NHS England and NHS Improvement

2020/21 BLOCK CONTRACT VALUES – CALCULATION METHODOLOGY IN RESPONSE TO COVID-19

INTRODUCTION

As described in Simon Stevens' and Amanda Pritchard's letter of 17 March 2020, all NHS trusts and foundation trusts are being asked to agree block contracts as part of the NHS response to COVID-19, thereby adopting local variations to PBR.

We are asking all organisations to move to a simplified basis of contracting for the duration of the crisis to ensure that NHS organisations have sufficient funding to respond to the crisis. To make sure that costs are fully covered, NHS providers will receive block contract payments from commissioners, and income from non-NHS sources. Where this is not sufficient to cover a provider's underlying cost base, additional central top up payments will be made. Further top up payments will be made to cover reasonable costs of responding to the crisis, net of any cost reductions eg for consumables not required. Similar top up funding arrangements will apply for commissioners.

Files have been shared on commissioner SharePoint and provider portal inboxes setting out the monthly block contract values to be paid for the period 1 April to 31 July.

Separate guidance will be issued in relation to contracting and cash payment arrangements and timings, and also for capital funding.

FORMAT OF SHARED FILES

Individual files have been shared with commissioners (CCGs, specialised commissioning hubs and direct commissioning regional offices) and providers (NHS trusts and foundation trusts).

Each file contains organisation-specific data showing the block contract value for each contractual relationship between commissioners and providers (based on the methodology described below).

The calculation is broken down into its constituent elements starting with the source data in column F, arriving at the **block contract value for each contractual relationship in column I.**

Calculation methodology – overview

1. Source data (column F) - the source data for the calculation of the block contract value is the Agreement of Balances (AoB) values from the 2019/20 Month 9 (M9) collection, with appropriate adjustments for any material inconsistencies following an internal review of the data. The values are based on the provider AoB M9 submissions. Only contracts in excess of £0.2m p.a (calculated by annualising the M9 AoB data on a straight-line basis) have been

included in the file in order to reduce the administrative burden of the contracting process at this time.

2. One-month value (column G) – the monthly value of the source data is the M9 AoB value in column F divided by 9 months.

3. Growth assumption (column H) – an inflationary uplift of 2.8% has been applied to all contract values across all sectors (acute, specialised, mental health, community and ambulance sectors). The inflationary uplift is calculated as follows:

    a. the tariff cost uplift factor of 2.5% across all services; and

    b. additional CNST funding of £198m equivalent to an additional 0.3% across all income.

4. Block contract value (column I) – **The block contract value for each month is calculated by applying the growth assumption to the one-month value from the M9 AoB**

LOW VOLUME ACTIVITY FLOWS AND NON-CONTRACT ACTIVITY (NCA)

We are expecting that the flows of activity to distant providers (usually treated as non-contract activity or NCA) will reduce significantly in the coming months due to restrictions on movement. For this reason and to help simplify the funding arrangements we are asking providers not to invoice for any activity which they undertake for CCGs other than those covered by the files above. Instead we will take account of the impact of income for low-volume flows, including NCA, in calculating the central top up payment.

PROVIDER TO PROVIDER BILLING

To further simplify financial arrangements we are also asking that all provider to provider billing ceases from 1st April. The revenue implications of this will be reflected in the central top up payments.

NON-NHS INCOME

We are implicitly assuming that patient and other income from non-NHS sources including from HEE and from local authorities will continue at the levels seen in 2019/20 during the next few months. This assumption will not hold for all areas, in particular for private patient income. We will monitor income levels through routine provider reporting, and where lower than expected we will adjust for this through the central top up funding described below.

FUNDING FROM NHS ENGLAND NATIONAL SOURCES

Planned revenue payments to providers from NHS England national budgets (e.g. FRF, MRET, PFI or transaction funding, national clinical excellence awards) will be taken into account in the top up funding calculation, as the costs that these revenue payments support are expected to form part of each organisation's cost base as considered for the top up payment.

MENTAL HEALTH PROVIDERS

Block contract values for mental health providers have been uplifted by the same 2.8% growth factor assumption as acute providers. CCGs should work with mental health providers to understand where additional investment over and above this block uplift can contribute to the

COVID-19 response and also provide the foundation for future transformation, e.g. by recruiting staff who can be used for COVID-19 in the short term and move into new services later. Providers will be paid for these investments through top-up payments during the COVID-19 period, transitioning to the normal commissioning arrangements in the longer term. Contract changes for Provider Collaboratives (PCs) for Mental Health will not be made, however we will still seek to implement the operational aspects of the policy.

SPECIALISED COMMISSIONING

The approach for Specialised services mirrors the methodology and approach set out above. This includes the payments for fast track Provider Collaboratives (PCs) from 1 April 2020. Fast track PCs will continue to behave as Provider Collaboratives, leading improvements in local systems and SMH services, although the transfer of financial, contractual and commissioning tasks will be delayed.

The 17th March letter stated that for specialised services commissioned by NHS England, high-cost drugs and devices (HCDD) would continue to be reimbursed separately, outside of the block payments. In practice, it is not proving practical, as an initial allowance for HCDD, based on M9 AoB, is included in the block payments. NHS England will make additional top-up payments to Trusts to cover the net impact of any in-year variances in expenditure and the impact of new drugs not in baselines.

We are working on further guidance and FAQs for Specialised Services which will include more detail on drugs and devices, and requirements for specialised commissioning provider reporting (e.g. critical datasets and Blueteq completion, including where necessary for commercial drug arrangements).

DIRECT COMMISSIONING

A single block contract value has been set for non-Specialised Direct Commissioning for each regional office and provider contractual relationship. This will incorporate Public Health (including s7a), Health and Justice, Armed Forces and Secondary Dental.

TOP UP PAYMENTS

Further guidance will follow, setting out details of the central top-up payments that will be made in addition to the monthly block contract values. It is our intention to make an on-account central top up payment on 1st April alongside the first block payments, and then continue with central top up payments from 15th April based on the more detailed calculations required to set the level of payment.

The calculations will be based on the difference between each organisation's underlying cost base taken from 2019/20 reporting, and the income expected from NHS and other sources. We will include detail on other income streams including car parking charges, private patient income, income from overseas patients, injury cost recovery scheme), and the approach to top-up payments with regards to changing costs (including approach to impairments and gains and disposals).

In addition to the central top up payments, providers and commissioners will continue to report additional covid-related costs alongside routine monthly reporting. Where an organisation's reasonable costs exceed the income from other sources, including the central top up payment,

a further covid top up payment will be made. These further payments will be made retrospectively.

FURTHER QUESTIONS

Queries should either be directed to regional teams or emailed to NHSI.FinPlan@nhs.net and we will incorporate responses to questions in the FAQ document that will be updated periodically.