Classification: Official

Publication approval reference: PAR1359

2022/23 National Tariff Payment System

Guidance on the aligned payment and incentive approach

31 March 2022

Contents

1. Introduction

1. The aligned payment and incentive approach is a type of blended payment that was initially introduced in the 2021/22 National Tariff Payment System (NTPS) and is proposed to continue for the 2022/23 NTPS, with some updates.[1] It is intended to support providers and commissioners achieve a stable transition away from the block payment arrangements used during 2020/21 and 2021/22, as part of the NHS response to the COVID-19 pandemic. It is also designed to set the foundation for further development of the payment system for 2023/24 and beyond. The aligned payment and incentive model for 2022/23 is therefore not a 'final' design; however, it still supports a number of key objectives linked to the NHS Long Term Plan.

2. Blended payment was first introduced in the 2019/20 NTPS for emergency care and adult mental health services. In line with the commitments in the NHS Long Term Plan, a blended payment approach remains the direction of travel for the NHS payment system.

3. Aligned payment and incentive agreements comprise two components:

   - **A fixed element** based on funding an agreed level of activity (see Section 3).
   - **A variable element** to increase or reduce payment based on the actual elective activity[2] levels and to reflect performance against existing quality measures (see Section 4).

4. Both of these components combine to aid NHS elective recovery by guaranteeing providers an agreed amount of income to fund elective inpatient and outpatient care. It then provides extra income where providers have been able to undertake additional activity, but can also recoup funding when activity

[1] For details of the proposals for the 2022/23 National Tariff Payment System, see: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/

[2] In the variable element, 'elective activity' would include elective ordinary, day case, outpatient procedures and first outpatient attendances. It also covers advice and guidance services.

plans haven't been met to offer fairness to commissioners and the taxpayer (see Section 4).

5. The aligned payment and incentive approach aims to support the delivery of system plans and encourage collaboration to agree the best way to use the resources available to systems. It provides a consistent approach to paying for both acute and non-acute secondary healthcare services, helping to address issues associated with a fragmented payment system.

6. The aligned payment and incentive approach also supports the continued collection of high quality costing, counting and coding information in a number of ways, including the following:

   - It provides a consistent payment approach across all of secondary care – acute, ambulance, community and mental health. It places greater focus on the whole system, seeking to achieve parity of data quality across all sectors.
   - The fixed element should be based on the latest available data and information. It also encourages local flexibility to forecast future requirements. High quality data will be vital to evidence this.
   - Clinicians should have an enhanced role in determining the level of fixed elements and how funding is disbursed within a provider or system in an efficient and innovative manner. Again, high quality data and information will be needed to support proposals, and to evaluate them.
   - Providers can build up their cost and activity profile in a number of ways, including making use of existing currencies (such as healthcare resource groups (HRGs) and those described in Annex B) as well as currencies that are being developed, such as the non-mandatory community currencies described in the supporting document Community services currency guidance: frailty and last year of life.
   - The approach should also refocus the effort going in to counting and coding by both commissioners and providers. The focus should move away from managing disputes and the technical nuances of a payment system and towards collaborating to develop a joint understanding of the true cost of service provision.

7. We are conscious of the rights of patients enshrined in the NHS Constitution and of our respective responsibilities and duties as set out in the NHS

Constitution and other related legislation. No aligned payment and incentive agreement, or the manner in which participating parties conduct themselves, should infringe or compromise those rights, responsibilities and duties. All parties should ensure that this does not happen.

8. In addition, aligned payment and incentive rule 2(b) states that providers and commissioners must abide by the NTPS principles for local price setting:

   - The approach must be in the best interests of patients.
   - The approach should promote transparency to improve accountability and encourage system working.
   - Providers and commissioners must engage constructively with each other.
   - The approach should consider how the aligned payment and incentive agreement could contribute to reducing health inequalities.

9. Section 3 of the 2022/23 NTPS sets out the aligned payment and incentive rules. Section 4 describes the local pricing principles in more detail.

10. To illustrate how the approach should be applied for specific areas:

    - Appendix 1 gives an illustration for maternity services
    - Appendix 2 explains how to support the innovative products covered by the MedTech Funding Mandate.

2. Scope of aligned payment and incentive agreements

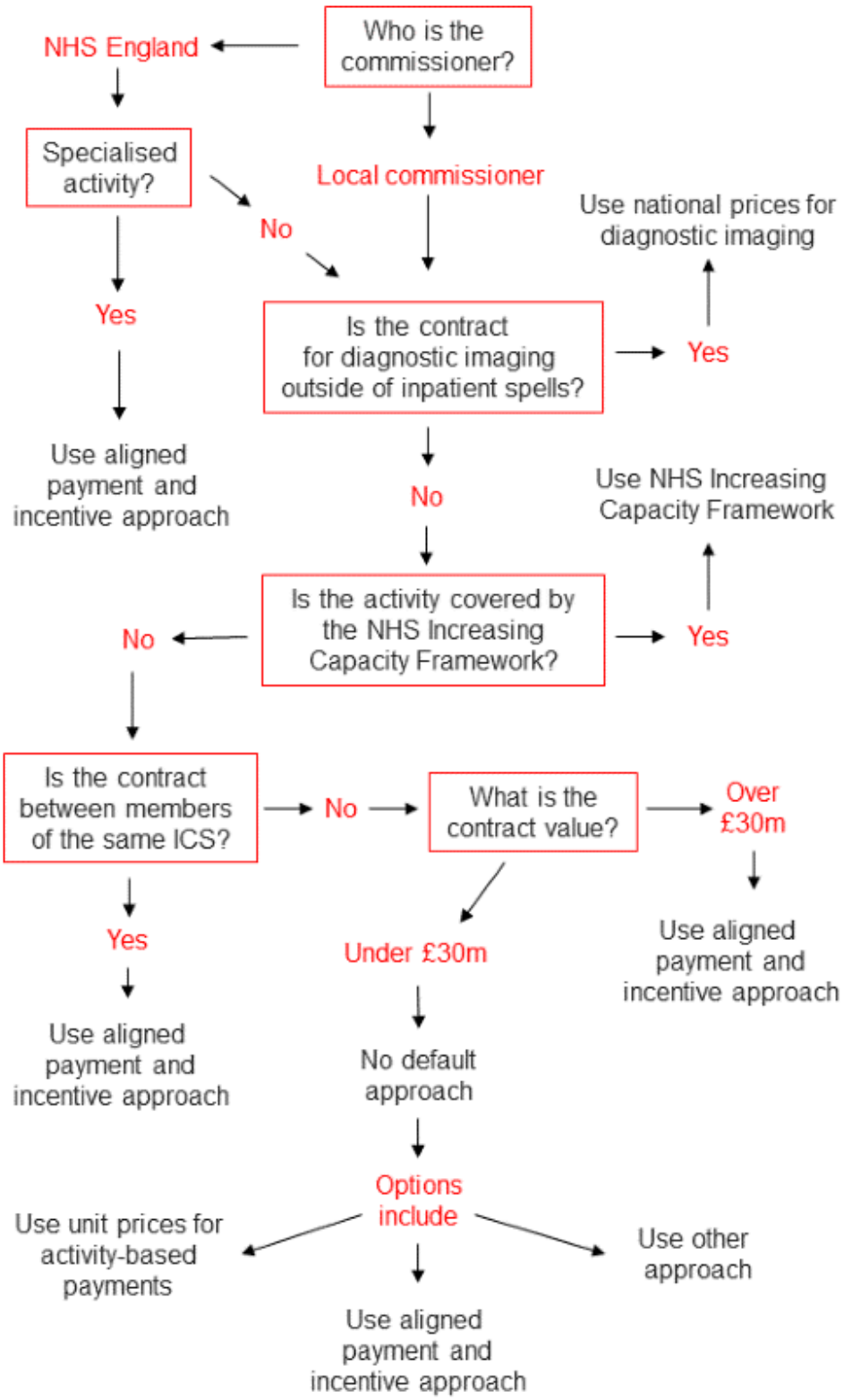
11. The aligned payment and incentive approach is applicable to almost all services within the scope of the NTPS – that is, all NHS-funded secondary care services including acute, maternity, community, mental health and ambulance services. Unbundled diagnostic imaging services continue to have national prices, although providers and commissioners can agree a local variation to fund these services through a fixed payment which links to their aligned payment and incentive agreement. See Section 8 of the 2022/23 NTPS for details of the local variation process.

12. Contracts between a provider and commissioner who are members of the same ICS[3] should use the aligned payment and incentive approach, regardless of the annual contract value. For contracts between commissioners and providers that are members of different ICSs and with an annual contract value of less than £30 million different payment arrangements may be more appropriate, but aligned payment and incentive is still recommended.

13. Aligned payment and incentive is not applied to contracts which are subject to the NHS Increasing Capacity Framework.

[3] In this context, 'member' means organisations that are mapped to ICSs for financial control purposes.

Figure 1: Application of the aligned payment and incentive approach



2.1 Contract threshold

14. The aligned payment and incentive approach applies to all contracts between a commissioner and a provider who are members of the same ICS, unless the contract is awarded under the NHS Increasing Capacity Framework.

15. For contracts between a commissioner and a provider who are members of different ICSs and with an expected annual contract value of **£30 million or more**, aligned payment and incentive agreements are required (again, unless the contract is awarded under the NHS Increasing Capacity Framework).

16. The intention is for the £30m or more threshold to apply at the level of the proposed ICB footprints.[4] As CCGs will remain in place at April 2022, we expect the 2022/23 contracts they sign with providers to take into account what an ICB-level contract value would be and then use aligned payment and incentive agreements accordingly. For example, in a system which currently has more than one CCG as a member, we would expect the CCGs to agree, jointly, a single contract with a provider, to be signed by each CCG as a separate party, but taking into account what their overall system contract value will be with that provider. Within that single contract, if the sum of the proposed annual values for the CCGs within that ICB is above £30 million, we would expect them to use the aligned payment and incentive approach – even if the values for some or all of the individual CCGs are below the £30 million threshold. (Further detail on collaborative contracting, under which multiple commissioners can sign a single contract with an individual provider, is available in the Standard Contract Technical Guidance.)

17. For contracts between a commissioner and a provider who are members of different ICSs and with an expected annual contract value of **less than £30 million**, but not under the Framework, contract partners are free to agree the approach locally. It is encouraged though, where it is possible and would not add excess burden, that an aligned payment and incentive approach is used. For example, an acute provider who has experienced relatively stable contract outturn values of below £30 million with a commissioner in a different system

[4] The commissioner landscape will change in 2022, subject to the passage of the Health and Care Bill through Parliament. If necessary, we will issue further guidance to help with any operational issues in implementing aligned payment and incentive agreements in light of the anticipated move from CCGs to ICBs.

over recent years, may decide an aligned payment and incentive agreement would be the simplest approach to take.

18. In other circumstances, alternative payment approaches may be more suitable. These could include block payments or the use of unit prices published in the NTPS. It may be desirable, for example, for a single specialty provider with multiple, separate commissioner contracts below £30 million to transact on a payment by activity basis rather than enter into different discussions across many different systems.

19. If the commissioner and provider are not able to agree an alternative payment approach, the unit and BPT prices (with relevant national variations) set out in the NTPS must be applied.

20. For activity with an expected annual value below £500,000, NHS providers and commissioners should refer to the low volume activity (LVA) payment arrangements set out as part of 2022/23 Operational Planning Guidance. These involve a commissioner paying an NHS provider a single fixed annual payment based on historic information to maintain the transactional benefits realised through the temporary COVID-19 financial arrangements.

2.2 NHS England commissioned services

21. All NHS England Specialised Commissioning contracts will use the aligned payment and incentive approach, irrespective of value.[5]

22. All other NHS England commissioned services contracts, such as health and justice, are subject to the thresholds set out in Section 2.1.

2.3 NHS Increasing Capacity Framework

23. Activity contracted under the NHS Increasing Capacity Framework is not covered by the aligned payment and incentive approach – instead the rules require the use of the unit and BPT prices published in the tariff, subject to any

[5] The Health and Care Bill contains proposals for joint working between NHS England and local NHS commissioners on the commissioning of specialised services, including the use of joint committees (www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2021/07/PAR817-NHS-England-and-NHS-Improvements-direct-commissioning-functions.pdf). In this document, however, we continue to refer to NHS England Specialised Commissioning which includes any commissioning carried out under such joint arrangements.

payment rules under the Framework. Where the NHS Increasing Capacity Framework isn't used, this guidance and the associated rules for aligned payment and incentive agreements apply, subject to the thresholds described in Section 2.1. It is worth noting that the Framework doesn't automatically apply uniformly to specific activity – the same activity may be covered by the Framework in one area but not in another.

24. Similarly, activity which has been subcontracted to another provider also requires the use of the unit and BPT prices published in the tariff. For example, when an NHS provider decides, with the agreement of the relevant commissioner,[6] to subcontract some of its elective activity to an independent sector provider, the commissioner should reimburse the NHS provider using unit prices, rather than the aligned payment and incentive rules.

2.4 BPTs and CQUIN

25. BPTs and CQUIN are explicit incentive payments which are part of the NTPS. Both of these form part of aligned payment and incentive agreements, with funding captured in the fixed element and then adjustments made, based on actual performance, through the variable element. Section 4.2 provides more information on BPTs and CQUIN.

2.5 Advice and guidance services

26. Advice and guidance services are a key part of national elective care recovery plans. The fixed element will cover the agreed costs associated with plans for outpatient transformation. This will include the level of advice and guidance activity which should be offered, the appropriate mix of face-to-face and virtual attendances and the shift to patient-initiated follow-up (PIFU) pathways. The variable element also applies to advice and guidance services, with funding increased or reduced based on actual activity undertaken. See Section 4.2 for more details.

6 The terms of the NHS Standard Contract are clear that a provider is not to sub-contract any of its obligations under the contract without the prior written approval of the co-ordinating commissioner; the Contract Technical Guidance contains detailed advice on sub-contracting arrangements at paragraph 38.

2.6 High cost exclusions

27. The costs associated with a range of high cost drugs, devices and listed procedures, and innovative products have historically been removed from national prices, with exclusion lists published in the tariff workbook (Annex A, tabs 14a, 14b and 14c). Providers received the funds for these on a 'pass through' or 'cost and volume' basis. The rationale for this is that usage is not necessarily uniform across patients and providers (and so incorporating these costs into prices would likely either under-reimburse or over-reimburse a provider) and that the cost of the excluded item is high compared to the HRG price. This means funding can be volatile with changes in activity.

28. For aligned payment and incentive agreements, the intention is to get funding directly to providers through the fixed element wherever possible. As such, funding for certain items should be included in the fixed element. These are items where usage is relatively consistent, predictable and less volatile. Other items should be excluded from fixed elements and paid for, according to the local pricing rules, on a cost and volume basis. There is no distinction between commissioners, with the same funding approach applying regardless of whether the item is commissioned by NHS England or local NHS commissioners.[7]

29. The list of high cost drugs in Annex A, tab 14b, shows items that are excluded from the tariff's national prices and unit prices. Of these items, it also indicates those whose funding should be included in the fixed element. Funded high cost drugs which are NICE approved and introduced in-year would be excluded from the fixed element and paid for on a cost and volume basis.

30. For high cost devices, all NHS England commissioned device categories will be excluded from the aligned payment and incentive fixed element. The reimbursement process, via the High Cost Tariff-Excluded Devices (HCTED) programme, is published under separate guidance. There are then four device categories which are funded by local NHS commissioners and should be excluded from the fixed element. Annex A, tab 14a contains the list of excluded high cost devices.

[7] In this document, 'local NHS commissioners' refers to either clinical commissioning groups (CCGs) or integrated care boards (ICBs), should ICBs become statutory organisations during the period the tariff is in effect.

31. The item costs for all innovative products (Annex DtA, tab 14c) are excluded from the tariff and funding should not be included in the fixed element. The technologies should be procured through NHS Supply Chain and there will a transition to the reimbursement process using the same reports as HCTED, with the costs reimbursed by the relevant commissioner. However, the costs of implementing the products should be included in the fixed element as this helps ensure savings accrue within the provider.

2.7 Evidence-based interventions

32. The aims of the Evidence-Based Interventions (EBI) programme are to prevent avoidable harm to patients, to avoid unnecessary patient activity, and to free up clinical time by only offering interventions funded by the NHS that are evidence-based and appropriate.

33. In the 2019/20 NTPS a national variation was introduced such that certain procedures, identified by the EBI programme, would not attract reimbursement unless an individual funding request (IFR) is made and approved.

34. For 2022/23, providers and commissioners will agree a fixed element to deliver an expected level of activity. This should reflect non-payment of EBI category 1 interventions (as specified by the EBI programme). For all elective activity within the scope of the variable element (see Section 4), the conditions around EBI activity remain. This means a provider can only claim reimbursement at the agreed variable rate (75% by default) for EBI activity if an IFR has been approved.

2.8 Overseas visitors

35. Where an overseas visitor is exempt from charges for NHS hospital treatment, or the NHS hospital service they receive is free, the NHS Who Pays? guidance sets out how the responsible commissioner can be identified.

36. Where an aligned payment and incentive payment approach is used by this responsible commissioner and the provider, the funding for this treatment should be factored into the agreed fixed payment. That is, the annual funding for overseas visitors' treatments should be estimated and included in the overall fixed payment.

3. The fixed element

37. The aligned payment and incentive approach means the majority of funding is agreed through a fixed element. Local determination of the fixed element is a key part of aligned payment and incentive agreements, but it is recognised that there is significant pressure on commissioners and providers for 2022/23.

38. While there is a degree of local freedom in deriving the expected value of the services captured by the fixed element – drawing on clinical expertise, new models of care and up-to-date information – the information provided here aims to guide providers and commissioners to reach an agreed fixed element.

39. The following steps provide a high-level guide for constructing and agreeing the fixed element. The steps calculate a value for a full year. If an agreement is for provision of services for a period less than 12 months, providers and commissioners should make pro-rata adjustments, including to the £30 million threshold and agreed activity levels, to reflect the shorter period.

40. Alongside the principles set out at paragraph 8, the fixed element should be:

    - reflective of efficient, expected provider costs – maximising the use of every NHS pound
    - used for delivering high-quality services agreed between commissioners and providers – patients receive the best possible care and experience
    - adjusted to reflect system planning assumptions – the health of populations is considered and improved.

41. Providers and commissioners should consider using the Core20PLUS5 approach when setting payments to achieve better, more sustainable outcomes and reduce healthcare inequalities.[8]

42. We are also developing a series of tools to support setting the fixed element. These will be launched on our FutureNHS workspace and will continue to be updated during the year. Contact pricing@england.nhs.uk for more details.

[8] For more details on ways to address issues around equality and health inequalities, please visit the NHS Equality and Health Inequalities Hub.

3.1 Identifying the services in scope

43. Section 2 describes what should be included within the scope of aligned payment and incentive agreements and what is to be determined locally.

44. Providers and commissioners must first identify and agree the exact services that the fixed element will cover. This will capture any changes to services based on agreed service transformation plans or in response to COVID-19. For example, the fixed element should the include costs associated with transforming outpatient services, including advice and guidance, patient initiated follow up (PIFU) services and virtual outpatient attendances. It will also cover 'business as usual' services the provider will carry forward from the previous year.

45. Aligned payment and incentive agreements do not include unbundled diagnostic imaging services as these retain national prices. However, for simplicity, providers and commissioners are encouraged to agree a local variation to fund this activity through a fixed payment which links to their aligned payment and incentive agreement.

46. As set out in Sections 2.4, 2.5 and 2.6, funding for BPTs, CQUIN, advice and guidance and certain high cost items are included in fixed payments. These are all then subject to the variable element, with their overall funding increasing or decreasing based on actual performance (see Section 4).

47. Other activities which should not be included include research grants, private patients, car parking and other activities not covered by the scope of the NTPS (see Section 2 of the 2022/23 NTPS).

3.2 Setting the fixed element

48. The aligned payment and incentive rules state that for any agreement, including the calculation of the fixed element, providers and commissioners should apply the principles for local pricing set out in paragraph 8 (and in Section 4.1 of the 2022/23 NTPS).

49. While there is no prescribed method for setting the fixed element for 2022/23, we encourage providers and commissioners to take a pragmatic approach, such as using the block payments for the second half of 2021/22 as the

starting point and reflecting any other guidance on setting contract values in the 2022/23 Operational Planning Guidance.

50. It is also important that they take into account factors such as:

- inflation
- efficiency
- demand for services
- other funding for specific services
- the expected costs of delivering the elective activity plan
- services changes resulting from the system plan.

51. For example, inflation, CNST and efficiency adjustments may need to be made to bridge the gap between the source data and the current year.

52. The most recent NTPS cost adjustments are:

Tariff year	2020/21	2021/22	2022/23 (proposed)
Cost uplift factor (inflation and CNST)	2.5%	3.1%	2.8%
Efficiency factor	1.1%	1.1%	1.1%

53. Providers and commissioners should consider whether these national adjustments are appropriate for individual system or organisational circumstances, such as where an organisation's cost base is differently weighted than the national tariff assumptions. For example, where a provider has a relatively higher proportion of its cost base made up of pay.

54. Providers and commissioners should discuss any changes in MFF values and agree how the effects should be applied to the fixed element value. They should also consider whether other price adjustments, such as specialist top-ups, are already be captured within the data used to calculate the fixed element and if further amendment would be needed.

55. As per paragraph 44, local plans should highlight any changes to the delivery of services or new models of care, and any anticipated variations in demand from previous years. This should include both national changes (eg changes

in funding requirement for services between local NHS commissioners and Specialised Commissioning) and local or system-level plans such as those linked to the Core20PLUS5 approach.

56. In all cases, it should be possible to trace a path from this figure for 2022/23 to pre-Covid levels of activity and spend.

57. The value of the fixed element will also need to give regard to how any additional funding, such as protected funding for mental health services, passes from local NHS commissioners or NHS England to providers.

58. For 2022/23, CQUIN remains part of the NTPS. To reflect this, providers and commissioners need to ensure that the fixed element includes CQUIN funding of 1.25% of the contract value. If the starting point for setting the fixed element is the emergency payment values for 2021/22, CQUIN funding will already be included. However, if another approach is used, providers and commissioners will need to consider if the 1.25% is included. Either way, the fixed element should be set to assumes that providers will fully attain CQUIN metrics. If attainment is less than this, funding should be deducted from the provider as part of the variable element (see Section 4).

3.3 Using an alternative to the fixed element

59. As with other rules in the national tariff, providers and commissioners can agree to use alternative arrangements if that is appropriate to their local situation.

60. Aligned payment and incentive rule 3 sets out that providers and commissioners need to apply to NHS England and NHS Improvement for approval to implement different payment arrangements. These arrangements must apply the local pricing principles set out in paragraph 8, and the application for approval would need to explain the reasons for the change.

61. Details of the approvals process are published on the locally determined prices web page.[9]

9 www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

4. The variable element

62. The variable element is intended to support elective activity, particularly in the context of the elective backlog that has built up during the Covid-19 pandemic, and quality of care. This section describes how the variable element operates.

4.1 Elective activity

63. The payment system can play a key role in supporting elective recovery. As NHS funding transitions out of the emergency Covid-19 arrangements, the Elective Recovery Fund (ERF) will change from a national mechanism as operated in 2021/22 to become incorporated into aligned payment and incentive arrangements.

64. Funding for elective activity in 2022/23 will be available from core allocations as well as separate funding agreed for elective recovery. This mirrors what was agreed for 2021/22.

65. The available recovery funding will be allocated directly to local NHS commissioners rather than being held centrally. As part of planning, systems will need to set elective activity plans with their providers based on the total funding allocated (ie both core and elective recovery funding).

66. Local NHS commissioners and providers must agree the expected costs of delivering the elective activity plan. This would then form part of the provider's fixed element.

67. The variable element is used to adjust the level of overall funding based on elective performance during the year. 'Elective' in this context refers to all ordinary elective activity, day case elective activity, outpatient procedures and outpatient first attendances. It does not include outpatient follow up attendances.

68. Where actual elective activity delivered is **above** the level agreed for the fixed element, the additional activity is paid for at a rate of **75%** of the NTPS unit price or, where a unit price is not calculated, a locally agreed unit price – ie, money is paid to providers.

69. Where actual elective activity delivered is **below** the level agreed for the fixed element, this is reflected by a reduction in the fixed payment at a rate of **75%** of the NTPS or local unit price – ie, money is recouped from providers to reflect the lower costs incurred.

70. National variations for the market forces factor (MFF) and top-ups for specialised services should be applied to the NTPS or local unit price used for the variable element.

71. It is worth noting that the variable element for elective activity is not intended to operate primarily as an incentive. Rather, it is meant to encourage:

    - setting of realistic but stretching activity plans with appropriate funding in the fixed element
    - sharing financial risk and recognising the provider cost base if those plans differ from activity delivered.

72. Overall, this approach should provide greater certainty for providers that funding is available if activity is delivered. The most consistent challenge we received around ERF funding in 2021/22 was the lack of certainty and we are keen to address that: if all activity plans are met, all available funding is fully utilised.

4.2 BPTs, CQUIN and advice and guidance

73. The variable element is also used to reflect actual attainment for BPTs, CQUIN metrics and levels of advice and guidance activity delivered.

74. When setting the fixed element, funding for agreed levels of BPT and advice and guidance achievement should be included. Actual achievement should then be tracked during the year, with funding increased or recouped in line with actual attainment.

75. For BPTs, the changes in funding should be based on the difference between the expected and actual levels of activity meeting BPT criteria. The value of this should be generated using the BPT and unit prices published in Annex A. For more information about BPT design and criteria, see Annex C.

76. The fixed element must also include the 1.25% CQUIN funding to reflect an assumption of full CQUIN attainment. Performance against the CQUIN metrics should then be tracked during the year, with commissioners able to recoup funding where CQUIN metrics are not achieved. For more information about the CQUIN design and metrics, see www.england.nhs.uk/nhs-standard-contract/cquin/cquin-22-23/

77. Funding should also be paid or deducted for advice and guidance activity that is different to the amount agreed in the fixed element. For more detail about expected levels of advice and guidance services, see the 2022/23 Operational Planning Guidance.

4.3 Using an alternative to the variable element

78. Where providers and commissioners would like to use an alternative to the variable element described in sections 4.1 and 4.2 (and aligned payment and incentive rule 2 (f)), they would need to apply to NHS England and NHS Improvement for approval.[10] In this application, they would need to provide a justification of how their arrangements will deliver the aim of supporting elective recovery and quality of care. They would also need to demonstrate how the arrangements apply the local pricing principles.

79. Details of the approvals process are published on the locally determined prices web page.[11]

[10] As advice and guidance levels would be initially locally agreed, there is no need to apply for changes to this part of the variable element.

[11] www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

5. Risk sharing

80. Given that the allocation and ownership of risk should be determined locally, a nationally prescribed risk sharing mechanism is not appropriate as it wouldn't be responsive to all circumstances.

81. Agreeing a suitable approach to risk sharing between all system partners can be a key driver of effective system working. To support this, the model System Collaboration and Financial Management Agreement (SCFMA) will continue to be published alongside the NHS Standard Contract.

82. The SCFMA is a means of recording locally agreed risk sharing arrangements and is intended to capture details of:

    - the organisations involved and the scope of the risk share
    - the aims and the agreed governance
    - the sharing of gains and losses and any break clauses.

83. The use of the SCFMA is non-mandatory for 2022/23. This is due to the expected passage of the Health and Care Bill, which would establish integrated care boards (ICBs), along with new legal duties on ICBs and partner NHS providers to work together to deliver system financial balance. As such, alternative ICB governance arrangements are likely to be developed that may deliver the aims of the SCFMA. However, the model SCFMA will continue to be published alongside the NHS Standard Contract. This can be used where local systems wish to adopt it.

6. Illustrative example

84. Providers and commissioners need to ensure that the fixed element of their aligned payment and incentive agreement reflects service delivery and resource requirements for 2022/23. This section gives an example of how this process could work.

6.1 Prior to the start of 2022/23

85. An acute provider and commissioner agree a fixed element of **£100m** to deliver services and any changes to the care model, as required by their system plan.

86. The fixed element includes funding for all services in 2022/23 and reflects inflation pressures, CNST and efficiency requirements. It also includes funding for some high cost drugs and the implementation costs of innovative items (see Section 2.6).

87. As part of the fixed element, the provider and commissioner have jointly agreed the following:

- The level of in-scope elective activity to be delivered to support the system elective recovery plan and what the value of this is, using the published unit prices or local prices. Of the £100m fixed element, it is estimated that £30m of this is attributable to the agreed level of elective activity.
- The level of non-face-to-face activity delivered by consultant-led services as part of the advice and guidance programme. Of the £100m fixed element, the estimated value of this activity is £5m.
- The planned level of BPT performance (ie, what the £100m is buying in terms of BPT attainment).

88. They agree that the initial fixed element included CQUIN funding so there is no need to increase this by a further 1.25%.

89. The total fixed payment is **£100m**, which is profiled monthly across the year.

6.2 During 2022/23

90. Where the actual in-scope elective activity delivered is different to that assumed in the fixed element, an adjustment is made for either under- or over-performance. If the level of elective activity is higher than planned, the variable payment pays 75% of the unit or local price for that activity. If it is lower, 75% of the unit or local price is recouped by the commissioner.

91. The provider has outperformed their planned level and the additional activity multiplied by 75% of the relevant prices is valued at **£2m**.

92. The provider has also delivered more consultant-led non-face-to-face activity than originally planned. It is locally agreed that this is valued at **£0.5m**.

93. Where the actual level of BPT performance is different to that planned, an adjustment is made to reflect actual performance. For example, if it was originally assumed that the provider would not attain the 50% attainment rate for the Spinal Surgery BPT but they actually delivered above 50%, then the commissioner pays the additional 10% BPT top up on all relevant activity delivered; this amounts to an additional **£0.2m**.

94. Where the level of CQUIN attainment is below 100%, the underperformance would be deducted from the provider. For example, the provider was expected to manage 70% of patients with confirmed community acquired pneumonia in concordance with relevant steps of the BTS Community Acquired Pneumonia (CAP) Care Bundle. In year, they did not reach this level and so the commissioner was able to recoup **£0.1m**.

95. For community and mental health providers, it is only CQUIN adjustments which are usually required in-year, unless locally developed schemes similar to BPTs are agreed which potentially lead to further adjustments.

96. In total, the provider is paid **£100m** as their fixed payment, with a further **£2.6m** (£2m + £0.5m + £0.2m - £0.1m) paid as the variable payment.

Appendix 1: Maternity services

97. Under the 2023/23 National Tariff Payment System, almost all secondary care activity, including maternity services, is covered by aligned payment and incentive rules. This appendix gives details of how the approach could be applied to maternity services.

98. For 2022/23, aligned payment and incentive will be used for all contracts between a provider and a commissioner who are members of the same ICS, and all other contracts above £30m. In the limited circumstances where maternity activity sits outside this scope, it is still recommended that aligned payment and incentive is adopted.

99. If a circumstance arises where the aligned payment and incentive is deemed not suitable, then it is recommend that any activity-based payments for maternity services are based on HRG-level prices, rather than the maternity payment pathway (MPP) prices.

100. Both HRG and pathway prices for maternity services are published in Annex A (tab 7a), while details of the pathway are available in Annex B.

Ensuring the fixed element reflects the resource requirements of maternity services

101. The Health and Care Bill sets out planned changes to commissioning arrangements as they are delivered across system footprints by ICSs, which are coterminous with Local Maternity Systems (LMSs). For maternity services, LMSs have been providing place-based planning and leadership across these landscapes for a number of years and are therefore well-placed to support the setting of activity plans and associated payment agreements.

102. For 2022/23, the majority of maternity services will be funded through aligned payment and incentive fixed elements, which is designed to meet the costs of delivering the service plan. Fixed elements can be used to provide certainty, and support planning and forecasting.

103. Fixed elements relating to maternity services should be aligned to Local Maternity System (LMS) plans by supporting the delivery of system objectives, including the training of staff to meet these needs.

104. Section 3 of this document describes in more detail the considerations for agreeing the fixed element. As per paragraph 44, any changes to service models for maternity services between the source data used and what is planned for 2022/23 should be reflected in the fixed element. This could be changes in the expected level of births, or changes to the configuration of service delivery between providers across a system.

105. The fixed element should also give regard to the Immediate and Essential Actions to Improve Care and Safety in Maternity Services within the Ockenden Report, which includes resourcing Maternal Medicine Networks and Birth-rate Plus. This is also set out in the most recent Priorities and Operational Planning Guidance: Implementation Guidance.

106. Where there is significant uncertainty around expected levels of activity for maternity services and therefore the correct value for payments, a local risk share agreements can be agreed, for example using the model SCFMA.

A note on provider-to-provider maternity payments

107. Under the proposed NTPS rules for 2022/23, there is no requirement for provider-to-provider payments for maternity services. Payment approaches should be reflective of the anticipated cost of delivering system plans and should therefore not require intra-provider cross-charging.

Appendix 2: MedTech Funding Mandate

108. The MedTech Funding Mandate requires commissioners to pay for the innovative products covered by the policy. The items covered by the Mandate are included as innovative products in tab 14c of Annex A of the NTPS. These are then excluded from the national tariff prices as well as from aligned payment and incentive fixed elements (see Section 2.6).

109. Uptake of these innovative products during 2021/22 has not increased as expected. Stakeholder feedback suggests this is due to confusion over which commissioner (CCG or NHS England) should pay, and whether funding was included in block payments.

110. For 2022/23, we have clarified the innovation payment policy. This aims to:

- support increased uptake and wider use of approved innovative technologies likely to generate savings on investment
- ensure that a sustainable payment approach is in place and that payments to providers reflect the cost of products and full implementation costs
- support multi-year funding approach as requested by the majority of stakeholders
- ensure that payment rules are efficiently and consistently implemented across healthcare systems, reducing potential inequalities between different areas
- encourage providers and commissioners to work closely together to achieve cultural change and ensure that mandated payment rules are complied with for the benefit of patients.

Innovation payment policy for 2022/23

111. The item costs of innovative products listed in Annex A, tab 14C are excluded from fixed payments and reimbursed by local NHS commissioners on a “pass through” or cost and volume approach, from existing allocations. Spectra Optia, which is for the treatment of sickle cell patients, is the only technology

that will be funded by NHS Specialised Commissioning, and is the only technology not available on NHS Supply Chain. Providers should consult their regional Academic Health Science Network on procuring this technology.

112. Providers should procure these products through the relevant NHS Supply Chain framework, rather than negotiate with suppliers. NHS England and NHS Improvement are working with NHS Supply Chain to improve the reporting and reimbursement MTFM technology costs. Once operational, commissioners will see the MTFM technologies purchased on their monthly High Cost Tariff Excluded Devices (HCTED) report detailing the cost of products ordered by each provider. Monthly reports will be shared with both providers and host commissioners to enable easier reimbursement, eliminating the need for complicated agreements with individual technology suppliers and commissioners. Purchases not made through supply chain will not appear on the reports and may not be reimbursed.

113. To optimise uptake and create the best possible environment to deliver expected benefits, funding for implementation costs should be included in the fixed element of aligned payment and incentive arrangements.

114. The products are subject to NTPS local pricing rule 3, which stipulates that the price the commissioner pays must reflect actual costs, the prices set under any applicable procurement framework or a reference price set by NHS England and NHS Improvement, whichever is the lowest.

115. To ensure that all costs associated with using the products are reflected in payments, commissioners and providers should consider and agree:

- upfront investment and full cost of implementation
- the profile of cash releasing savings
- the benefits that release capacity
- how benefits to other providers in the same ICS are unlocked.

116. When setting fixed payments, providers and commissioners will need to consider the associate implementation costs of the items.

Full implementation costs	Considerations for benefits realisation
Set up / upfront investment • business case development • Infrastructure development / adjustment	Are all the benefits accrued to the provider implementing the technologies?
Training	Are all the benefits cash releasing?
Backfill	How will capacity releasing benefits be managed?
Project / data management / reporting	What is the profile of cost savings accrued and how are they evidenced?
Maintenance / calibration of products	How will benefits realisation be managed?
Pathways / estates adjustments	How can services and capacity be best arranged?

117. The fixed element, which will be used to pay for non-product related costs, should be set based on planned activity and best available cost data. This will involve providers and commissioners agreeing all known upfront and implementation costs, ensuring that efficient resource and capacity management are achieved to maximise uptake.

118. Risk sharing agreements or locally designed variable payments could be used to address variations from plans or to incentivise specific areas such as patients' outcomes and data quality, based on local agreement on outcome measures.

Cost effectiveness, expected benefits and available support

119. Cost effectiveness analysis across different providers over different years should reflect savings achieved and capacity released as a result of using the products. Commissioners and providers should set out and agree expected cost saving and capacity to be released, with payments adjusted accordingly.

120. Expected benefits from using innovative products may be:

- profiled over a number of years
- a combination of real cash savings and released capacity

- across different providers from the one implementing the product
- commissioners could achieve savings with different providers involved, under the potential range of contracts and payment approaches adopted.

121. The Academic Health Science Network (AHSN) will provide the necessary support in relation to implementing the MedTech Funding Mandate, highlighting benefits, and ensuring that providers and commissioners understand the reporting and reimbursement processes.

122. The AHSN has:

- knowledge of the technologies and existing relationships with the suppliers
- a suite of resources to support implementation, including business case templates and implementation toolkits
- experience supporting providers and their relevant clinical teams who have chosen to adopt the technologies
- relationships in all localities that can help develop links between commissioners and providers to support implementation of the Policy and the individual technologies

123. The Innovation, Research and Life Science (IRLS) Group within NHS England and NHS Improvement have developed business cases for established products outlining key benefits, cost savings over three years and budget impact, as well as case studies demonstrating how successful implementation can be achieved.

124. These documents, together with the updated MedTech Funding Mandate policy, approved products for 2022/23, signalling documents and other relevant information can be accessed through https://future.nhs.uk/MTFM/grouphome.

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