

Response ID ANON-WSRN-QKPJ-Z

Submitted to **2021/22 tariff engagement**

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About you

Which tariff engagement workshop did you attend?

Event attendance:

30 October - afternoon

If you did not attend a workshop, how did you find out about the policies discussed?:

Attended by colleagues

What is your name?

Name:

Richard Knight

What is your email address?

Email:

richardknight@locsu.co.uk

What is your organisation?

Organisation:

Local Optical Committee Support Unit (LOCSU) and Association of Optometrists (AOP), Association of British Dispensing Opticians (ABDO), Federation of Ophthalmic and Dispensing Opticians (FODO).

What type of organisation is it?

Org type:

Representative body

If 'other':

Potential 2021/22 financial framework

Were a financial framework based on the broad principles set out above to be proposed, to what extent would you support such a move?

Neither support nor oppose

Please explain the reasons for your answer:

We support the Long Term Plan (LTP) objectives to:

- transform the “traditional model of outpatient” care which it describes as “outdated and unsustainable”
- avoid “up to a third of outpatient appointments - saving patients 30 million trips to hospital, and saving the NHS over £1 billion a year in new expenditure averted”
- treat and support more patients “in community and primary care”
- to “boost ‘out-of-hospital’ care, and finally dissolve the historic divide between primary and community health services.”

We therefore support most of the broad principles of the proposed financial framework as the funding mechanism designed to achieve these objectives. We were reassured at the tariff workshop and by questions later in this consultation that other payment models will still have an important role to play. We therefore propose the current text on blended payment is changed to:

“To develop blended payments where this is in the best interests of patients comprising a greater fixed component and simplified incentives framework; and maintain and evolve other reimbursement models, including activity-based-payments, where this helps deliver optimal outcomes.”

Note on CCGs: CCGs are referenced as the conduit to such funding. We recognise that the sessions have explained that CCGs are stated as the current commissioning bodies for the time being, as opposed to the future standard, and that there is more work to be done in developing the framework. In our view, it is unlikely that CCGs have a long term role in disseminating such funding. If the LTP is to be realised, CCGs are too small and numerous to meet these objectives in the future. We recognise that legislation is required to affect such changes.

How do you think financial governance in your system would need to develop in order to support such a financial framework, were it to be implemented?

FF system governance:

There will need to be greater accountability and transparency of funding and organisation. STPs suffered from the perception that they were vehicles for funding cuts. The NHS/Government cannot allow ICSs to be perceived in this manner otherwise they run the risk of failure.

Are there any areas in addition to the key considerations that you think we should be focusing on in developing a future financial framework?

FF considerations:

N/A

Do you have any other comments on the potential 2021/22 financial framework?

Other comments FF:

N/A

Blended payment for 2021/22

To what extent do you agree that the blended payment approach described would support the objectives of the NHS Long Term Plan?

Neither agree nor disagree

Please explain the reasons for your answer:

We think there is room for both blended payments and FFS. Blended payments potentially represent a more efficient and wholistic method of funding end-to-end pathway care than the existing methods for shared care services and those that are set up to take pressure directly from outpatients. However, activity-based payments are more suitable for services such as those our members provide. A combination of both systems has the potential to provide the financial underpinning to achieve the LTP objectives. We were therefore reassured by the tariff workshop which explained that there is still a role for activity-based reimbursement.

However, we need to ensure that blended payments do not become block contracts rolled over in perpetuity with risk and costs laying with providers. Block contracts are likely to act as an impediment to decommissioning secondary activity that can be more efficiently provided in the primary setting i.e. the core aim of the LTP. We are pleased that the NHS pricing team shared these goals and is keen to avoid these risks.

To what extent would you support setting the scope of blended payment for almost all services covered by the national tariff?

Neither support nor oppose

Please explain the reasons for your answer:

Given that blended payments will be used for secondary care services it would seem appropriate to include services covered by mandated and non-mandated tariffs.

Local pricing rules are more likely to apply to services commissioned in primary and community care settings using the Standard Contract. Including these within blended payments might act as a barrier to delivering the LTP objective to transform models of outpatient care with greater out of hospital care.

For example if a budget for a service best suited to being delivered in primary care settings becomes imbedded in the fixed element of a blended payment model within secondary care this might be as difficult to "undo" as a block contract. This is why those services without a national price should for now remain out of scope of blended payments.

To what extent would you support setting a fixed payment based on the costs of delivering a level of activity that conforms to the ICS system plan?

Neither support nor oppose

Please explain the reasons for your answer:

As above.

What guidance would you find most useful for agreeing the fixed payment locally?:

Guidance that explains the interaction between national tariffs and local pricing (where applicable).

To what extent would you support the fixed payment including items currently excluded from the tariff, such as high cost drugs and devices and genomic tests?

Neither support nor oppose

Please explain the reasons for your answer:

To what extent would do you support including a variable element for some elective activity in the blended payment?

Neither support nor oppose

National methodology for helping flow money around providers within a system

Please explain the reasons for your answers:

This offers greater local flexibility while retaining the overall national direction that has been lacking in the past.

To what extent would you support having a threshold provider/commissioner contract value below which the blended payment arrangements would not apply?

Support

...about right

Please explain the reasons for your answers:

A threshold will allow for local flexibility for smaller services while allowing blended payments for higher cost (integrated) services.

Where local prices apply, we think a minimum fee with additional fees applied in certain circumstances would allow for the greatest local flexibility and better patient outcomes.

To what extent would you support host CCGs paying for activity below £0.2m, with allocations adjusted to compensate?

Don't know

Please explain the reasons for your answer:

This really depends on the future of CCGs as queried in our previous answer. Our expectation is that ICSs begin to assume many of the current responsibilities of CCGs—this is the logic of the LTP—notwithstanding the need for legislation to make this explicit.

Another factor to continue is local variation. In many areas a low volume service would easily fit within this, but in other areas it would be less appropriate.

What would be your preferred default payment approach for contracts valued between £0.2m and £10m?

Activity-based payment

If 'other', please specify:

Please explain the reasons for your answer:

These contract values are likely to include services commissioned from smaller and multisite providers based in primary and community settings where activity-based payments are working well and support patient choice and quality care. This will also allow commissioners to adjust blended payments in secondary care to slowly shift activity out of hospital and achieve the NHS Long Term Plan objectives.

To what extent would you support retaining national prices for diagnostic imaging services?

Support

Please explain the reasons for your answer:

This model appears to work well.

To what extent would you support a Standard Contract requirement for a System Collaboration and Financial Management Agreement alongside a blended payment, to help share risk across a system?

Neither support nor oppose

Please explain the reasons for your answer:

Given that blended payments are to be focused on secondary care it would seem, based on existing wording in the Standard Contract, that this will be the case already.

Do you have any comments on the 2020/21 model SCFMA, suggestions for how it could be improved or views on whether its focus should be broadened beyond financial balance?:

We have a concern that this could lead to a capping of service numbers which is potentially inimical to patient health. It is right and proper to ensure that services are not being misused, but where the activity is from genuine need (which it will be in most cases) then a pressure to stop activity will not lead to positive patient outcomes.

Financial incentives and best practice tariffs

To what extent would you support a review of the financial sanctions for failure to achieve national performance standards in the NHS Standard Contract?

Support

Please explain the reasons for your answer:

We agree with the NHS tariff workshop statement that "There is a case for simplifying and streamlining these incentives, and aligning them more explicitly to NHS Long Term Plan objectives. These changes are likely to evolve over a number of years."

We would support a more detailed and long-term review of financial incentives, in this case sanctions, to ensure these work as intended. Given the complex

nature of such sanctions and the current pandemic we would suggest this is consulted on separately at a later date.

To what extent would you support the retirement of the day case and outpatient procedure BPTs if their financial incentives are replicated in a blended payment design?

Neither support nor oppose

Please explain the reasons for your answer:

To what extent would you support BPTs becoming non-mandatory with guidance on how to capture them within any blended payment agreements?

Oppose

Please explain the reasons for your answer:

If they are non-mandatory they are unlikely to be used as commissioners will resort to known measures. If these changes are to be made, they need to be done so properly.

For primary eyecare services, our expectation and hope is that activity-based payments will remain in place.

If this approach were taken, what guidance would you find most helpful to support use of existing BPTs within a blended payment arrangement?:

To what extent would you support the further integration and streamlining of financial incentives in future years?

Neither support nor oppose

Please explain the reasons for your answer:

This is the logical progression of these proposals, and those of the LTP. There will be two types of services delivered in primary care: firstly, current services which may be better delivered on a fee basis; secondly, shared care, typically outpatient-type services. From a commissioning and pathway basis these may be more effectively paid for as blended payment/whole pathway services.

However, more information is needed before we can offer support. We would need to see and reflect on the evidence from the first round of reforming the NHS reimbursement model for secondary care first.

What would be the key considerations for doing so effectively?:

Collecting clinical evidence and economic data to assess the outcomes of the first wave of NHS reimbursement reforms.

Other tariff policy areas

To what extent would you support setting the 2021 tariff for one year?

Support

Please explain the reasons for your answer:

Given reforms are planned for secondary care services setting tariff for one year would appear to be a logical approach.

To what extent would you support a local guidance framework for adjusting prices to account for costs arising from Covid-19?

Strongly support

Please explain the reasons for your answer:

This is more urgent for primary care settings where support to manage increased costs associated with Covid-19 infection prevention and control measures (including PPE) has not been met by commissioners in a consistent way.

Looser framework to be flexibly applied locally

Please explain the reasons for your answer:

Given the Government's policy of local responses to COVID (notwithstanding the current four week national lockdown) it makes sense to allow for local application.

To what extent would you support setting prices for 2021/22 by rolling over the price relativities and currencies from 2020/21?

Neither support nor oppose

Please explain the reasons for your answer:

To what extent would you support making no further adjustments to the tariff to reflect the arrangements for the central funding of overhead costs of Supply Chain Coordination Limited (SCCL)?

Neither support nor oppose

Please explain the reasons for your answer:

To what extent would you support continuing to pause the specialist top-ups transition path for 2021/22?

Neither support nor oppose

Please explain the reasons for your answer:

Do you have any comments on the potential approach to specialist services top-ups for 2021/22?:

To what extent would you support making no substantial changes to the high cost drugs and devices lists for 2021/22?

Neither support nor oppose

Please explain the reasons for your answer:

To what extent would you support moving to the next (third) step of the MFF glidepath introduced following the 2019/20 data and method update?

Neither support nor oppose

Please explain the reasons for your answer:

Future payment system development

What would be your highest priorities for any future payment system?

Future priorities rank - Aligning incentives for primary care and social care with those of the wider system:

2

Future priorities rank - Aligning quality incentives with system working and Long Term Plan objectives:

1

Future priorities rank - Enhancing data infrastructure and making better use of existing data:

3

Future priorities rank - Exploring other approaches to calculating a fixed payment:

Future priorities rank - Improving payment building blocks such as costing and currency data:

Future priorities rank - Supporting innovative contractual models:

Future priorities rank - The role of clinicians in payment decisions:

Future priorities rank - Whole system approach to payments, contracting and incentives:

Future priorities rank - Other:

If 'other', please specify:

Please explain the reasons for your answer:

Aligning incentives to the LTP has to be the number one priority if the LTP is to succeed.

From the perspective of primary care, the first two options above amount to the same thing: in other words, if primary care is not correctly incentivised, and commissioning is not truly integrated, then the LTP will not be realised.

Finally, improved data showing actual outcomes versus predictions/intentions is a must.

What forward guidance and information on national payment policy would you find helpful to support local planning and to successfully implement any new payment approach?

Future guidance:

N/A

Impact on equality and health inequalities

If they were implemented, what impact do you feel the policies outlined are likely to have on equality and addressing health inequalities?

Negative impact

Do you have concerns that there are distinct groups with protected characteristics that our policies may impact negatively? :

Yes: there is the risk that if primary care is not utilised fully, especially in areas of deprivation and rural areas, that health inequalities may increase. Full consideration must be given for payment models to ensure that the primary eye care needs of all patients are met including those at risk of sight loss with protected characteristics as defined by the Equalities Act 2010. One way of doing this would be to implement additional fees to be applied locally on top of a wider minimum fee.

Please explain the reasons for your answers:

Sight loss can occur at any age but is more common in older age and in areas of deprivation. Conditions like glaucoma are also more prevalent in certain ethnicities.

When developing new reimbursement models the direct and indirect impacts on access to care for these and other at-risk groups has to be considered to avoid worsening equalities and health inequalities.

When pricing reforms are implemented without factoring this in there can be a negative impact. One recent example of this was the NHS pricing team reducing the payment for follow-up care which risked adversely affecting glaucoma care, a long-term condition which can result in blindness and which depends on ongoing follow-up care.

There is the risk that if eye care needs are not understood when designing payment models and the NHS does not fully utilise primary eye care infrastructure is not utilised fully, especially in areas of deprivation and rural areas, that health inequalities may increase. Full consideration must be given for payment models to ensure that the primary eye care needs of all patients are met. This will also be critical to ensuring the NHS meets the LTP goal of reducing unnecessary outpatient activity, with ophthalmology outpatients needing transformative change for this to be achieved.

We would be happy to discuss how this can be managed within existing proposals to transform the payment model for NHS care.

Any other comments

Do you have any other comments about the tariff or any other aspect of the payment system and wider NHS financial architecture?

Any other comments:

None other than those already made.

Do you have any comments or suggestions on how we could improve how we engage with you on our proposals?

Engagement:

N/A