BMA House
Tavistock Square
London WC1H 9JP

T 0207 383 6253
E jware@bma.org.uk

BMA

England

Pricing team
NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

By email: pricing@improvement.nhs.uk

Dear Sir/Madam

The BMA (British Medical Association) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The Association welcomes the opportunity to provide our comments on the proposed 2019-20 National Tariff Payment System.

We hope that our comments are useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Lena Levy
Head of Public Health and Healthcare
British Medical Association

BMA

BMA response to NHSI consultation on proposed changes to the national tariff, 2019-20

Executive summary

- There are currently huge financial challenges facing the NHS, which the additional £20.5 billion promised by the government as part of the Long Term Plan package will only partly address. In this context, and given the uncertainty ahead for the NHS post-Brexit, we agree that a one-year tariff is sensible, but we would want to see a return to a multi-year approach in future.
- The proposed changes to payments for emergency care represent a step away from purely activity-based payment models in secondary care – something the BMA has long called for to promote integrated working and reduce perverse incentives. However, it is important that that providers are not forced to set unrealistic baselines and that measures that aim to reduce hospital emergency activity go hand in with ensuring that other parts of the system have sufficient resources to support this. Clinician input into any locally agreed changes is vital.
- The proposed changes to the Market Forces Factor could cause significant disruption at a difficult time for NHS trusts. The omission of both PFI and rurality from the proposed approach is also a missed opportunity.
- We are concerned that proposed changes to the way the NHS procures products risk leaving NHS organisations with funding shortfalls if expected savings from the new approach do not materialise.
- Significant changes to payments for outpatient appointments are proposed, but it is not clear what safeguards will be in place to ensure that any move towards greater use of non-face-to-face and non-consultant appointments are based on robust evidence and are safe for patients.

Proposal to set the tariff for one year

The BMA broadly agrees with this proposal. We welcomed the 2017/19 two-year tariff due to the greater stability it could bring and the possibility of making long term planning easier. However, in light of the uncertainty ahead over the next year for the NHS and the UK economy around our exit from the EU, we agree a one-year tariff is sensible. We also recognise that a single year approach provides greater opportunity to review the effectiveness of the changes being proposed for this year, such as the blended tariff for emergency care. Over the longer term however we want to see the return to a multi-year tariff.

Blended payment for emergency care and abolition of the marginal rate emergency tariff (MRET)

The BMA has long argued that existing payment systems in secondary care represent a significant barrier to encouraging greater integration of services across traditional organisational boundaries. It is now widely recognised that payment systems that encourage organisations to take on more activity as a means of gaining additional income have led to perverse incentives. The BMA would like to see payment systems fundamentally reformed to encourage different parts of the NHS to collaborate across divides based on shared incentives that have high quality patient care at their core.

The proposals for a new blended payment for emergency care are a step in the right direction towards achieving this. We agree that local areas should be able to maintain different payment models they have already agreed, or agree new alternative approaches, enabling enough flexibility for areas that feel ready to move to more advanced payment models.

We do have some concerns in this area, however:

- Creating a more integrated NHS and reducing unplanned emergency admissions will require significantly more funding, so it is important to be realistic about how much health systems will be able to achieve in the coming years. It is vital that where commissioners aim to reduce pressure on emergency departments, they build up capacity in parts of the system (such as community and primary care) that are expected to do more to keep patients out of these settings.
- It is vital that clinicians are adequately consulted on and engaged in any local changes to payment models. There is a risk that growing variation in (increasingly complex) payment models across England will create a confusing network of different systems, reducing overall transparency and accountability. It is vital that adequate evaluation is built into this process and that as much information as possible is public – this will improve transparency and also encourage different areas to learn from each other and develop common approaches. In future, once there is more information available on the effectiveness of different approaches, there should be national parameters (with room for local flexibility) to ensure that variation in payment models is consolidated.
- The inclusion of ambulatory care in the new blended tariff approach seems counterintuitive if the aim is to encourage trusts to reduce their emergency department activity. Ambulatory care is commonly used as a way of reducing traditional ED attendance and/or hospital admissions. The inclusion of ambulatory care in the proposed new tariff means there is little incentive for trusts to shift care away from the front door via ambulation.

We agree with the proposal to abolish the marginal rate emergency tariff (MRET) and the 30-day readmission rule as national rules. As we have said in previous submissions, the principle behind the MRET rule is flawed – providers have little control over demand within emergency services and penalising them financially for closing services or redirecting patients when services have become unsafe puts acute trusts under additional strain.

Updating the data and methodology used to calculate the market forces factor (MFF)

We agree that in principle it makes sense to ensure that the data used to calculate the MFF is fully up to date. However, we share the concerns highlighted by stakeholders in the consultation document that the proposed changes could cause disruption at a time of significant pressure and uncertainty for the NHS. We recognise though that the proposed transition period will help mitigate some of these risks.

We would echo the views of other stakeholders that PFI (private finance initiative) costs need to be addressed alongside the MFF, given the significant impact these have for many trusts. We recognise that NHSI has proposed elsewhere a lump-sum compensation scheme to address this, and we look forward to seeing further detail and working with NHSI to implement this.

Finally, the consultation document notes that including measures relating to rurality has been raised by other stakeholders but does not set out what assessment has been made of whether this should be included. We would welcome further detail from NHSI on what assessment they have made in this area and what steps are being taken to ensure that rural areas receive adequate funding.

Changes in arrangements for procuring products for the NHS

We agree in principle with the aim of reducing procurement costs for the whole NHS through a more centralised approach. However, we echo concerns expressed by other stakeholders about the level of financial risk the proposed approach places on providers, whose funding will effectively be cut in the expectation that the new approach through Supply Chain Coordination Ltd (SCCL) will deliver sufficient savings. We urge NHSI to change it's approach here and ensure that savings are confirmed before any money is cut from the tariff. The consultation document mentions that NHSI will review the savings achieved from the new procurement model – it is vital that if this review takes place its findings are made public.

Maternity payment pathway

The proposal to make maternity pathway prices non-mandatory comes with risks (identified in the consultation document) that this change could lead to unnecessary disruption and more protracted negotiations between commissioners and providers. A longer-term solution is needed including legislative change if necessary. The BMA has longstanding policy advocating bringing public health back within the remit of the NHS, which would solve this problem.

Changes to pricing for outpatient services

The consultation document proposes a number of changes to the way outpatient services are priced, including creating non-mandatory prices for non-face-to-face follow-ups for specialties with national prices, as well as non-mandatory prices for non-consultant-led first and follow up attendances and changes to the front-loading of first attendances. These are significant changes and careful monitoring will be required to measure the impact they are having on patient care in the NHS.

Crucial to the viability of these changes is whether increasing non-face-to-face and non-consultant contacts in the NHS will be clinically appropriate as suggested in the consultation. It is not clear from the consultation document what safeguards, if any, will be in place to ensure that patient safety is kept paramount, and that non-face-to-face and non-consultant appointments are used based on robust evidence. There is a risk that without safeguards, trusts (given the financial pressure they are under) will see the proposed changes as an opportunity to reduce costs, which should not be prioritised ahead of patient safety. We would welcome clarification on this point from NHSI.

It is vital that there is adequate engagement with consultants and others working in outpatients' services – as well as with patients – at a local level where the proposed new approach is undertaken (and in the more radical pilots mentioned in the consultation document as being about to get underway, about which the BMA would welcome further information).

Specifically in relation to non-face-to-face appointments, there is a risk that incentivising this approach could disadvantage patients who do not have access to or cannot use the required technology. We must not incentivise an NHS where you become a second-class patient if you cannot use digital technology – again, we would welcome clarity from NHSI on how it intends to avoid this.

Finally, it is important to consider the impact of incentivising reductions in follow up appointments on the wider system. For example, reduced follow up appointments could potentially increase A&E attendances or shift workload towards other parts of the system such as general practice.