HFMA response
December 2020

The HFMA's response to *proposed new arrangements for paying for low-volume activity flows*

Who we are

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

Do you believe that implementation of these proposals would reduce costs and administrative burdens for the NHS overall?

Yes, we believe that the implementation of the proposed new arrangements for paying for low-volume activity flows would reduce costs and administrative burden for the NHS overall. The HFMA's Commissioning Steering Group has been advocating this approach for some time.

This has been demonstrated by the approach during the pandemic, where both commissioners and providers have welcomed the reduction in transactional processing as it has enabled staff to focus immediately on the pandemic response. In the longer term, the reduction of administrative burden would free up staff time to support service transformation.

Do you agree with our proposal to set the threshold for the new arrangements at an expected annual contract value of £200,000? If not, what figure would you propose?

There is some appetite within our membership to suggest that the threshold could be set at a higher level, based on the success of increasing it to £500,000 for the second half of 2020/21. However, we support the reasoning of setting the initial threshold at £200,000 due to the small marginal gains in invoice reduction at a higher threshold and the risk of creating perverse incentives at a higher level.

For some providers, the need to develop relationships and negotiate contracts with commissioners where activity exceeds £200,000 but who have not traditionally contracted with the provider, could reduce the efficiency impact of the proposed low volume activity (LVA) changes. This may be further complicated by the lack of a default payment approach between the LVA threshold and the £10m upper limit where the blended payment approach applies, as there is not an existing relationship to build on.

Do you agree with the detailed changes we are proposing to the NHS standard contract to support the LVA approach?

We recognise that changes are required to the NHS standard contract in order to enact this new approach. However, there are some areas where clarification is needed.

- the term ‘named commissioner’ is not used consistently through the contracting guidance as it sometimes includes the co-ordinating commissioner for low volume activity and sometimes not.
- the draft contract confirms that a named CCG can terminate a contract but in future may be party to the contract as an LVA CCG; members have suggested that it would be helpful to include a worked example to illustrate this point.
- there appears to be an inconsistency in the use of indicative activity plans (IAP) and expected annual contract values, where the absence of an IAP means that the low volume activity plan automatically defaults to zero, but the expected annual contract value could still include a financial value for it.

Do you think we should build financial adjustments for actual levels of low volume activity into the new arrangements, or treat payment on a simple block basis?

The proposed approach to low volume activity is primarily designed to reduce administrative burden. If in year financial adjustments are applied, there is a danger that some of the reduction advantage will be lost, with a new validation industry created instead. We therefore believe that payments should be on a simple block basis.

However, the proposals highlight that the initial adjustments will be based on activity for the three years up to, and including, 2019/20 where the impact of the pandemic began to be felt. Covid-19 may continue to have an impact on people being treated out of area while travel is broadly discouraged to control the spread of the virus. It will therefore be necessary to review the appropriateness of the block values as the new approach is implemented and begins to become business as usual, which may be outside of the standard annual update proposed.

Do you see any risks or disadvantages in the proposed new approach? What are these and how best can they be mitigated?

Some specialist providers hold low value contracts with distant CCGs to deliver specific services. The proposed approach states that no service will be out of scope. However, there may be areas where

specific low value contracts need to remain in order to recognise and specify a particular service. Our members have highlighted this as an issue within the mental health sector but there may be others.

Despite the drive to end out of area placements, these still remain for many mental health trusts and CCGs. These can be of significant value and could cause a distant CCG to move from a low-volume activity commissioner to being required to be a signatory to the contract, for the duration of that placement. A mechanism is required to enable CCGs to move between classifications. This may also be an issue for specialist trusts; the financial analysis for Great Ormond Street for example, shows a number of CCGs which could easily exceed the £200,000 threshold with just one additional child requiring care. In addition, some out of area placements may fall within the £200,000 limit but there is still a need to have a defined relationship between the commissioner and provider due to the specialist nature of the care required.

The proposals need to recognise, and specify, the necessary exceptions to the approach. The HFMA would be pleased to support work in this area.

For some CCGs, spend on low volume activity may represent a significant contribution to the achievement of the mental health investment standard (MHIS). Some of our members are already reporting an adverse impact on the MHIS due to the temporary arrangements put in place for this activity during the pandemic. It will be necessary to reset the baselines for the MHIS to recognise the shift in funding.

The financial analysis shows significant funding swings of around £5m gain or loss for some CCGs. While this approach should simplify financial processes and administration, for CCGs already reporting a deficit, the loss of funding could have a significant impact. It will therefore be essential to provide clarity around the adjustments to all parties. While we support a simple block payment approach, it may be necessary to introduce a 'cap and collar' arrangement for the aggregate effect on a CCG to ensure that it operates on a cost neutral basis.

The financial analysis will need to be reviewed and amended as CCGs and providers merge to form new organisations. There are some recent changes that have not been reflected in the accompanying analysis for this consultation, which may affect the achievement of thresholds and therefore the appropriate contract form.

Consideration must also be given to recharging cross border flows with devolved nations, as some systems may need to be maintained in order to recharge, or pay, correctly.

What factors do we need to consider in setting up the new arrangements to work for the period beyond 2021/22?

As mentioned in response to question 4, the level of financial adjustment will need to be reviewed as the new approach is implemented. We know that basing future contracting arrangements on historic data is no longer valid due to the impact of Covid-19 and changes in healthcare practice. It is also recognised that behaviour has changed during the pandemic so recent non-contract activity is unlikely to be representative of the future steady state. Any rolling average will have to include a compensatory factor for late 2019/20, 2020/21 and all, or part, of 2021/22, if activity in these years is to be included.

The *Who pays?* guidance[1] that sets out which commissioner should pay for activity will need to be updated to reflect the new LVA arrangements. The *Model collaborative commissioning agreement*[2] may also require updating to reflect the revised terminology.

Overall, do you support the new arrangements broadly as proposed?

Yes, we broadly support the new arrangements and welcome the intention to remove unnecessary cost and resource usage from the NHS. This change will enable the NHS finance function to remove

[1] NHS, *Who pays? Determining which NHS commissioner is responsible for making payment to a provider*, September 2020
[2] NHS, *Model Collaborative Commissioning Agreement*, June 2016

significant non-value-added work from their role and focus on service transformation and improving patient care.

Please check the outputs of the analysis described in paragraph 34 of the consultation document. Does the analysis contain any material errors?

We are unable to comment on specific material errors, but we believe that there are some recent organisational changes and mergers that have not been reflected in the accompanying analysis for this consultation, which may affect the achievement of thresholds and therefore the appropriate contract form.

Is there a good reason not to use a three-year average figure as we have proposed?

No. We support the use of a three-year average figure, but we know that basing future contracting arrangements on historic data is no longer valid due to the impact of Covid-19 and changes in healthcare practice. It is also recognised that behaviour has changed during the pandemic so recent non-contract activity is unlikely to be representative of the future steady state. Any rolling average will have to include a compensatory factor for late 2019/20, 2020/21 and all, or part, of 2021/22, if activity in these years is to be included.

The average figure used will also need to be adjusted to take account of tariff changes and MFF amendments over time.

Contact

Submitted by the Healthcare Financial Management Association. For further information please contact:

Sarah Day
Policy and Research Manager
Healthcare Financial Management Association
1 Temple Way
Bristol
BS2 0BU

Email: sarah.day@hfma.org.uk