Response form for the report on the local modifications regime

If you would like any part of the content of your response (as distinct from your identity) to be kept confidential, you may say so in a covering letter.

We would ask you to indicate clearly which part or parts of your response you regard as confidential. We will endeavour to give effect to your request, but as a public body which is subject to the provisions of the Freedom of Information legislation, we cannot guarantee confidentiality.

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Job title: Technical Editor

Organisation: Healthcare Financial Management Association

Nature of organisation:

The Healthcare Financial Management Association (HFMA) is the professional financial voice of the NHS. We are a representative body for finance staff in healthcare. Our members work predominantly in the NHS and our aim is to maintain and develop the financial management contribution to healthcare in the UK.

Our comments draw on the expertise of the HFMA's Payment by Results Special Interest Group.

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Please write your answers to the following questions below. Please expand the boxes or continue on further sheets if necessary. Then follow the instructions at the end of this form to return your response to Monitor.

Question 1: Do you have any comments on the criteria for a good framework that Frontier set out in the introduction to the report?

The HFMA welcomes the criteria identified in the introduction to the report in particular the recognition that the approach used be proportionate in cost and take into account overall provider efficiency.

However, we also recognise that local health economy affordability is an important consideration in making a rules-based system work effectively.

Question 2:

Do you agree that, where possible, any local modifications should be arrived at by negotiation and agreement between the commissioners and providers of services? In addition to the licence condition on constructive engagement, do you have any suggestions on how Monitor can encourage agreements?

The HFMA supports the principle that any local modifications should be agreed between providers and commissioners working together to find a solution to a specific issue or situation.

In our view, constructive engagement and agreement is best supported by clarity of expectation within a rules-based system. It is important that discussions between commissioners and providers focus on securing agreement and are not diverted to matters of interpretation or the management of expectations. The HFMA would therefore welcome clear guidance and rules for those situations where local price modification may be appropriate. This would be particularly helpful as clinical commissioning groups will be funded on a capitation basis.

We have some concerns that the process outlined for agreeing local modifications to tariff is predisposed towards the resolution of significant or structural issues for example, whether the additional costs involved with a PFI hospital would warrant such a modification. We note that future commissioning allocations may reflect modifications. However, given the basis on which commissioners are and will be initially funded, it is likely to be a challenge to fund major structural issues from allocations. We are therefore concerned that resourcing local modifications, particularly where they result from provider application, may prove to be unaffordable and/ or unsustainable for a local health economy. While both parties may agree that a justification for the modification exists, the commissioner may simply not be able to fund an additional cost pressure 'for no more activity' and so either engagement will be limited or will not result in a resolution.

In our view, the challenge of engagement is to balance the influence and funding of commissioners against the needs and development of providers, particularly with the greater commercial awareness which will be required of providers when competing within the 'any qualified provider' framework.

The HFMA would also welcome clarification of the mechanism to be available for dealing with other local price adjustments through variations to national prices. For example, it would be helpful to understand how the following situation could be resolved in the future or if the existing flexibilities would still be available. NHS Mid Essex previously agreed a local price in relation to breast reconstruction. The procedure (immediate diep breast reconstruction) originally grouped to a single tariff irrespective of whether the reconstruction was done at the same time as a mastectomy. Rather than bring patients back into hospital for the reconstruction procedure, the regional plastic surgery service based at a local trust was able to undertake these procedures as a single inpatient admission. However, as the cost of the combined procedure was higher than the tariff at the time, it was unsustainable. A local adjustment to tariff was agreed for a time-limited period (ultimately the tariff was refined to accommodate immediate and delayed reconstruction). The local modification was worth around £150k to the trust and there was a clear benefit to patients in terms of a single admission to hospital. The single admission was also less expensive than the alternative two admissions for commissioners and the adjustment was applied at HRG level for all commissioners using the service. The request was clearly evidenced by the trust and supported by commissioners.

Question 3: What are your views on using the 'whole provider' analysis during a transition period?

The HFMA supports the need for a recognised transition period to deal with the existence of cross-subsidies which currently exist within the national tariff. The HFMA also welcomes the recognition that cross-subsidisation is itself, a key factor and therefore looking at the overall financial health of an organisation is important in assessing the impact of a local modification to tariff. The HFMA recognises that the picture regarding cross-subsidisation is complex and it is difficult to isolate the underlying causes of financial performance of individual service lines. In our view therefore, understanding cross-subsidisation requires detailed long term analysis.

From a commissioning perspective, there may be concerns that a local price modification will enable a provider to generate a greater surplus than required to be sustainable. In our view, providers do tend to reinvest surpluses so the money is not taken out of the system but invested by the provider rather than the commissioner. We would therefore welcome a requirement for providers to outline how the extra funding received would be used to derive a direct benefit to patients.

Question 4: Do you have any comments on the proposed components of the 'long-term toolkit' (structural difference, benchmarking, quality and wider implications tests)?

The HFMA welcomes the comprehensive nature of the 'long term toolkit' and believes it to be a suitable mechanism against which to measure the appropriateness of a local price modification.

In our view, the case for local modifications to price should be clearly evidenced by robust cost information for the service or healthcare resource group concerned.

We would also welcome further clarification in relation to the benchmarking criteria. Obtaining the greatest benefit from benchmarking requires an appropriate comparator group to be used. This will be fundamental to establishing whether any inbuilt level of inefficiency actually exists or if the provider is genuinely efficient but experiences higher costs in providing a particular service(s). We recognise that the delivery of acute care is dependent on many factors including what services are available through community provision. In our view, benchmarking is a good tool for highlighting areas for further investigation and discussion but we would have concerns if it were to be used as an absolute measure or definitive answer.

We also have some concerns in relation to the burden of proof as it may be possible for commissioners to require more proof or continue to request further evidence beyond that which may be necessary for a local agreement to be made. It requires commissioners to take a pragmatic view of the evidence provided and the role of the NHS Commissioning Board and clinical commissioning groups should be further considered in any future guidance.

Question 5: Do you agree that Monitor should rely on a complaints system, rather than monitoring providers' compliance with the conditions of a local modification?

We welcome the principle that modifications are to be time limited. Any variance from the national tariff needs to be justified and transparent so as to avoid an adverse impact on local clinical priorities and to maintain equity and fair access to services. However, placing sole reliance on complaints to indicate the presence of a significant issue may mean that a situation is already considerably developed before review and/or corrective action takes place. We would anticipate that the majority of complaints will take the form of an application by a provider.

We would therefore welcome further consideration of assurance and review in relation to all local modifications that took into account the impact on the whole of the local health economy.

Question 6: Do you have any comments about the practicality of implementing the different parts of the framework?

We would anticipate that the framework will apply to a very small volume of exceptions. In our view, the criteria for a local modification should not be set too high to artificially limit applications nor too low to avoid the system being overwhelmed. We would therefore suggest that a maximum number of appeals per provider could be introduced.

However, in our view it is important to recognise that there will be very few issues which are individually of high value for an individual provider or a single service line. Rather, in our view, providers are more likely to encounter the impact of a structural issue across a number of service lines with the corresponding difficulties of isolating the impact.