

Contracts and payment guidance October 2020 – March 2021

September 2020

Contents

Introduction	3
Overview of payment arrangements.....	3
Calculation of system funding envelopes	4
System funding for COVID-19 related services.....	9
System performance and efficiency	12
Elective incentive scheme	12
Independent sector acute services.....	12
Better Care Fund (BCF)	13
National funding for service development and transformation.....	13
Primary medical care.....	14
Continuing healthcare	14
Running costs	14
Income from Health Education England	15
Income from Local Authorities	15
Research and development	15
Other direct commissioning.....	18
Capital.....	19
Cash payments and regime	19
Contracts with NHS providers – signature, documentation and implied terms	21
Independent sector providers commissioned under the NHS Standard Contract	22
Contract management – all providers.....	23
Annex 1. Process for amending block contract values	24
Annex 2. High cost drugs and devices	27
Annex 3. Detailed guidance on electives.....	31

Introduction

1. The letter 'Third Phase of NHS Response to COVID-19' dated 31 July 2020¹ set out the key principles of the financial framework for the period 1 October to 31 March 2021.
2. The purpose of this guidance is to outline further detail of the financial arrangements for the NHS for this period. This guidance supersedes information issued previously, including guidance and FAQs covering the first half of 2020/21.
3. If you have any queries in relation to this guidance, please contact nhsi.phase3finance@nhs.net.

Overview of payment arrangements

4. Systems will be issued with fixed funding envelopes comprising:
 - A. **CCG allocations and block contracts** – CCG allocations will continue to be non-recurrently adjusted based on expected expenditure positions, including the national calculation of opening block contract values for services commissioned from NHS providers within and outside of the CCG's home system;
 - B. **System top-up** – additional funding to support delivery of a system breakeven position consistent with the principles of the projected top-up during M1-M6. This funding will now be issued by a lead CCG within each system rather than directly by NHSE/I;
 - C. **Growth funding** – additional funding allocated to systems to support underlying growth in the cost base, linked to allocations growths of CCGs in the system. It is intended that this funding will cover new services and capacity growth since the reference period baseline and over the remainder of the year;
 - D. **COVID-19 allocation** – additional funding to cover COVID-19 related costs for the remainder of the year, noting key exclusions; and
 - E. **Directly commissioned services** – formally specialised commissioning and other directly commissioned (ODC) services remain commissioned outside of the system, but system envelopes take account of funding inflows to NHS providers for these services and deficit costs incurred in delivering all services. Systems are therefore expected to manage full costs within the envelope issued. Nationally calculated block contract values for these services will be issued. Regional commissioners will receive fixed allocations for the remainder of the period.

¹ <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf>

5. The following services will be funded outside of the system funding envelopes:
- A. **High cost drugs and devices** – funding for Cancer Drugs Fund (CDF) and Hepatitis C (Hep C) medicines will return to being funded based on usage, and as such funding for these medicines has been removed from the opening block contract values and the block value will be amended on a periodic basis based on usage to reimburse for these items. A small proportion (in terms of financial value) of specialised high cost drugs have been included within the opening block contract values and funding will not be adjusted based on usage. For the remaining specialised high cost drugs and devices, funding will still be included within opening block values, and the block value will be subject to amendment on a periodic basis based on usage. Refer to Annex 2 for further detail.
 - B. **Temporary COVID-19 services which are funded by government on an actual cost basis** (e.g. Nightingale hospitals, hospital discharge programme, COVID-19 testing services) – relevant organisations will be funded on an actual cost basis for specific COVID-19 services. Costs will be monitored, and services will be subject to amendment based on costs incurred and the maximum budget available. Further detail on funding arrangements is set out in the relevant section in this document.
 - C. **Non-clinical services contracted by NHS England and NHS Improvement (NHSE/I) that are ordinarily transacted via invoicing** – adjustments have been made to system funding envelopes such that full billing can resume from M7 for non-clinical services ordinarily transacted via invoicing to central corporate budgets, e.g. specialist pharmacy services. Billing should only relate to expenditure on services incurred from M7. Centrally funded revenue support (e.g. FRF, PFI revenue support) will remain within system envelopes.
 - D. **Allocation adjustments, including national service development funding (SDF)** – SDF allocations will be adjusted to reflect funding already captured within system envelopes and revised priorities for 2020/21. CCG and NHSE/I regional allocation adjustments will resume per normal processes.
 - E. **Elective incentive scheme and funding for IS activity** – adjustments to system envelopes will be processed based on performance against the elective incentive scheme expected level, including the additional cost of IS activity above the levels funded in system envelopes.

Calculation of system funding envelopes

Block contracts between NHS commissioners and NHS providers

6. Opening block contract values for NHS providers will be nationally calculated and shared with organisations and systems as part of planning.

7. Adjustments may be actioned to block contracts to reflect service changes. Changes to block contracts which affect organisations outside of the system will require approval by the relevant region(s) and notification to the national finance team. Depending on the nature of the adjustment, commensurate net neutral (at a national level) changes to system top-up values will be actioned to insulate systems from changes to block contracts. A national tracker of contract values will be maintained to support this process. Further detail on this process is set out in Annex 1.
8. Individual files will be shared with commissioners (CCGs and NHSE/I regional commissioners) and NHS providers (NHS Trusts and Foundation Trusts). Each file contains relevant organisation-specific data showing the block contract value for each contractual relationship between commissioners and providers.
9. As with the M1-M6 framework, block payments made to NHS providers by their host CCGs will continue to include an allowance for non-contract activity (NCA) with out-of-area commissioners. Consequently, invoicing for NCAs continues to be suspended.

Updates to block contracts

10. The calculation methodology for the block contracts is consistent with the approach for M1-M6² with the exception of the amendments noted below.
11. Where the amendments also relate to expenditure changes then an equivalent adjustment has been made to the underlying expenditure expectation which informs the calculation of the top-up. The amendments to the M1-M6 method are:
 - a. The national de minimis level for contracts has been increased to £500k (annualised), however discretion has been used to set blocks below this level where it has been considered appropriate. Offsetting movements in the system top-up mean that the de minimis does not impact total system funding;
 - b. Material service changes, with equivalent adjustments as relevant to commissioner and/or provider underlying expenditure expectations;
 - c. Material errors identified in the M1-M6 block contracts, with equivalent adjustments as relevant to commissioner and/or provider underlying expenditure expectations. This includes significant changes in respect of commissioner to provider funding flows which were incorrectly left within underlying net expenditure positions despite the pausing of commissioner to provider invoicing outside of blocks.

² <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Covid-19-block-contract-methodology.pdf>

- d. Specialised block contracts have been updated to remove funding for CDF and Hep C medicines. The funding for these excluded items will move back to a payment based on usage which will be transacted based on adjustments to the block contract values. Refer to Annex 2 for further detail.

CCG allocations

12. For M7-M12, CCG allocations will continue to be non-recurrently adjusted to reflect expected expenditure positions.
13. The calculation methodology for adjusted CCG allocations is consistent with the approach for M1-M6³, with the exception of the following amendments:
 - a. Adjustments to block contract values as described in the 'Updates to block contracts' section of this guidance document;
 - b. Removal of expenditure equal to non-recurrent SDF funding received in 2019/20 where we would reasonably expect the associated costs to have been removed. Where funding for these programmes are included within block contract values, CCGs should adjust block contract values by reference to the process outlined in Annex 1;
 - c. The expenditure baseline (against which the expenditure expectation has been developed) for CCG delegated primary care expenditure and CCG running costs has been updated from 2019/20 M11 to 2019/20 M12;
 - d. The growth rate applied to generate the running cost expenditure expectation has been updated to be the lower of: 2019/20 (M12 YTD) excluding spend with NHS providers (included within block contracts) uplifted by 3%; and the 2020/21 published running cost allocation excluding spend within NHS providers (included within block contracts).
 - e. The expenditure expectation for CCG-commissioned acute IS services has been updated to reflect M1-M4 2020/21 average run-rate; and
 - f. Removal of expenditure related to the genomic testing and complex knee revision surgery payment reform proposals set out in the 2020/21 National Tariff consultation. Where funding for these services is included within block contract values, CCGs should adjust block contract values by reference to the process outlined in Annex 1. Funding has been transferred to Specialised Commissioning. For the providers commissioned to deliver the revised service, block contract uplifts will be agreed with specialised commissioning.

³ <https://nhs.uk/sharingpoint.com/TeamCentre/Finance/FinancialControl/Pages/GCh4.aspx#4.4>

14. The system top-up, growth funding and COVID-19 funding will be distributed to a lead CCG within each system. As part of the planning process, systems should identify their lead CCG.
15. As part of system-led planning, systems should by mutual agreement determine the distribution of the funding allocated at a system level. Funding due to NHS providers should be paid by the lead CCG alongside block contract values and COVID-19 funding.
16. Normal processes for adjusting allocations will resume for the distribution of additional agreed funding, e.g. funding for delivery of national service development and transformation programmes (SDF).

System top-up funding

17. Except for specific COVID-19 services (identified in the 'Funding for COVID-19 related services' section), national prospective and retrospective top-up funding will end on 30 September 2020.
18. Instead, additional funding has been issued to those systems where expected expenditure is in excess of income.
19. For the purposes of the calculation of system top-up funding, system funding is calculated as the aggregate of:
 - a. Adjusted allocations for CCGs within the system;
 - b. NHS provider income inflows from block contract arrangements with NHS commissioners outside of the system – i.e. CCGs outside of the system, specialised commissioners and other direct service commissioners; and
 - c. Non-NHS income – System funding envelopes are based on the expectation, as set out in the Phase 3 recovery letter, that organisations will return non-NHS income to the levels seen in 2019/20. The exception to this is car parking income for NHS staff; the NHS People Plan confirmed that NHS staff should continue to have free car parking for the duration of the COVID-19 pandemic. Additional funding for this commitment has been included within the COVID-19 funding allocations. Organisations should make all reasonable efforts to recover income as quickly as possible. Recognising the challenge this poses, when assessing financial performance, the impact of non-NHS income will be isolated to allow the national team to continue to discuss with the Government the treatment of income shortfalls against 2019/20 levels.
20. System expenditure is calculated as the aggregate of CCG and NHS provider underlying cost bases taken from 2019/20 reporting uplifted for 2020/21

inflationary pressures excluding intra-system commissioner and provider transactions.

21. The methodology for the calculation of NHS provider expected underlying expenditure is consistent with the M1-M6 method, with the following amendments:
 - a. Uplift for the full year effect of inflationary pressures;
 - b. Adjustments for material service changes and errors – this includes significant changes in respect of commissioner to provider funding flows which were incorrectly left within underlying net expenditure positions despite the pausing of commissioner to provider invoicing outside of blocks;
 - c. Provider expenditure expectations have been updated for pay uplifts for consultants, specialty doctors and associate specialists announced on 21 July 2020. Our expectation is that the pay uplift will be implemented in September pay and backdated to April 2020 and therefore the backdated pay component will be claimed as part of the September retrospective top-up process; as such no provision has been made for backdated pay claims in setting the M7-M12 expenditure expectations;
 - d. Additional funding for providers for the estimated cost of the local clinical excellence award (LCEA) round for 2020/21;
 - e. Updated CNST expenditure values;
 - f. Updated depreciation and amortisation expenditure expectation based on M1-3 actuals;
 - g. Updated debt regime values to adjust for the value of the loan interest rate compared to a 3.5% rate of return;
 - h. Removal of expenditure for non-clinical services, equal to the value of direct invoices to/additional CCG allocations from NHSE/I central corporate departments in 2019/20. This adjustment enables billing for non-clinical services between NHS providers and NHSE/I or additional allocations from NHSEI to CCGs to resume from M7; and
 - i. Removal of expenditure related to those specialised high cost drugs (CDF and Hep C medicines) which are funded outside of the funding envelopes.
22. The methodology for the calculation of CCG expected underlying expenditure is set out in the 'CCG allocations' section of this guidance document.

Growth funding

23. Additional funding has been distributed to systems to reflect underlying expenditure growth (e.g. staffing and service expansion) which may have occurred since the reference period which was used to set system funding envelopes.
24. This additional funding has been calculated with reference to the underlying allocation growth of the CCGs within each system as well as the total cost base of the system. Whilst funding is distributed to the lead CCG within each system, this funding is intended to cover total cost base pressures across the whole system.

System funding for COVID-19 related services

25. Systems will receive a fixed non-recurrent COVID-19 allocation to cover anticipated additional costs for the remainder of 2020/21 as relevant to their services. There will be no further general retrospective payments for costs incurred from 1 October 2020.
26. All future COVID-19 costs are funded through the fixed COVID-19 funding allocation except for the specific exclusions discussed below.
27. The exclusions discussed below include items which will be reimbursed on an actual cost basis. For these items, the monthly cost reporting process will continue. NHS providers will continue to be reimbursed in arrears by NHSE/I and CCGs by allocation adjustment following a process of validation of reported costs. No invoicing should be established for these items.
28. In exceptional circumstances, the principles outlined in relation to funding for COVID-19 may need to be overruled. These measures may be triggered at local, regional or national levels by the NHSE/I National Incident Response Board (NIRB) depending on the circumstance.
29. The non-recurrent COVID-19 fixed funding will be included within funding allocations and distributed to a nominated lead CCG within the system. As part of the planning exercise, systems should identify their nominated lead CCG and determine by mutual agreement the distribution of funding. Funding due to NHS providers should be paid by the lead CCG alongside the block contract values and top-up funding.
30. System funding allocations have been calculated based on national COVID-19 costs incurred during Q1 of 2020/21. Further adjustments have been applied to these figures to exclude one-off or time limited costs.
31. National funding has been distributed to systems on a fair share basis relevant to the sector, i.e. CCG target allocation for CCG costs and total provider expenditure for provider costs. An adjustment has been made to recognise that

ambulance providers have incurred a greater cost for COVID-19 related services than the average provider.

Personal protective equipment (PPE)

32. PPE will continue to be procured nationally, funded and overseen by DHSC. NHS organisations should continue to utilise national reserves. DHSC's national reserves are being expanded to cover months of supply in preparation for the winter period, including building supply from UK manufacturing sites. DHSC do not expect additional local procurement or locally co-ordinated manufacture of equipment to be necessary to meet demand for PPE items and therefore no funding is available outside of system funding envelopes. Where systems have been or have proposals to support local manufacture of equipment, these should be raised with DHSC.
33. Further details will be set out in separate guidance by DHSC.

Nightingale Hospitals

34. Operating budgets for the Nightingale hospitals have been agreed with the host NHS providers for the remainder of the financial year. These cover costs while on standby, and in the event of any re-opening that may be needed, provided this re-opening is in line with the nationally agreed clinical model for the site.
35. These costs will continue to be reimbursed to host NHS providers on a pass-through basis as currently.
36. Where regions use Nightingale facilities for any other use, including diagnostic usage, this may be completely appropriate and will be funded locally.

NHS COVID-19 testing services

37. As a consequence of the urgency of the initial response to COVID-19, NHS testing services were established rapidly and funded through redeployment of existing NHS provider resources and retrospective claims for additional funding.
38. Testing is now overseen by DHSC's NHS Test and Trace service, and the NHS will be funded for COVID-19 testing services by Government on a capped actuals basis. This means that, for a clear set of deliverables, there is a maximum budget, with funding up to that maximum for the actual costs NHS providers incur.
39. NHSE/I national and regional teams are working with pathology networks to confirm delivery plans for the NHS laboratories that will be commissioned to deliver as part of this service going forward.
40. Commissioned NHS providers will be reimbursed for the revenue costs they incur (excluding supplies which are funded centrally) within guide cost parameters, which are calculated at a current average of £24 per test for rt-PCR virus testing for eligible cohorts and £40 per test for social care antibody testing.

Through additional capital investment in infrastructure, we expect that the average cost of testing will reduce. Commissioned providers will be required to demonstrate this reduction in order to access ongoing revenue funding for the delivery of this service.

41. NHS providers who have not been commissioned to deliver the service should not establish testing without formal approval and will not be able to access funding to reimburse costs incurred from establishing testing unapproved by the DHSC NHS Test and Trace service.
42. Further details will be set out in separate guidance.

Hospital discharge programmes

43. The Government has put in place two schemes in which CCGs together with Local Authorities are commissioning discharge services for patients discharged since 19 March 2020:
 - Scheme 1 – funds patients discharged from 19 March to 31 August inclusive. Those patients discharged under the first scheme remain funded by the first scheme until they have the appropriate post-discharge assessment (such as a CHC assessment).
 - Scheme 2 – funds patients discharged from 1 September 2020. Those discharged under the second scheme will only be funded by the scheme for up to six weeks after their discharge.
44. CCGs will continue to draw down funding for Scheme 1 in the usual way – using the non-ISFE returns for the programme. This scheme will also fund the costs of additional CHC assessment staff per the guidance issued on the resumption of CHC assessment processes:
<https://www.gov.uk/government/publications/reintroduction-of-nhs-continuing-healthcare/reintroduction-of-nhs-continuing-healthcare-nhs-chc-guidance>.
45. CCGs will be required to drawdown funding separately for Scheme 2 and report this separately through a distinct non-ISFE return. We anticipate communicating a maximum annual budget for this scheme at CCG level.
46. Further guidance on the discharge scheme is available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912199/Hospital_Discharge_Policy_1.pdf.
47. Revised ‘Who Pays?’ guidance (<https://www.england.nhs.uk/who-pays/>) has also been published to support the new arrangements for hospital discharge, and this makes clear how CCG responsibility for drawing down funding and making payments to providers under Schemes 1 and 2 is to be determined.

NHS 111 first programme

48. Additional funding will be available for the NHS 111 first programme. Further details will be published once the terms of the scheme have been confirmed.

System performance and efficiency

49. Providers and CCGs must achieve financial balance within these envelopes. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. It is important that a focus on efficiency is maintained so that systems exit 2020/21 with an affordable run-rate position for 2021/22.

Elective incentive scheme

50. The resources provided through the system funding envelopes for the remainder of the year are fully sufficient to fund activity at the levels set out in the letter 'Third Phase of NHS Response to COVID-19' dated 31 July 2020⁴. To further support local systems in realising our shared ambitions for recovery a financial incentive scheme will be in place.
51. Further details will be set out in separate guidance.

Independent sector acute services

52. The nationally funded contract for independent sector (IS) acute services is intended to remain in place until October 2020. After this date, our intention is to move away from a national capacity contract arrangement to local commissioning for all acute IS services. A national call-off framework is being procured to support systems to contract for additional IS capacity and we expect it to be used for all activity funded by the system envelopes. Further details on the revised IS framework will be issued in due course.
53. Within system funding envelopes, systems are funded for:
- IS services sub-contracted by NHS providers at historical levels; and
 - IS services contracted by CCGs at M1-M4 2020/21 average run-rate.
54. As part of the elective incentive scheme (EIS), systems will be funded at 100% of National Tariff prices for IS activity within the scope of the EIS in excess of the level funded in system envelopes.
55. Further detail on the activity reporting process and funding calculation is set out in separate guidance on the EIS.

⁴ <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf>

Better Care Fund (BCF)

56. The requirement remains for CCGs to achieve the minimum contribution to the BCF and within that the requirement for the minimum contribution to social care to grow by an average of 5.3% in cash terms continues to apply.
57. NHS and Local Authority partners should continue to work together to develop and deliver their BCF operational plans for the remainder of the year.

Mental Health

58. Each system, through their constituent CCGs, will receive funding to meet the mental health investment standard (MHIS) 'gap' as set out in the recent MH financial planning files. The MHIS templates capture actual spend for M1-6 and forecast for M7-12. Providers should work with their commissioners to agree the distribution of MHIS funding and incorporate into plans appropriately.
59. Systems will receive their full annual allocation of MH SDF; some of this will have been provided already through block contracts and allocations and/or the retrospective top-ups in M1-6, and the remainder will flow as additional SDF funding as described in the section on 'National funding for service development and transformation'.
60. In distributing the overall funding envelope (including additional COVID funding), systems should ensure that they recognise the additional costs incurred by Mental Health providers in responding to COVID (including but not limited to packages of care to avoid delays in discharge of MH patients to support bed flow, expediting delivery of all age 24-hour crisis support including phone lines, implementing new models of A&E provision for MH patients and MH support to both staff and patients impacted by COVID) and reflect the priority given to MH in the Phase 3 letter.
61. Further guidance on MH service planning and MHIS requirements are published at: <https://future.nhs.uk/MHLTPat>.

National funding for service development and transformation

62. System funding envelopes have been adjusted to remove expenditure equal to non-recurrent SDF funding received in 2019/20 where we would reasonably expect the associated costs to have been removed or for which a revised distribution to CCGs is proposed by national programmes. This adjustment applies to M7-12 only, no retrospective adjustments have been made for M1-6.
63. Where funding attached to the adjustment outlined above is included within provider block contract values, commissioners may process adjustments to provider block contract values by reference to the process outlined in Annex 1.
64. System-level SDF allocations have been communicated for specific Mental Health, Primary Care and Greener NHS.

65. Separate schedules will be issued setting out the following:
- a. Adjustments to remove non-recurrent SDF funding from system envelopes (per the above);
 - b. SDF allocations which are recurrently embedded within system-level allocations and continue to be so for M7-M12; and
 - c. Additional SDF allocations for M7-M12 for agreed investments.
66. Further funding and confirmation across SDF programmes with associated guidance will be issued shortly.
67. Organisations should include costs related to SDF-funded programmes in plans only where funding for programmes have been confirmed.

Primary medical care

68. No additional COVID-19 specific funding for primary medical (General Practice) has been allocated by Government beyond September 2020. Details of what is funded and how to claim appropriate funding up to this point can be found at: <https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-general-practice/>.
69. SDF funding for primary medical care has been communicated to regional teams. CCGs should work with regions or programmes directly to understand how and how much funding will be transacted for the remainder of 2020/21.

Continuing healthcare

70. There is no additional allocation for business as usual continuing healthcare (CHC) costs, but there is specific funding for additional capacity for CHC assessment staff where these are in addition to normal staffing levels. This is funded from the hospital discharge scheme that started on 19 March 2020. Refer to the Hospital discharge programme section of this document for further information.
71. Further guidance on CHC services has been issued at: <https://www.gov.uk/government/publications/reintroduction-of-nhs-continuing-healthcare/reintroduction-of-nhs-continuing-healthcare-nhs-chc-guidance>.

Running costs

72. As outlined in section 'Calculation of system funding envelopes', the running cost expenditure expectation for M7-M12 has been updated. The running cost allocation (RCA) will continue to be non-recurrently adjusted based on this expenditure expectation.
73. The ultimate spending limit on running costs is the 2020/21 published RCA. CCGs may re-prioritise spend within their envelopes where their adjusted RCA is below their published RCA. No additional funding will be provided for this – this

is on the basis that adjusted allocations (across all CCG allocations) are based on 2019/20 spend and this approach funds spend where it was incurred, i.e. where CCGs re-prioritised their RCA in 2019/20 to other service areas (either core or delegated primary care) this will be funded through adjustments to other CCG allocations. In these instances, setting RCA equal to the published allocations would duplicate funding captured within other CCG allocations.

74. Where CCGs opt to re-prioritise spend within their system envelopes to restate the adjusted RCA to published levels, this should be notified to the national team.

Income from Health Education England

75. Health Education England (HEE) have confirmed to NHS providers the funding arrangements for training activity for the remainder of 2020/21⁵. Following a period of block payments from HEE to NHS providers for April to July 2020 inclusive, HEE has restarted payment by activity: (i) from August 2020 for postgraduate medical and dental trainees, and (ii) from September 2020 for other training activity. NHS providers should plan to facilitate training activity as soon as it is safe and practicable to do so, noting the changes to the funding arrangements, and given the importance of developing the future NHS workforce.

Income from Local Authorities

76. Local Authorities have been funded for the cost of commissioning services from NHS providers, including AfC pay uplifts. NHS providers should agree contracts with LAs based on appropriate funding of services.
77. Arrangements put in place for the funding of core services should not overrule separate arrangements in place for the hospital discharge programme and BCF.

Research and development

78. NIHR commissioned research programmes should be funded through the normal reimbursement processes directly between NIHR and NHS providers.
79. Until 30 September 2020, NHS providers should charge the cost of the NIHR SIREN research programme to NHSE/I through the COVID-19 cost claims process against the COVID-19 testing cost category. Further guidance will be issued shortly on the reimbursement mechanism for the SIREN programme from 1 October 2020.

⁵ <https://www.hee.nhs.uk/our-work/education-funding-reform/funding-through-Covid-19-response>

Specialised commissioning

80. Specialised commissioners will receive a fixed allocation for the remainder of the year. This allocation will include funding for non-NHS COVID-19 related services where relevant.

Specialised high cost drugs and devices

81. Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this.
82. For the majority of other specialised high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.
83. Reimbursement for high cost drugs and devices will depend on accurate data reported through the National Commissioning Data Repository (NCDR) system. It therefore remains imperative that providers continue to report required data relating to spend and usage, including submission of Drug and Device Patient Level Contract Monitoring, Blueteq forms and the High Cost Tariff Excluded Devices Financial Reconciliation Process.
84. Refer to Annex 2 for further detail.

Provider collaboratives for specialised mental health, learning disability and autism services

85. Fast track provider collaboratives (PCs) for specialised mental health, learning disability and autism services are planned to go-live during 2020/21. Under these arrangements, identified lead providers will take clinical pathway and financial responsibility for the delivery of in-scope services for specific populations.
86. The issued system funding envelopes and block contract values have not been amended for changes due to the implementation of PCs pending final approval of go-live timing.
87. At the point that go-live is agreed, the lead provider for each PC will receive a budget to commission these services for their population. Providers who previously held contracts with specialised commissioning for services within the scope of the PCs will have a reduction in their contract value with specialised commissioning and this value will be transferred to the lead provider of the PC.
88. The lead providers will then sub-contract with other providers to deliver the full scope of services. For 2020/21, the starting expectation is that lead providers will sub-contract with NHS providers at the same contract value as the reduction

from their block contracts in order to maintain system financial stability, although the contract terms may differ as appropriate. Changes to contract values in 2020/21 due to service changes are expected to be agreed locally and notified to regional teams. In any instance where this would materially affect an individual systems' ability to deliver their system position, this will need to be agreed with the relevant regional NHSE/I team before being actioned.

89. Although in general NHS commissioners and NHS providers are not required to sign written contracts, it is likely that some formal contractual documentation will be necessary to support these new arrangements. This may mean that some providers, both NHS providers and non-NHS organisations, are asked to agree new or revised written contracts or sub-contracts for in-scope services. NHSE/I specialised commissioning teams will discuss and agree appropriate arrangements with the providers affected.

Complex knee revision surgery

90. In line with the consultation notice (para 296) in the 2020/21 National Tariff Payment System documentation, we will be proceeding with the plan to test a new payment approach for knee revision surgery in 2020/21.
91. £12.9m (FYE) has been transferred from the total amount allocated by the tariff to orthopaedic services to Specialised Commissioning. This has been transacted as a reduction in the expected expenditure positions of systems and therefore a reduced system top-up value for M7-M12. Commissioners should work with their providers to flow this change to block contract values as appropriate.
92. Regional networks of specialist providers will be established and will lead local systems in the delivery of best practice in line with clinical standards for revision knee replacement surgery that will be published by the British Orthopaedic Association (BOA) and the British Association for Surgery of the Knee (BASK).
93. The role of the networks will be to ensure that revision knee surgery is undertaken in an appropriate specialist centre and that all revision cases are discussed by a multidisciplinary team (MDT).
94. Funding has been transferred to specialised commissioning who will then fund designated lead providers of knee revision surgery a top up payment to reimburse the cost of setting up and running the regional MDTs and to recognise the most complex activity will be undertaken at the lead centres. The top up will be paid in addition to the funding included within the opening M7-12 block contracts with CCGs for core activity.
95. Further details will be issued in separate guidance.

Genomic testing services

96. In line with the consultation notice (para 144) in the 2020/21 National Tariff Payment System documentation and the ambitions set out in the NHS Long

Term Plan (LTP), we will be proceeding with the plan that all cancer genetic tests are reimbursed outside of national tariff prices.

97. £77.8m (FYE) has been removed from all admitted patient care and outpatient prices and transferred to specialised commissioning. This has been transacted as a reduction in the expected expenditure positions of systems and therefore a reduced system top-up value for M7-M12. Commissioners should work with their providers to flow this change to block contract values as appropriate.
98. A 'hub and spoke' network of genomic laboratories has been established. Seven Genomic Laboratory Hubs (GLHs) led by a lead provider are responsible for the delivery of genomic testing services for their designated providers. Referring providers should work with their local GLH to establish appropriate testing pathways.
99. Block contract values for the GLH lead providers will be increased to reflect the change in delivery model for these services.
100. Prior to 2020/21, a number of cancer molecular diagnostic tests (NRAS/KRAS testing, BRAF Testing, KIT testing, ALK Testing (1), ALK Testing (2), Oncotype DX, PD-L1, Prosigna and EnoPredict) were already reimbursed outside of national tariff prices. These tests will continue to be commissioned per current arrangements and are funded through system funding envelopes. A review of funding arrangements is proposed for 2021/22.

Other specialised commissioning adjustments

101. Provider block contracts with specialised commissioning for M7-12 will also be updated to reflect:
 - a. Impact of agreed service changes relating to gender identity, spinal services, gender clinic procurement, as well as a tranche of Hep C elimination initiatives;
 - b. Increases to reflect planned expansion in Operational Delivery Networks (ODNs) in 2020/21; and
 - c. Planned increases relating to CAMHS, gender surgery and haemoglobinopathy, in addition to other locally specific adjustments.

Other direct commissioning

102. Regional commissioners will receive a fixed allocation for the remainder of the year. This allocation will include funding for non-NHS COVID-19 related services where relevant.

Pharmacy, dental and ophthalmology

103. Regions should continue to claim for additional COVID-19 related costs that are explicitly funded in line with NHSE/I communications. Details of payment arrangements can be found in the update letters to each area of primary care:

- **Pharmacy:**
<https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-community-pharmacy/>.
- **Dentistry:**
<https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-dental-care/>.
- **Ophthalmology:**
<https://www.england.nhs.uk/coronavirus/publication/updates-and-guidance-for-optical-settings/>.

104. Regions should also estimate the reduction in patient income in relation to dentistry and include this as a cost on their COVID-19 finance returns.

Public health flu and COVID-19 vaccination programmes

105. Additional funding will be available for flu and future COVID-19 vaccination programmes. Further details will be published once the terms of the scheme have been confirmed.

Capital

106. Capital charges should be included in plans as appropriate for expected costs on approved capital, noting that PDC is not payable on COVID-19 capital.

107. Approved capital comprises where an MOU has been issued or approval has been notified pending receipt of an MOU.

Cash payments and regime

108. The method of payment for block contracts, system top-up, growth funding and COVID-19 allocations will remain through Invoice Payment File (IPF) and Payment Requests. Commissioner to provider invoicing may return only for a limited number of NHSE/I non-healthcare items.

109. Commissioners should continue to pay NHS provider block and fixed top-up payments on 15th of the preceding month until further notice. We are reviewing the timing of the clawback of the advance payment and resumption of normal payment terms and further guidance will be issued on this in due course.

110. Due to the timing of the system planning exercise, on 15 September commissioners should pay NHS providers a block payment for M7 equal to the M6 block. NHSE/I will continue to pay NHS providers the projected top-up for M7

on 15 September, but this payment will be recharged to the lead CCG within each system responsible for distribution of system top-up.

111. The M7 block and recharged projected top-up value should be trued-up to agree to the output of system planning as part of the 15 October payment, as well as issuing the November advance payment.
112. For COVID-19 programmes funded on an actual cost basis outside of system funding envelopes, NHS providers will continue to be reimbursed in arrears by NHSE/I and CCGs will be reimbursed by allocation adjustments, following a process of validation of reported costs.
113. Amendments to NHS provider funding for specialised high cost drugs and devices will be reimbursed in arrears through amendments to the specialised block payment values.
114. Further detailed payment guidance outlining the governance arrangements for payment requests and invoice payment files (IPF) will be issued shortly.

Table 1. Payment timeline

Payment date and source	M6	M7	M8
Block	15 August (Commissioner)	15 September* (Commissioner)	15 October** (Commissioner)
Projected top-up (M1-M6) / System top-up (M7-M12)	15 August (NHSE/I)	15 September* (NHSE/I recharged to CCGs)	15 October** (CCG)
System COVID-19 top-up (M7-M12)	n/a	15 October (CCG)	15 October (CCG)
Funding for COVID-19 pass-through funded programmes	n/a	15 November (NHSE/I)	
Retrospective top-up	15 November (NHSE/I)	n/a	n/a

**Based on M6 block and projected top-up values*

*** Including true-up of 15 September transitional payments once system planning has concluded*

115. If NHS providers do require supplementary cash support for revenue requirements, they should follow the normal procedure to access such support and work with their systems to minimise future requirements.

116. Additional cash requirements above those paid through the block contract arrangements would be subject to a 3.5% dividend. DHSC guidance provides further technical detail on the cash regime⁶.
117. Cash balances will continue to be monitored throughout the period to ensure that organisations are not generating excess cash balance due to the financial framework. Where this is the case, NHSE/I reserve the right to review and amend funding.
118. It remains important that providers and commissioners pay promptly during this time, so that cash flow for NHS and non-NHS suppliers of goods and services (including, for example, NHS Supply Chain) does not become a barrier to service provision. In line with Cabinet Office guidance (PPN 02/20) NHS organisations should aim to do the following:
 - a. payment of all invoices within 7 days of receipt of goods and service;
 - b. process part payments on the undisputed elements of all invoices currently on hold; and
 - c. ensure that all invoice queries are resolved within a further 7 days.

Contracts with NHS providers – signature, documentation and implied terms

119. NHS commissioners and NHS Trusts/NHS Foundation Trusts ('NHS providers') are not required to, and should not, sign contracts between them for 2020/21. The nationally mandated terms of the NHS Standard Contract for 2020/21⁷ will apply for these relationships from 1 April 2020 to 31 March 2021. Commissioners and NHS providers must not vary from the national terms. For services directly commissioned by NHS England, the 2020/21 published reporting requirements⁸ will form part of the nationally mandated terms.
120. Any existing contracts with NHS providers already signed must be set aside for the period through to 31 March 2021, and payment must instead be made in accordance with the payment arrangements described above, rather than as set out in the existing contract.
121. Although the nationally mandated terms of the Contract, set out primarily in the General and Service Conditions, will always apply, the absence of a written contract may create uncertainty about those elements of the Contract which are normally agreed locally and recorded in the Particulars. In this regard, it will be essential that a pragmatic and cooperative approach is taken locally.

⁶ <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts#history>

⁷ <https://www.england.nhs.uk/nhs-standard-contract/20-21/>

⁸ <https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/>

122. Unless there is clear evidence to support an alternative interpretation (i.e. that the parties have agreed something different for 2020/21), the parties should assume that the agreed local content of each 2019/20 contract will continue to apply during 2020/21.
123. This will not apply to the Schedules dealing with activity and finance (2B, 2C, and all of 3) – these are superseded by the block payment arrangements.
124. In exceptional circumstances for large procurements it may be appropriate to establish formal documentation with an NHS provider where the contractual arrangement were intended to be a service specific standalone contract at the time of procurement.
125. Block payments to NHS providers will be deemed to include CQUIN, but the practical operation of CQUIN (both CCG and specialised) for NHS providers will remain suspended until March 2021. NHS providers are not required to carry out CQUIN audits or submit CQUIN performance data, but commissioners and NHS providers should continue to pay regard to the good practice processes highlighted within CQUIN and make appropriate decisions on how to implement these alongside published clinical guidance.
126. Organisational-level financial sanctions under the Contract remain suspended until 31 March 2021. Commissioners must not withhold funding from NHS providers in relation to failure to achieve the national standards in Schedules 4A and 4B or local standards in Schedule 4C, or under the provisions in GC9 for remedial action plans, or under SC28 for information breaches.
127. For specialised high cost drugs and devices, full reimbursement to providers from 1 October onwards will be contingent on completion of accurate contract data from 1 April 2020 onwards. Refer to Annex 2 for further detail.

Independent sector providers commissioned under the NHS Standard Contract

128. For non-NHS providers not covered by national agreements, commissioners should already have put in place written contracts for 2020/21, in accordance with previous guidance⁹. Commissioners should continue to operate these contracts but may need to update certain elements in line with the latest national guidance on the resumption of planned services within hospitals and on prioritisation within community services.
129. As described for NHS providers above, the operation of CQUIN, any local incentive schemes and financial sanctions for non-NHS providers remain suspended for 2020/21. Commissioners should continue to make CQUIN

⁹ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Covid-19_NHS-contracting-and-payment_26-March.pdf

payments at the full applicable rate to non-NHS providers through to 31 March 2021 (that is, at 1.25% of actual contract value).

130. Commissioners should also consider whether it is appropriate to:
- a. move away from any temporary block payments which may have been agreed for April to July 2020, reverting instead to payment for actual activity or service delivered; and/or
 - b. phase out any relief granted to providers under the Force Majeure provisions of their contracts, and/or to require providers to step up actions in mitigation of Events of Force Majeure.
131. Commissioners should continue to have regard to Cabinet Office Procurement Policy Notes on arrangements under COVID-19 and to related NHS-specific guidance¹⁰.

Contract management – all providers

132. Providers must do all that they reasonably can to comply with the requirements set out in the national terms of the Contract. The provisions of the Contract offer protection for providers as a result of an event of force majeure and/or their response to an emergency situation.
133. In practice, in-year discussions between commissioners and providers should focus primarily on ensuring the return to needed non-Covid activity levels and local management of the COVID-19 response.
134. The 2020/21 Contract contains some new requirements relating to national initiatives. Commissioners and providers should exercise common sense; where the necessary national guidance to support a new requirement in the Contract has not been published, or where a new requirement has been suspended as part of the COVID-19 response, commissioners should act accordingly.
135. A number of national reporting requirements on providers were initially relaxed under COVID-19; updated guidance has now been provided for commissioners and providers to follow¹¹.

¹⁰ <https://www.england.nhs.uk/coronavirus/publication/guidance-to-nhs-organisations-on-ppn-note/>

¹¹ <https://www.england.nhs.uk/coronavirus/publication/next-steps-on-nhs-response-to-Covid-19-letter-from-simon-stevens-and-amanda-pritchard/>

Annex 1. Process for amending block contract values

Introduction

1. Systems may, through agreement across the relevant organisations and relevant NHSE/I teams, action adjustments to the opening provider block contract values in order to support matching resources to their system delivery model.
2. In all instances, changes must be affordable within the funding issued.
3. All commissioner to provider invoicing has been suspended (except for specific NHSE/I non-healthcare activity transactions) and therefore amendments to funding must be actioned through variations to the block contracts.
4. A process for amending block contracts between organisations within different systems has been designed to support organisations to amend contract values whilst stewarding the utilisation of system funding which has been distributed with the intention that all systems are able to deliver a breakeven position. The process will also generate a comprehensive source of block contract values which will support the planning process for 2021/22.

Intra-system contract value variations

5. Changes to block contracts between a CCG and provider within the same system can be actioned based on system agreement. All variations should follow the appropriate organisational and system level governance and approval arrangements.
6. The relevant CCG is required to notify the national team of updates to intra-system block contract values, but no additional approvals process is required.

Inter-system contract value variations

7. Changes to block contracts between a CCG and NHS provider within different systems, or between a regional commissioner and NHS provider require additional approvals.
8. Aggregate changes to a contract value should not be requested/actioned below the de minimis threshold of £200k (annualised), i.e. £100k for the M7-M12 period. The de minimis threshold will be reviewed on a periodic basis.
9. The process to action changes is:
 - a. Local agreement to amend a block contract value is reached between the relevant commissioner and provider, and the relevant systems and regions for each organisation. It is expected that all request variations will have followed the appropriate organisational and system level governance and approval arrangements.

- b. Locally agreed changes are shared with the national team on the prescribed template. The prescribed template will request information on the nature of the adjustment, net expenditure impact to the impacted organisations/systems and evidence of local agreement.
 - c. The national team will review requests and confirm whether an adjustment to the system top-up of impacted systems is required. These adjustments will be net neutral at the national level. The purpose of this review is to mitigate the risk that inter-system block contract values are amended to the detriment/advantage of different systems. The process is not intended to assume commissioning responsibility nor determine whether the adjustment is appropriate for service delivery; these responsibilities remain with local commissioners.
10. There are 4 levels of approval relevant to the process:
- a. CFO of the Commissioner and Provider organisations (required for all variations)
 - b. System Finance Lead
 - c. NHSE/I Regional Team
 - d. NHSE/I National Team
11. A variation approval matrix will be provided alongside the detailed process guidance. This matrix will identify the necessary approvals for key variation types
12. The proposed list of variation categories includes:
- a. System top-up funding distribution
 - b. Growth funding distribution
 - c. COVID-19 funding distribution
 - d. High cost drugs and devices funding adjustments
 - e. MHIS and MH SDF funding
 - f. SDF funding adjustments
 - g. Elective incentive scheme funding adjustments
 - h. Service changes
 - i. Other – explanation will be required
13. Data requirements will be customised for each variation category.
14. A national schedule of block contracts will be maintained by the national team and provide the definitive source of data for planning and transactions between commissioners and providers. Critically, this schedule will be used as the definitive source of contract values between NHS providers and regional

commissioners for the purposes of monthly payments and therefore its accuracy is critical.

15. A range of standardised reporting outputs will be created from the national schedule of block contracts to support reporting to systems and their commissioner and provider organisations. Systems will be asked on a periodic basis to confirm the schedule of block contract values.
16. Further detailed guidance will be issued on the template, timelines and submission process.

Annex 2. High cost drugs and devices

Specialised high cost drugs

1. Reimbursement for Specialised high cost drugs and devices will be changing from 1 October 2020. This annex provides further detail of the reimbursement process by each category of drug.
2. Funding for Cancer Drugs Fund (CDF) and Hepatitis C (Hep C) medicines will return to being funded based on usage, and as such funding for these medicines has been removed from the opening block contract values and the block value will be amended on a periodic basis based on usage to reimburse for these items. A small proportion (in terms of financial value) of specialised high cost drugs have been included within the opening block contract values and funding will not be adjusted based on usage. For the remaining specialised high cost drugs and devices, funding will still be included within opening block values, and the block value will be subject to amendment on a periodic basis based on usage.

Cancer Drugs Fund (CDF)

3. The element of NHS provider block funding relating to CDF is being removed from the system funding envelopes. In line with the calculation of block values overall, the value removed is based on rate of expenditure between months 8 to 10 in 2019/20 as reported through the National Contract Data Repository (NCDR) system and the provider's drugs patient level contract monitoring data submission (DrPLCM).
4. Providers will then be reimbursed from 1 October 2020 onwards for actual usage of CDF drugs on a cost and volume through periodic amendments to the block contract values.
5. Full reimbursement to providers from 1 October onwards will be contingent on completion of accurate data from 1st April 2020 onwards. Data requirements will be equivalent to those asked for in 2019/20 i.e. complete and accurate information in the provider's drugs patient level contract monitoring submission (under the service category CDF) and Blueteq.
6. Only spend that can be successfully cross checked to Blueteq will be reimbursed to providers via adjustments to individual provider blocks. Validation and assurance processes will operate as they did in 2019/20. However, there will not be a return to local invoicing - all payments to providers will run through as adjustments to provider blocks once validation and assurance processes are complete.
7. Further detail will follow through regional teams on the timing of validation and payment processes.

Hepatitis C drugs

8. The approach to Hep C reimbursement will be the same as that adopted for CDF, as outlined above.

Other specialised high cost drugs (HCDs)

9. For the majority of other specialised high cost drugs, in-year provider spend will be tracked against a notional level of spend included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on a cost and volume basis. This will leave a smaller list of HCDs which will continue to be funded as part of the block arrangements.

HCDs returning to a cost and volume process

10. For those drugs on cost and volume, in order to create a baseline to track actual usage against after 1 October, a notional HCD baseline position has been calculated for each provider representing the value of HCDs providers are funded for in 20/21 block values. This notional baseline is based on provider expenditure on the associated drugs in the reference period for calculating the block contract values uplifted for expenditure growth on drugs funded within system envelopes (0.566%).
11. Provider spend on relevant drugs will be tracked from 1 October onwards against this notional baseline spend value with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs. This adjustment to the provider block value can be negative or positive depending on overall expenditure compared to the baseline level across all drugs in this category.
12. The cost impact of new NICE drugs in-year will be included as part of this reimbursement process.
13. There will not be a return to local invoicing. All payments to providers will be processed as adjustments to provider block contract values once validation and assurance processes are complete.
14. As above, reimbursement will depend on the provision of accurate data submitted through existing systems i.e. complete and accurate information in the provider's drugs patient level contract monitoring data submission (DrPLCM, under the service) and Blueteq if relevant. Only spend validated by the regional CSU team will be in scope of reimbursement. Providers should be submitting the most up to date and accurate YTD position in their DrPLCM each month. If queries are resolved, this should be reflected in the provider's latest DrPLCM submission.

HCDs remaining in block values

15. For a portion of specialised HCDs there will not be a return to cost and volume reimbursement. Drugs that fall under this category are generally those not

expected to be volatile in terms of uptake, and where there are no requirements for additional incentives to encourage uptake or additional data requirements to support commercial arrangements. Indirect costs relating to drugs (such as delivery charges) will also be funded from existing block amounts and won't be subject to cost and volume reimbursement.

16. Providers should still submit data on these drugs and may still receive price check queries relating to these drugs.

Existing tariffs for non-drug costs (e.g. CAR-T)

17. Where there exists a tariff payment for non-drug spend (i.e. CAR-T), in line with existing policy for these drugs, NHSE/I will include the payment for such tariffs as adjustments to provider blocks, with no local invoicing, when the new financial regime starts from 1 October onwards. The adjustment will take into account payment already included in the block.

Chemotherapy procurement banding

18. For providers who have moved from coding chemotherapy drug spend in procurement banding terms to coding the drug spend in DrPLCM starting from 1st April 2020, the notional baseline will include an additional adjustment to account for this.

Compliance with national frameworks

19. There are national framework prices in place for some medicines (for example, the framework for Adalimumab). These medicines may be commissioned by CCGs or Specialised Commissioning. It is important all providers adhere to their allocated products for these national frameworks, both to generate savings at a system level and also because these are important in generating best value for the NHS as a whole. Effective compliance with such national frameworks in 2020/21 will therefore also be a condition of reimbursement for high cost drugs under the cost and volume reimbursement processes described above from 1 October 2020.

CCG commissioned high cost drugs

20. CCG commissioned high cost drugs will remain funded system funding envelopes/provider block contracts for the remainder of 2020/21 but will be subject to the requirement to comply with national frameworks above.

High cost tariff excluded devices (HCTED)

21. The specialised commissioning (HCTED) programme is currently in the implementation phase. Under the Zero Cost Model (ZCM) expenditure is paid to NHS Supply Chain directly by NHS England. A new transaction model, the Visible Cost Model (VCM), was introduced in late 2019/20 with NHS providers

directly reimbursing NHS Supply Chain and NHS England then reimbursing the NHS providers.

22. The amount of funding relating to the pass through value of devices in NHS provider baseline blocks will be used in conjunction with the information from NHS Supply Chain to track and amend the block values from M7 onwards for (i) the full year effect of 2019/20 migrations from pass-through to the ZCM; (ii) new migrations from pass-through to the VCM and (iii) transfers from ZCM to VCM.

Further guidance

23. Further guidance will be shared with providers via regional teams. This will include the list of specialised high cost drugs by individual drug name, split to show whether they are subject to the cost and volume or block arrangements described above, and notional baseline levels for high cost drug and device spend that will be tracked and reimbursed on a cost and volume basis from M7 onwards. Further detail will also follow on the data, validation and payment timetable and on the accounting treatment of devices under the VCM.

Annex 3. Detailed guidance on elective incentive scheme

Introduction

In the letter setting out the third phase of the NHS response to COVID-19 sent on 31 July 2020, we set out that block payments would flex to reflect elective activity levels. This was followed by a letter from Amanda Pritchard and Julian Kelly sent on 20 August 2020 which set out more details of how this elective incentive scheme for the system would work. This annex sets out the detailed guidance for how this scheme will operate.

Expected activity levels

From September 2020 onwards, systems are expected to deliver the following activity:

- In September, delivering at least 80% of last year's activity for both overnight electives and for outpatient/day case procedures, rising to 90% from October through the balance of the year.
- At least 90% of their last year's levels of MRI/CT and endoscopy procedures, with the goal to reach 100% by October; and
- 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year.

Systems have been fully funded to achieve these levels of activity. The elective incentive scheme will support systems in achieving these aims by paying systems additional money for any activity undertaken above these levels and deducting money for activity below these levels, representing the marginal costs of delivering or not delivering this activity. The scheme will operate on a monthly¹² basis.

Scope of activity

The scope of activity for the relevant month covered by the scheme is as follows:

- Elective activity is defined as spells with:
 - Ordinary elective admission or a Day case admission
 - a discharge date in that same month (even if there are days in the spell in different months)
 - a priced HRG contained in the 2020/21 national tariff consultation
- Outpatient procedures:
 - with a procedure appointment date in that month
 - which has been recorded as attended
 - which group to a HRG with a price as contained in the 2020/21 national tariff consultation
 - Activity for HRGs which do not have a OPROC national price and are priced as OP attendance are included in OP attendances calculations.
 - with TFC 501 or 560 will be excluded

¹² Not cumulative

- Outpatient attendances:
 - with an attendance appointment date in that month
 - which has been recorded as attended
 - with any WF subchapter HRG (ie first and follow up, consultant-led and non-consultant-led, face to face and non-face to face, multi-professional and single professional)
 - which do not group to a HRG with a price as contained in the 2020/21 national tariff consultation
 - with a TFC which isn't 501, 560, 710-724, 812

For all activity types, zero priced and unbundled activity is excluded. Activity for subchapter NZ (maternity) is excluded.

Both CCG and NHSE commissioned activity is within scope of the scheme.

Activity for NHS patients in England are in scope for the scheme, and this is based on Administrative Category of 01 – NHS patient and exclusion of activity for overseas visitors and devolved administrations.

Calculation of baselines

Each system will have baseline activity calculated as follows:

1. For elective and outpatient procedures activity in scope, the monthly 2019/20 activity will be multiplied by the relevant tariff price¹³ adjusted in line with relevant tariff payment rules including MFF¹⁴
2. For September 2019, the total value of activity calculated in step 1 will be multiplied by 80%
3. For October 2019 to February 2020 data, the total value of activity calculated in step 1 will be multiplied by 90%
4. For outpatient attendances in scope, 100% of the monthly 2019/20 activity will be multiplied by £175 for every first attendance and by £87 for every follow up attendance.
5. The baseline for September 2020 will be calculated by adding together the values in steps 2&4 and multiplying by a factor (22/21) to adjust the baseline to take account of the differing number of working days between September 2019 and September 2020.
6. The baseline for each month from October 2020 until February 2021 will be calculated by adding together the values in steps 3&4 and multiplying by the relevant factor to adjust the baseline to take account of the differing number of working days between the relevant month in 19/20 and 20/21.

¹³ As set out in the 2020/21 statutory tariff consultation

¹⁴ These include MFF, specialist top ups, excess bed days but exclude best practice tariffs (except for those BPTs where "Tariff differentiated on daycase vs elective" and that have automatic flag for payment to be calculate in NCDR i.e. BP28, BP32, BP63, BP68, BP73, BP77, BP79, BP87, BP88, BP91, BP92, BP94, BP95, BP96 along with BPT related to TFC 329). Any changes resulting from procedures on the evidence based intervention list and high cost exclusions are also excluded.

7. The March 2021¹⁵ level will be calculated by taking February 2020 activity per working day and scaling this up using the average ratio of March to February per working day activity in 2017, 2018 and 2019, adjusting the 90% elective and outpatient procedure expected level.

The system baselines will be split into an NHS provider delivered baseline and an independent sector delivered baseline. The independent sector delivered baseline will include all activity directly commissioned by CCGs or NHS England as well as all NHS provider sub contracted activity.

Activity delivered by the independent sector will be identified using provider codes and provider site codes¹⁶. We are aware that previously some NHS provider sub-contracted activity has not identified the independent sector site code as where the activity has taken place, and so would appear in the NHS provider delivered baseline. We are therefore asking systems to make an estimate of the value of any such activity that took place in each month between September 2019 and March 2020 and this value will be used to make an adjustment between the NHS provider baseline and independent sector baseline for the purposes of running the elective incentive scheme.

We are also asking systems to report the value of any activity¹⁷ for 2019/20 baseline purposes which is not being flowed through SUS so that the incentive scheme applies to a comprehensive set of activity data.

All NHS providers within a system and all patients treated in the independent sector from a CCG within the system, or sub contracted from an NHS provider in the system, irrespective of the location of the independent provider, will count towards the system expected level.

Calculation of payments – September

The value of actual activity undertaken each month from September 2020 will be calculated in the same way as described in steps 1 and 4 above.

For NHS provider activity where the value of elective and outpatient procedure activity exceeds the baseline for that month, 75% of the difference between that value and the baseline will be paid to the system. Where the value of elective and outpatient procedure activity is below the baseline for that month, 25% of the difference between that value and the baseline will be removed from system finances.

Similarly, for NHS provider activity, where the value of outpatient attendance activity exceeds the baseline for that month, 70% of the difference between that value and the baseline will be paid to the system. Where the value of outpatient attendance

¹⁵ This is calculated differently to account for the impact COVID-19 had on elective activity in March 2020.

¹⁶ Site code (of treatment) as specified in the NHS data dictionary [https://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/s/site/site_code_\(of_treatment\)_d_e.asp](https://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/s/site/site_code_(of_treatment)_d_e.asp)

¹⁷ As defined in the “Scope of activity” section of this guidance

activity is below the baseline for that month, 20% of the difference between that value and the baseline will be removed from system finances.

For independent sector delivered activity, where the value of activity undertaken is above the expected level, 10% of the difference will be paid to systems. Where the value of activity is below the expected level, 10% of the difference will be removed from system finances.

These adjustments will be processed after the calculation of the retrospective top-up, such that systems will be funded to achieve a breakeven position against reasonable expenditure excluding the items described above. The financial incentive scheme adjustments will then be applied on top of the retrospective funding.

Calculation of payments – October onwards

The value of actual activity undertaken each month from October 2020 will be calculated in the same way as described in steps 1 and 4 above.

For NHS provider activity where the value of elective and outpatient procedure activity exceeds the baseline for that month, 75% of the difference between that value and the baseline will be paid to the system. Where the value of elective and outpatient procedure activity is below the baseline for that month, 25% of the difference between that value and the baseline will be removed from system finances.

Similarly, for NHS provider activity, where the value of outpatient attendance activity exceeds the baseline for that month, 70% of the difference between that value and the baseline will be paid to the system. Where the value of outpatient attendance activity is below the baseline for that month, 20% of the difference between that value and the baseline will be removed from system finances.

For independent sector activity, where the value of IS activity (whether locally contracted or through the national contract) exceeds the baseline for that month, 10% of the difference between that value and the baseline will be paid to the system. Where the value is below the baseline for that month, 10% of the difference between that value and the baseline will be removed from system finances.

In addition, for independent sector activity, where the value of locally funded IS activity (i.e. excluding activity funded through the national contract) exceeds the funded baseline for that month, 100% of the difference between that value and the funded baseline will be paid to the system. Where the value is below the funded baseline for that month, 100% of the difference between that value and the baseline will be removed from system finances.

Counting and Coding

In operating the scheme, NHSEI will adhere to the principles in the standard contract for counting and coding changes. For this scheme this means where activity is counted and coded in a different way for activity undertaken in 2020/21 compared to how it was recorded in 2019/20 (in setting the baseline) NHSEI will seek to

financially neutralise any effect. This is likely to be particularly important for two areas:

- Coding of NHS provider activity sub contracted to the independent sector. We are requiring systems to make an estimate of the value of activity recorded in this way in order to ensure baselines can be adjusted to reflect an accurate position. For recording activity in 2020/21 providers should follow the guidance set out in the NHS Data Dictionary and record the IS site code where the sub contracted activity is delivered.
- Coding of new ways of delivering outpatient attendances. Where providers are undertaking activity virtually which was previously delivered face to face, this should be coded as a non-face to face attendance and the incentive scheme will not penalise providers for switching between modes of activity. If non-face to face activity delivered in 2019/20 was not previously comprehensively recorded, systems should inform NHSEI of the likely size of this activity.

Systems should report to NHSEI any significant counting and coding changes in their system which would affect the operating of the incentive scheme, in particular where services may have moved across system boundaries.

We will issue a template for systems to return which will capture the requests on IS sub-contracted activity, activity which hasn't flowed through SUS and any major counting and coding changes, including activity moving across system boundaries.

Payment details

The system level payments/deductions will be made to the lead CCG allocation as a non-recurrent allocation adjustment. The payments/deductions will relate to performance against the total expected levels – i.e. will comprise performance for relevant specialised and other direct commissioning services. Systems will determine how the adjustments flow, for example:

- Where adjustments relate to CCG-commissioned IS activity – we would expect that the adjustment would be retained by the CCG to recognise reduced/increased spend with the IS sector; and
- Where adjustments relate to NHS provider delivered activity – we would expect, as a starting point for consideration, that the adjustment would be flowed to NHS providers in relevant proportions to the activity delivered to match income adjustments and expenditure.

Monthly process

The calculation of the system level payments/deductions will be made each month and follow the same process:

1. Monthly data available in SUS and in NCDR a few days later
2. Calculation of incentive payments and communication of payment levels to systems

3. Check and challenge process
4. Post reconciliation data available from SUS and in NCDR a few days later
5. Recalculation and issuing of final incentive payments
6. Systems inform NHSEI how money will flow around providers and commissioners in the system
7. Adjustments made to CCG allocations and block payments

The timescales and deadlines for financial reporting will be set out and communicated in the normal way. The timeline for year-end will be communicated in due course.

Worked examples

Example 1 – Increase in activity above baseline

	Baseline £m	Actual £m	Difference £m	Incentive payment £m
NHS Provider A elective	10	11		
NHS Provider A outpatient attendances	8	7		
NHS Provider B elective	20	21		
NHS Provider B outpatient attendances	10	12		
Total system elective	30	32	2	1.5
Total system outpatient attendances	18	19	1	0.7
Independent sector	5	4	- 1	-0.1
Total System	53	55	2	+2.1

Example 2 – Activity at baseline level, but different mix of activity

	Baseline £m	Actual £m	Difference £m	Incentive payment £m
NHS Provider A elective	10	9		
NHS Provider A outpatient attendances	8	10		
NHS Provider B elective	20	19		
NHS Provider B outpatient attendances	10	9		
Total system elective	30	28	-2	-0.5
Total system outpatient attendances	18	19	1	0.7
Independent sector	5	6	1	0.1
Total System	53	53	-	+0.3

Example 3 – System activity below baseline level, but increased in one provider and reduced in another

	Baseline £m	Actual £m	Difference £m	Incentive payment £m
NHS Provider A elective	10	11		
NHS Provider A outpatient attendances	8	8		

NHS Provider B elective	20	18		
NHS Provider B outpatient attendances	10	9		
Total system elective	30	29	-1	-0.25
Total system outpatient attendances	18	17	-1	-0.2
Independent sector	5	5		
Total System	53	51	-2	-0.45