NHS Standard Contract 2021/22

Proposed new arrangements for paying for low-volume activity flows: A consultation

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Introduction

1. We are consulting on significant changes, to take effect from 1 April 2021, to the arrangements for contracting and paying for low-volume flows of activity between CCGs and NHS Trusts / NHS Foundation Trusts. This will largely, but not solely, affect what is known as “non-contract activity”. These changes would embed, on a permanent basis, the short-term simplification which has been introduced for 2020/21 in response to the Covid-19 pandemic.

2. The intention of the changes would be to reduce the level of bureaucratic burden which the historic arrangements create, cutting – by a very significant extent – the number of low-value invoices being submitted by Trusts and reducing the amount of CCG and Trust staff time which is spent on issuing, validating, contesting and settling such invoices.

3. If approved following this consultation, the new arrangements will be introduced by a combination of changes to the NHS Standard Contract for 2021/22 and changes to the way in which NHS England and NHS Improvement manage CCG allocations.

4. This document explains the proposed changes and invites feedback, which should be sent to england.contractsengagement@nhs.net, using the standard template available at https://www.england.nhs.uk/nhs-standard-contract/21-22/, or via the online survey available at https://www.engage.england.nhs.uk/consultation/nhs-standard-contract-2021-22/. **The deadline for receipt of responses is Thursday 31 December 2020.**

5. We are consulting on the proposed changes now, in the autumn of 2020, in order to ensure that the new system, if approved, can be introduced in a planned and effective way, with adequate time to ensure that CCGs and Trusts can put in place the necessary enabling arrangements for 2021/22.

Summary

6. The proposed new arrangements can be summarised as follows.

    a) From 1 April 2021, the national terms of the NHS Standard Contract would be changed, so that each (main) contract held by an NHS Trust or NHS Foundation Trust with a CCG becomes, effectively, a contract with every CCG in England.

    b) CCGs with an expected annual contract value of £200,000 or more with that Trust would be required to be direct signatories to that contract for 2021/22 and to make payments for services direct to the Trust, as currently. As now, these CCGs would identify one of their number (usually the CCG in whose area that Trust is located) to act as Co-ordinating Commissioner, with a key role in managing the contract.

c) CCGs with an expected annual contract value of less than £200,000 would automatically become commissioner parties to that contract, though they would not be required to sign it. But, to reduce the administrative burden, payment to the Trust for the services which it provided to patients from these CCGs would be made by the Co-ordinating Commissioner for that Trust.

d) Under the new system, each CCG would cease to be responsible for payments to a range of more distant Trusts, but most CCGs would become responsible for a new flow of payments to the Trust or Trusts located in their areas.

e) To neutralise the net financial effect (which would be different for each CCG), NHSE/I would calculate the expected impact of the new arrangement (based on data from the Integrated Single Financial Environment for the period 2017/18 to 2019/20) and make an appropriate non-recurrent adjustment to each CCG's allocation for 2021/22. (In terms of any further financial adjustments to be made, to reflect actual in-year activity levels, there would be a balance to be struck between simplicity and precision; this is explored further in paragraphs 26-29 below.)

Background

7. Current NHS legislation means that CCGs are responsible for arranging healthcare for their populations, defined primarily on the basis of GP registration. But patients are not always provided with care and treatment locally; those taken ill in an emergency have to be treated wherever they are, and legal rights to choice of provider mean that, for elective acute and mental health services, patients may opt to be treated at more distant providers.

8. In practice, therefore, there is at least a small flow of patients from each CCG to each NHS Trust and NHS Foundation Trust in England, however distant. (This does not apply to the same extent with non-NHS organisations which provide NHS-funded services; there are many more of these, often small organisations, mostly providing non-emergency local services only.)

9. Since the NHS "internal market" was introduced, there has been a pragmatic system for managing these low-value flows of activity to distant providers as "non-contract activity" (NCA). For very small values, there has been no expectation that a separate written contract would be put in place between the commissioner and the distant provider; rather, it has been accepted that the provider would see and treat patients as necessary from the distant commissioner, under an implied (ie unwritten) contract, assumed to be broadly on the terms of the provider's contract with its main host commissioner.

10. This approach has minimised one aspect of administrative burden (namely, the requirement for written contracts), but the current NCA arrangements still lead to a very high burden in terms of invoice production and validation. In practice, each Trust is invoicing most CCGs in England each month, but often for very low

values; invoices with a value of less than £10,000 account for 82% of total Trust-to-CCG invoices by number, but only 1% by total value.

11. This is clearly inefficient. The direct charges which result from invoice processing via NHS Shared Business Services (SBS), plus the staff costs involved in preparing and submitting invoices (in Trusts) and validating and approving them (within CCGs and CSUs) will often be higher than the total amount being invoiced.

Benefits and disadvantages

12. The key benefit of the new approach lies in simplifying the system for contractual payments between CCGs and Trusts, reducing administrative burden in line with the direction of travel set out in the NHS Long Term Plan. The new arrangements we are proposing would mean that, rather than invoicing large numbers of CCGs each month for NCA, each Trust will be able to build invoicing for NCA into its existing contractual payment arrangements with its Co-ordinating Commissioner. Our calculation is that this will reduce the number of invoices flowing from Trusts to CCGs by around 340,000 in a full year – with an annual direct saving in SBS transactional charges of approximately £1m annually and potential for Trusts to save an estimated £3m in transactional charges. The reduced workload for finance and analytical staff in Trusts, CCGs and CSUs will create opportunities either for further savings or for staff time to be focussed on more productive activities related more directly to improving patient care. It is estimated that the cost of staff administering NCA is at least £20m annually.

13. Simplified payment relationships are also likely to mean fewer time-consuming disputes between CCGs and Trusts, and the new approach will also simplify the year-end Agreement of Balances process, as each NHS organisation will have fewer financial transactions to account for and fewer other organisations to agree balances with.

14. In order to operate effectively, the new arrangement would require NHS England and NHS Improvement to take a more directive approach than hitherto, in terms of mandating the specific contractual relationship which must exist between each CCG and Trust and the specific collaborative arrangements which must exist between CCGs. A CCG would no longer always be able to place its own separate contract with a local Trust – rather, it might be required to sign up to a joint contract with other CCGs, with a different CCG taking on the lead role as Co-ordinating Commissioner. There is a trade-off here between national mandation and local control; on balance, our view is that the benefits (in improved efficiency overall) outweigh the disadvantages – but we welcome feedback on this point.

Additional detail

15. We have set out below some additional detail about the rationale for the new system and how it would be intended to operate.

Scope of the new approach

16. The new approach would apply to relationships between CCGs and NHS Trusts / NHS Foundation Trusts only. It would apply to all of the healthcare services which a Trust provides to a CCG – no services would be excluded.

17. The existing approach to NCA would remain in place, on broadly the same basis, for relationships between CCGs and non-NHS provider organisations.

- CCGs commission services under the NHS Standard Contract from a very wide range of non-statutory organisations. Some are independent sector hospital operators (which may attract NCA referrals under choice rules), but the majority are small organisations providing local services only – voluntary sector bodies, care homes, and GPs, pharmacies and optometrists providing local enhanced services. It would not be appropriate to create a situation where all such providers automatically held a contract with each CCG in England.

- The concept of NCA is not strictly relevant to NHS England as commissioner of services. NHS England is one legal entity, and its NHS Standard Contracts with providers generally cover the whole population of England for the services which it commissions. (We are aware that there may be potential to streamline invoicing arrangements for some directly-commissioned services; we will look to address this where possible, but this will not require amendment to the national terms of the Contract.)

The £200,000 threshold

18. We propose to set a threshold of an expected annual contract value of £200,000 for each individual CCG-to-Trust relationship.

19. The rationale for this is as follows.

- £200,000 is the value above which, under NHS England's Contract Technical Guidance since 2014, a written, signed contract should always be in place.

- Setting the threshold at £200,000 deals with the great majority of low-value invoices, but generally only affects longer-distance relationships between CCGs and Trusts, under which there is actually little scope for the CCG to influence the volume of activity which happens. Setting the threshold higher – at £500,000, say – would only achieve a marginal further reduction in invoices created (370,00 as opposed to 340,000).

- We recognise that, if we set the threshold too high, we could create a perverse financial incentive for CCGs to encourage referrals to, or presentations at, relatively nearby providers, in order to avoid financial liability and at the expense of patient choice and patient care; setting the threshold at £200,000 means that the risk of this will, in practice, be very low.

We welcome feedback on whether £200,000 is the right level for the threshold.

Changes to the national provisions of the NHS Standard Contract for 2021/22

20. These new arrangements would require a range of changes to be made to the national terms of the NHS Standard Contract for 2021/22. The proposed changes can be viewed in the draft Contract documents we have published at https://www.england.nhs.uk/nhs-standard-contract/21-22/.

21. In summary, the key changes are:

- to introduce a distinction between Named Commissioners (those CCGs above the £200,000 threshold who will sign the contract themselves, who will have their own Indicative Activity Plan and Expected Annual Contract Value, and who will continue to make payments direct to the Trust) and Low-Volume Activity (LVA) or LVA Commissioners (those CCGs below the £200,000 threshold who will be party to the contract but will not sign it);

- to enable, as a matter of administrative efficiency, the Co-ordinating Commissioner to arrange payment on behalf of the LVA Commissioners; and

- to amend arrangements relating to Prior Approval Schemes (PAS), to confirm that LVA Commissioners are bound by the Co-ordinating Commissioner's PAS.

22. Our intention is to make changes only to the full-length version of the Contract, not the shorter-form version. Every NHS Trust and NHS Foundation Trust should be operating, for its main CCG contract, under the full-length version, whereas the shorter-form version tends to be used for smaller, non-NHS providers.

Completing contract and supporting documentation

23. CCGs will need to review their Collaborative Commissioning Agreements (CCAs) to ensure that they reflect the new arrangements. (CCAs enable multiple CCGs to sign the same contract with a provider, with one CCG identified as the Co-ordinating Commissioner.) For 2021/22 onwards, only Named Commissioners should normally be parties to the CCA for any specific Trust contract. (Further detail about CCAs is included in our Contract Technical Guidance, and model versions are available at https://www.england.nhs.uk/nhs-standard-contract/.)

24. In terms of the completion of the Particulars of each local CCG-Trust contract, we envisage that:

- only Named Commissioners would be listed as parties on page 3 and sign the contract on page 8;

- each Named Commissioner would have its own identified Indicative Activity Plan (shown within Schedule 2B) and Expected Annual Contract Value (shown within Schedule 3F);

- the Expected Annual Contract Value for the LVA Commissioners would also be shown in Schedule 3F, as a separate aggregated entry for all the relevant CCGs (the value used for this would be the value from the final analysis published by NHS England and NHS Improvement under paragraph 37 below); and

- the Co-ordinating Commissioner and the Trust would derive an Indicative Activity Plan for the LVA Commissioners, based on historic activity data held by the Trust and as consistent as possible with the LVA Commissioners' Expected Annual Contract Value; this would be shown in Schedule 2B, as a separate aggregated entry for all of the LVA Commissioners.

<u>In-year responsibilities for payment and contract management</u>

25. In-year, the Co-ordinating Commissioner would act in that role in respect of both the Named Commissioners and the LVA Commissioners. Any duties, rights and obligations in relation to payment for services delivered for the LVA Commissioners' patients, and to contract management in relation to those services, would fall to the Co-ordinating Commissioner, acting as the LVA Commissioners' agent.

<u>Adjusting payment and allocations to reflect actual levels of low-volume activity</u>

26. As described in paragraph 6e), there are choices in terms of whether we treat LVA payments as simple one-off blocks, based on expected activity – or as indicative amounts, with retrospective adjustments to reflect actual activity levels

    - One option would be for the LVA payment from the Co-ordinating Commissioner to the Trust to be treated as a simple block, set at the historic average level, with no subsequent financial adjustment to reflect the actual level of in-year activity being made (either between the host CCG and the Trust or to CCG allocations). This would be the simplest and least burdensome approach.

    - At the other end of the spectrum, we could treat the initial LVA value as an indicative "on account" payment only, with the Trust reporting actual LVA levels to the Coordinating Commissioner each month and with payment being adjusted accordingly. At the same time, Trusts could report the same data to NHSE/I, allowing in-year adjustments to CCG allocations also. This would produce a more accurate outcome, in terms of Trusts being appropriately reimbursed and individual CCGs bearing appropriate costs; it would give an ongoing incentive for Trusts to collect accurate data; and it would reduce administrative burden overall – but it would be significantly more labour-intensive than the block approach, requiring Trusts – for instance – to calculate and bill for best practice tariffs and CQUIN.

    - The impact of Covid-19 may also be relevant here. As described in paragraph 6e), we have constructed our proposals for adjustments to CCG allocations based on data for the three financial years up to an including 2019/20. Covid-19 is likely to have reduced activity flows to more distant providers in the short

term, and it is difficult to predict whether historic patterns of activity pre-Covid are a good guide to what will happen in 2021/22.

27. There would in any case be a limitation in terms of the validation which could be undertaken by the Co-ordinating Commissioner of payments made in respect of LVA Commissioners. The Co-ordinating Commissioner would not have access to backing datasets for the relevant activity, and what it could do in terms of validation would be limited to basic mathematical checks. On balance, we do not see this as a significant disadvantage. It is arguably a waste of NHS resource for significant effort to be spent on validating low-value NCA invoices, and NCA validation focusses mostly on whether the correct commissioner has been identified. Under the new system, this would no longer be of such importance.

28. It is also useful to consider here the financial impact at individual provider level. If we set the threshold at £200,000, then – for the majority of Trusts – a relatively small proportion of their total commissioner income will come via the LVA route in future. For 95% of Trusts, the proportion will be below 3%; but it would be higher for a small number of more specialised providers. If we choose the block approach, this is the proportion of Trust income we would effectively be fixing.

29. We welcome feedback on what approach would be most appropriate.

<u>Application of CCG commissioning policies</u>

30. The commissioning policies of the Co-ordinating Commissioner, as set out or notified to the Trust under the contract, would apply in respect of the LVA Commissioners. This would be true in respect of, for instance,

    - Service Specifications included in Schedule 2A; and

    - Prior Approval Schemes notified under SC29.

    A CCG which was one of the LVA Commissioners would not be able to require its own specific Prior Approval Schemes to apply to a Trust.

<u>Multiple contracts</u>

31. There may be instances where Trusts hold multiple separate CCG contracts – one main one covering the bulk of its services, for instance, plus others which have resulted from separate procurement exercises. In such cases, the Co-ordinating Commissioner and the Trust would have to ensure that the relevant details in relation to flows of activity from LVA Commissioners (the Indicative Activity Plan and the Expected Annual Contract Value) were included only in the appropriate local contract (which would usually be the Co-ordinating Commissioner's main contract with the Trust).

<u>Updating LVA arrangements from year to year</u>

32. We have been considering to what extent we would need to update the arrangements from year to year in the future. We would certainly need to

accommodate factors such as CCG and Trust mergers, and there would be a case for updating, periodically, the three-year rolling average value for each CCG / Trust relationship to reflect more recent actual data. Changes to specialised services identification rules might also require the financial values to be updated. We welcome feedback on these and other factors affecting the ongoing operation of the new approach.

Consultation questions

33. We welcome feedback about the principles of the proposed new approach, including on the questions set out below.

Question 1	Do you believe that implementation of these proposals would reduce costs and administrative burdens for the NHS overall?
Question 2	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?
Question 3	Do you agree with the detailed changes we are proposing to the NHS Standard Contract to support the LVA approach?
Question 4	Do you think that we should build financial adjustments for actual levels of Low Volume Activity into the new arrangements, or treat payment on a simple block basis?
Question 5	Do you see any risks or disadvantages in the proposed new approach? What are these and how best can they be mitigated?
Question 6	What factors do we need to consider in setting up the new arrangements to work for the period beyond 2021/22?
Question 7	Overall, do you support the new arrangements broadly as proposed?

34. We also wish to test more specifically that the national data which we propose to use to underpin the new arrangements is sufficiently robust. We have therefore published a separate analysis (available at https://www.england.nhs.uk/nhs-standard-contract/21-22/), showing

- our assessment (based on data from the Integrated Single Financial Environment for the period 2017/18 to 2019/20) for each CCG-to-Trust relationship of whether the relationship is above or below the £200,000 annual threshold, thus indicating our current view on

  - which CCGs must be signatories to the “host” contract with a particular Trust for 2021/22 as Named Commissioners, making payments on account and reconciliation payments for their activity by that Trust; and

  - which CCGs would instead become non-signatory parties to the “host” contract with that Trust as LVA Commissioners, with no need to sign the

contract and with payments on account and reconciliation payments being made by the Co-ordinating Commissioner;

- our assumption as to which CCG would act as Co-ordinating Commissioner in respect of each Trust; and

- our assessment of the initial non-recurrent adjustment which would be needed to each CCG's financial allocation for 2021/22, to offset the net effect of each CCG becoming responsible for payments to its local Trust(s) for flows from other CCGs estimated at less than £200,000 annually; (these adjustments are generally small relative to overall CCG allocations, typically well under +/- £5m, though with some higher values for CCGs which host more specialist Trusts in London).

35. We therefore invite CCGs and Trusts to

- feedback their views on the specific questions in paragraph 33; and

- check the outputs of the analysis described in paragraph 34 and inform us of any material errors and/or where they believe that there would be a good reason not to use a three-year average figure as we have proposed.

Feedback should be sent to england.contractsengagement@nhs.net, using the standard template available at https://www.england.nhs.uk/nhs-standard-contract/21-22/, or via the online survey available at https://www.engage.england.nhs.uk/consultation/nhs-standard-contract-2021-22/.. **The deadline for receipt of responses is Thursday 31 December 2020.**

Next steps

36. Once the consultation closes, we will review the feedback received and announce, in the autumn, whether or not we will be proceeding with the new arrangements for 2021/22.

37. If we decide to proceed, we will publish, early in 2021:

- a revised draft NHS Standard Contract for 2021/22, reflecting the necessary changes to enable the new arrangements to proceed, with supporting guidance as necessary; and

- a final binding version of the analysis described in paragraph 34.

It will be essential that CCGs and Trusts do then enter contracts for 2021/22 on exactly the basis set out in that analysis. Otherwise, there is a risk that contractual responsibility for payment will not align to allocation of funding.

38. There would be, as usual, a further consultation during the winter on other changes to the NHS Standard Contract for 2021/22 – but CCGs and Trusts would

be able to prepare for the 2021/22 planning and contracting round with full clarity about the new LVA arrangements. Each CCG would know exactly

- those Trusts with which it would be required to sign a 2021/22 contract; and
- those other CCGs with which it would need to sign a Collaborative Commissioning Agreement.