TO THE SERVICE TO UNDERSTAND WHY THEY DON'T WANT TO USE THE RULES (E.G LOCAL "ASSESSMENT" ~~CARE~~ TARIFFS.

2. CONTRACTS ARE BASED ON TOTAL COST TO BE "AFFORDABLE" AND DETAILS ARE WORKED IN TO FIT.

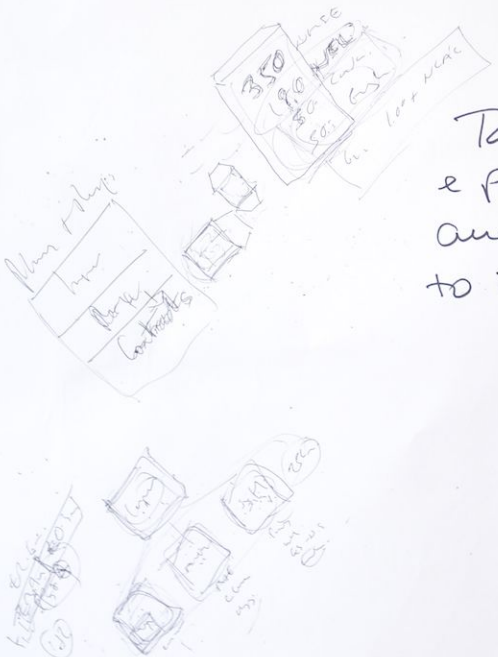
3 TO ENSURE COMPLIANCE ENSURE UNIVERSAL AFFORDABILITY BY USING THE RULES

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

Quality of documentation (supporting guidence) has deteriorated — Can we go back to having one document that's properly indexed please!

Aren't we all compliant?? where are all the non-compliant organisations?

Talk to commissioners & providers before auditing the provider to identify concerns



Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?

- Do we need someone independent to escalate issues to? A referee.
- When escalating at the mo', Monitor / NHS England TDA / NHS England who have vested interests in the outcome.
- Guidance is not definitive. ⇒
- Enquiries posed are sometimes receive vague responses / open to interpretation.
- What is it about enforcing the tariff that is for benefit of patients?
  If you assume tariffs are right, then that it is best for patient follows BUT
  If in local patch it is not right, then that it is best for local patients BUT
  we have a set of rules to allow flexibility.
  Don't enforce something that is not perfect.
- Monitor is at stage of understanding why people break away from tariff
- Need clarity around spirit, framework to pin tariff + rules to.
  Tariff & Local modifications need to be an easy process - if commissioner + provider agree why additional layer.

Actions that we want Monitor to take to follow rules in tariff document?

Thinking about the proposals and ideas you've discussed today, how can we ensure that their implementation at local level complies with the rules and principles in the national tariff?