# Developing the payment system for 2021/22

Engagement on national tariff and related contracting policies for 2021/22

# Contents

1. Introduction ..... 2

2. Blended payment and contracting ..... 5

Blended payments for 2021/22 ..... 5
Financial incentives ..... 12
Contracting for 2021/22 ..... 13

3. Other policy areas ..... 15

Setting prices for 2021/22 ..... 15
Adjusting prices to account for COVID-19 costs ..... 16
Market forces factor ..... 17
Centralised procurement ..... 18
Complexity adjustments and specialised top-ups ..... 18
High cost exclusions ..... 19

4. Future payment system ..... 20

# 1. Introduction

1. This document sets out the key payment system, and related contracting, policy areas that NHS England and NHS Improvement are developing for the statutory consultation on the next national tariff payment system (NTPS), due to take effect from 1 April 2021.

2. The tariff policies are being developed to align with the wider NHS financial framework for 2021/22. The overarching aims of this framework are to:

   - support recovery and restoration of NHS services
   - deliver an affordable position within the NHS mandate
   - build on the learnings of the COVID-19 emergency financial framework
   - encourage and enable effective system working.

3. It is expected that there will be comprehensive integrated care system (ICS) coverage by April 2021, with ICSs and sustainability and transformation partnerships (STPs) already working to embed and accelerate joint working arrangements. This system working has been reinforced by the financial framework for the second half of 2020/21, which has established system allocations for the system top-up and COVID-19 fixed funding, encouraging system collaboration in service design and resource planning.

4. The 2021/22 financial framework is expected to build on this, focusing on appropriate financial governance and cost control while working at system rather than organisation level. This would involve measures including:

   - issuing a system top-up allocation, alongside CCG allocations, so that a system has funding to cover the cost of delivering services efficiently (including previous central 'sustainability funding', such as the Financial Recovery Fund – FRF)
   - moving towards blended payment and away from episodic and activity-based payment approaches.

5. This document describes the potential blended payment approach in more detail.

6. As well as working to align with the financial framework, developing the next tariff has also been affected by the highly unusual context of 2020 and the COVID-19 pandemic.

7. Given the uncertainty this has caused, and to allow potential need to make changes as services evolve, we expect to propose setting the tariff for one year – the 2021/22 NTPS.

8. For 2021/22, we are considering how best to ensure the payment system:

   - builds on this shift away from activity-related payments introduced for 2020/21 and continues towards the NHS Long Term Plan (LTP) objective of moving to population-based funding
   - supports increased system working and the development of ICSs
   - supports systems to reduce the backlog in elective activity
   - supports the positive innovations introduced in response to COVID-19, such as increased use of virtual outpatient appointments
   - encourages equality and addresses health inequalities.

9. We think introducing a consistent blended payment approach across almost all secondary healthcare services, including both the acute and non-acute sectors, would effectively achieve these aims. This potential blended payment approach is discussed in Section 2.

10. In addition to the work on blended payments for a large amount of activity, we are considering potential developments to other tariff policies and prices for 2021/22. These are presented in Section 3.

11. We expect the payment system proposed for 2021/22 to be a pragmatic step forward from 2020/21, not the end of payment reform. In Section 4, we set out some key priorities for an effective future payment system that have emerged from discussions with stakeholders. We are keen to ensure that our proposals for 2021/22 are consistent with these priorities and represent a logical step in the right direction.

12. You can give feedback on all of the topics included in this document through our online survey. The survey home page includes a downloadable Word

version of the questions to help you compile a response. However, all responses should be submitted through the online survey, not via email.

**Please note:** From 19-30 October 2020, we ran a series of engagement workshops to discuss the potential policies for 2021/22, following up with a survey. We received a wide range of feedback and thank all attendees for their contributions. The survey accompanying this document is closely aligned to that from the workshops, so you may not feel the need to submit an additional response – although any further thoughts would be welcome.

13. The deadline for feedback is midnight at the end of **10 December 2020**.

14. We will carefully consider all the feedback we receive and use it to inform the proposals that are included in the statutory consultation on the 2021/22 NTPS.

15. If you have any questions, please contact pricing@improvement.nhs.uk

# 2. Blended payment and contracting

16. Blended payment was initially introduced in the 2019/20 NTPS for emergency care and adult mental health services as a framework involving a fixed payment and at least one of a quality- or outcomes-based element, a risk-sharing element and a variable payment.

17. The proposals for the 2020/21 NTPS included blended payments for outpatient attendances and maternity services. However, due to COVID-19, providers and commissioners have agreed block payment arrangements for the year, as a departure from national prices and any national blended payment arrangements. As such, the blended payments for outpatient and maternity services have not, in practice, been implemented.

18. During the engagement and consultation on the tariffs for both 2019/20 and 2020/21, feedback on blended payment was generally supportive, but significant concerns were addressed around the potential complexity. This was particularly the case when a provider or commissioner might have multiple different blended payment arrangements for different services. We have been considering how to avoid this issue in our proposals for 2021/22.

19. Any move to broaden the scope of blended payment has implications for other aspects of payment and contracting, including the operation of financial incentives. We have been working closely with the team responsible for the NHS Standard Contract to ensure that payment and contracting proposals for 2021/22 are aligned.

## Blended payments for 2021/22

20. For 2021/22, we are considering how best to build on the financial arrangements for 2020/21, and progress the LTP goal of moving away from the activity-based payments. We also want to ensure that the payment system supports positive innovations in service delivery introduced in response to COVID-19, such as the shift to non-face-to-face outpatient appointments.

21. To do this, we are considering proposing a blended payment model for the vast majority of secondary healthcare services. This would greatly broaden the scope of blended payments, and would replace the individual service-level blended payments introduced in previous tariffs.

22. The blended payment model for 2021/22 would include a fixed payment, based on the costs of delivering a level of activity that conforms to the ICS system plan, and a variable element for some elective activity. Alongside the blended payment arrangements, providers and commissioners would need to sign up to a System Collaboration and Financial Management Agreement (SCFMA), under the terms of the NHS Standard Contract. The SCFMA would serve to share financial risk across the system (for more details, see 'Contracting for 2021/22'). CQUIN and best practice tariffs would continue to incentivise care quality (see 'Financial incentives'), although we have started a longer-term project to look at simplifying and streamlining quality incentives.

23. The blended payment would not have to use tariff prices to set the fixed payment and would be subject to pricing rules for calculating the payment rather than national prices specified in the NTPS. We are considering retaining national prices for diagnostic imaging. We feel that prices should support increasing activity in this area as a result of COVID-19 recovery work, as well as direct access to these services from GPs and shifting the service model to delivery via diagnostic hubs. However, systems would be able to choose, through agreement of local variations, to include diagnostic imaging within the scope of their blended payments.

24. In this section, we briefly outline the potential blended payment design, including: the fixed and variable elements, the services that would be covered and the thresholds that would form part of the model. We also look at how financial incentives might best be arranged within a blended payment environment and what the implications of moving away from unit prices might be for best practice tariffs (BPTs).

## Blended payment elements

### Fixed payment

25. We are considering asking providers and commissioners to base the fixed payment element of the blended payment on the costs of delivering a level of activity which conforms to their ICS system plan.

26. The value of the fixed payment would be determined locally but, for NHS providers, we would expect that the starting point for discussion between providers and commissioners is likely to be the payment arrangements in place for the last six months of 2020/21 (as set out in section 4.A of Contracts and payment guidance October 2020–March 2021).[1] However, more details of this starting point will be confirmed in the statutory consultation and planning guidance. Discussions should also consider the resources available to the system, based on the system financial envelope, as well as inflation, productivity, efficiency, service transformation and overall demand estimates. Where appropriate, local areas may choose to consider other ways of determining the fixed payment, such as methodologies based on historic financial figures or more forward-looking predicted capacity costs.

27. Any activity undertaken using the elective framework agreement (which we anticipate to include some independent sector activity) would be outside the scope of blended payments and would be reimbursed on the basis of published prices. Any non-NHS provider activity outside the framework would be subject to the blended payment rules, including the thresholds (see below).

28. Fixed payments would be expected to include funding for new ways of delivering services, such as the creation of Maternal Medicine Networks for specialist maternity activity. We are also considering whether items currently excluded from the tariff, such as genomic tests, should be included in the fixed payment. For high cost drugs, we are considering whether it would be appropriate to continue with the approach introduced in the second half of 2020/21, with different categories reimbursed in different ways but with the fixed payment covering CCG-commissioned drugs and those that are not

[1] See also paragraphs 10-12 of the Contracts and payments guidance for more details of the block payment arrangements.

expected to be volatile in uptake or require additional incentives or data to support commercial arrangements.

29. Setting a fixed payment in this way would build on the payment arrangements for 2020/21 – and would represent a marked shift away from activity-based payments or the use of individual prices to determine fixed payments (as was the case for the emergency care blended payment). As discussed in Section 4, we would expect the approach to setting fixed payments to evolve in future years.

30. We would continue to publish unit prices, calculated in the same way as national prices in previous tariffs. The prices could be used for services where blended payment does not apply.

31. We welcome feedback on this approach, and suggestions of the types of guidance that areas would find most useful to support agreeing a fixed payment locally.

**Variable element**

32. A variable element within the blended payment could be used to: incentivise activity; allow funding to follow the patient; mitigate financial risks of activity above or below plan; provide incentives to collectively manage demand.

33. For 2021/22 we are considering including a variable payment for elective activity. This would support:

    - focus on the reduction of the elective backlog
    - ICSs to deliver activity in line with their system plans.

34. While the variable element could be entirely down to local agreement, initial feedback from systems is that a centrally-designed default arrangement would be preferable. We have considered a number of options for how such a model might work – summarised in the following table.

| Variable element features | Potential strength | Potential weakness |
|---|---|---|
| Systems must have a **variable rate for their highest priority specialties**, but the rates and level at which they are paid are determined locally | Allows systems to use **local knowledge and intelligence** to make key decisions | May be **inflexible** in determining the number of specialties considered |
| **100% paid for all elective activity** above and below the **level agreed in fixed payments** | Employs a tried-and-tested mechanism, suggesting it is already **well-understood** | Suggests a **lack of focus** on areas which need it most |
| **75% for activity above plan and 25% for activity below plan**, paid at system rather than national level | May promote **system collaboration** to agree plans | Once plans are agreed, the role of variable payment is wholly focussed on providers, **not focussed on the system** |
| Nationally determined highest priority specialties **have a 100% mandated variable payment**, but all other variable elements are locally agreed | Gives clear **national steer** to control the highest priority specialities | May **miss opportunity to use local knowledge and opportunity** to identify other priority areas |

35. We welcome feedback on which of these options would be likely to be most effective. We would also welcome views on the approach to incentivising elective activity implemented in the second half of 2020/21.

36. Local areas could also choose to introduce additional variable elements for other services or activities within their blended payment arrangements.

## Scope of the blended payment

37. The blended payment arrangements would apply to all NHS-funded care services currently covered by the NTPS – including acute, community, mental health and ambulance – where the contract value is above a set threshold (see Thresholds below). All providers of such services would need to agree a blended payment with their commissioner, including for activity commissioned by NHS England.

38. We anticipate that the blended payment approach would cover all NHS England Specialised Commissioning activity, with no threshold for this activity.

The blended payment would involve Specialised Commissioning agreeing fixed payments with providers to deliver their services.

39. While having an impact on the funding of acute services, moving to blended payment would also affect how non-acute services are funded:

- For **community providers**, funding is currently largely based on block contracts which are rolled over from previous years, with some adjustments for inflation and efficiency. Blended payment would mean community providers receive a fixed payment based on the costs of delivering activity anticipated in the system plan. This may or may not be related to the preceding year's payment. In the absence of sufficient local data and confidence to inform shifts in funding, the approach for 2021/22 may be relatively simple. However, we would expect systems to look to implement the principles of blended payment, including the use of variable rates where appropriate and including community services in the agreement of system-wide risk sharing. We are also developing community currencies and better community service data collection, which should provide more robust data to support blended payment agreements in future years.

- The current tariff rules say that **mental health** providers should adopt a blended payment approach (including fixed, variable and outcome elements) for their adult mental health services, but may agree different approaches locally. In practice, the blended payment is not widely used and most providers are paid based on historic blocks, increasing with the Mental Health Investment Standard (MHIS). The 2021/22 blended payment for mental health would follow the same approach as other services and involve a fixed payment, variable payments where appropriate and a system-wide risk share including mental health services. It should also ensure agreements are consistent with the ICS system plan and resources available through the MHIS. Local areas would be able to continue to use already agreed outcomes elements if they chose to.
- We are also reviewing the mental health currency model for potential use in future tariffs. We want to ensure the currencies are clinically appropriate and fit how providers are recording data. As with the work on community currencies, this would support better informed blended payment agreements to evolve over time. For more detail, see *Mental health currency review*, published alongside this document.

- Currently the NTPS rules say that **ambulance** providers should be paid per unit of activity for four categories (calls; hear and treat; see and treat; see, treat and convey) with the prices agreed locally. In practice, most providers agree block contracts with their commissioners, with some agreements including risk shares. These funding arrangements are closer to the proposed blended payment for 2021/22 than the activity-based approach in the current tariff rules.
- We will continue to work with the ambulance sector as national policy develops and more detailed costing data becomes available to make sure that payment arrangements support appropriate service delivery.

## Thresholds

40. As mentioned above, we expect to propose that the blended payment would apply for commissioner/provider contracts above a set threshold. We want to ensure that payment arrangements are proportionate and keep the burden of multiple different contract negotiations to a minimum.

41. We have been working to understand where best to propose this threshold and are considering an annual contract value, between a provider and individual commissioner, of £10 million. Our analysis suggests that setting the threshold here would mean that blended payment arrangements would apply for the vast majority of activity, by value, without requiring a very large number of individual contracts to be negotiated. It would also mean that many small community service contracts (some of which have been tendered and awarded on a multi-year basis) would be out of scope.

42. While the thresholds would apply to the majority of contracts, we are considering different arrangements for some. We would expect all Specialised Commissioning activity to be covered by blended payment arrangements. Contracts under the national framework agreement for elective activity, which we expect to reimburse much activity undertaken by independent sector providers, would be exempted from the blended payment.

43. While blended payment would be the default payment approach for high value contracts, we are looking to formalise and permanently embed the approach for low-volume flows of activity introduced on a pragmatic temporary basis in 2020/21. This would involve a provider's host commissioner paying for

services, on behalf of more distant commissioners, where the annual value of the activity flow is below a set amount (eg £0.2 million), with adjustments made to CCG allocations to compensate. This approach would significantly reduce the burden of separate invoicing and payment validation. However, putting in place permanent new arrangements would require changes to the NHS Standard Contract and related guidance. As such, there is a separate detailed consultation on the proposed changes to the contract, which would take effect from 1 April 2021.

44. For activity between these two thresholds (ie above £0.2 million but below £10 million), rather than specifying that the default payment approach should either be based on fixed payments or on prices, we are considering not setting a default payment approach. This would then leave the nature of payments down to local agreement. This could lead to a mix of contracts on block and those based on prices, which may be appropriate. However, we welcome feedback on this potential approach.

## Financial incentives

45. Currently, the NHS uses a range of financial and non-financial incentives for commissioners and providers to deliver quality improvements and transformation. Financial incentives targeting improvements in quality include:

    - best practice tariffs (BPTs), part of the NTPS
    - clinical processes in the CQUIN scheme
    - financial sanctions under the NHS Standard Contract. The contract is also regularly refreshed to include new policy and delivery requirements and, where providers fail to deliver against these, allows commissioners to withhold payment in certain circumstances.

46. For 2020/21, these incentives were not applied during the COVID-19 response.

47. Together, these levers are an important set of tools to draw attention to and deliver improved patient experience, clinical quality and safety goals. However, we feel that there is a case for simplifying and streamlining them, ensuring that financial incentives are used where they are likely to have the greatest impact and reducing the bureaucracy they can generate. Incentives

could also focus more explicitly on the objectives in the NHS Long Term Plan. Our ambition is to simplify the various incentive schemes, but retain the strong clinical signals that exist in the current system.

48. We are aware that the blended payment model we are considering is likely to require changes to the operation of BPTs in particular, as the blended payments are not expected to be calculated based on unit prices. With these issues in mind, we are considering the following for 2021/22:

    - Removing certain financial sanctions under the NHS Standard Contract.
    - Retiring the day case and outpatient procedures BPTs, where the desired outcomes would be financially incentivised by blended payments.
    - Publishing other BPTs on a non-mandatory basis, allowing systems to agree locally how to use them within their blended payment arrangements. We would offer guidance for how systems might reflect BPT achievement levels within their fixed payment calculation. This would all operate within the system financial envelope.
    - Retaining CQUIN value at 1.25% and using the existing CQUIN design process for 2021/22.
    - Working with stakeholders to understand how best to support and sustain future performance in areas currently incentivised.

49. In future years, and as the blended payment design evolves, we would work on how to further integrate and streamline the current incentive approaches, where there is sufficient evidence and clinical consensus that doing so would be appropriate. We welcome feedback on the feasibility and desirability of this.

## Contracting for 2021/22

### System Collaboration and Financial Management Agreements

50. Alongside the blended payment, we are working with the NHS Standard Contract team to consider how the current model System Collaboration and Financial Management Agreement (SCFMA) could be developed and strengthened for 2021/22.

51. The SCFMA was introduced from April 2020 as part of the NHS Standard Contract. The intended requirement was that each system would put in place

a written agreement for how the different NHS organisations would approach the management of financial risk across the system as a whole. The aim was to promote collaboration across NHS organisations within each local system as they delivered the system financial improvement trajectory for 2020/21 – and to support sustainable management of NHS finances in the longer term.

52. The current model SCFMA is not a mandatory template. Rather, it sets minimum expectations. Any locally completed SCFMA must:

- describe the collaborative behaviours expected of the parties
- require open-book accounting by, and financial transparency between, the parties
- describe processes for reaching consensus and resolving disputes about how best to use financial and other resources available to the ICS/STP
- set out a mechanism for management of the aggregate financial position of the parties to achieve and maintain the system financial improvement trajectory for the ICS/STP.

53. We welcome feedback on how the model SCFMA could be strengthened for 2021/22. We are particularly interested to hear views on whether its focus should be broadened beyond delivery of system financial balance.

## Contracting and payment for low-volume flows of activity

54. As mentioned in the Thresholds section above, we are consulting separately on potential changes to the NHS Standard Contract for 2021/22, and related guidance, to embed the approach for low-volume flows of activity introduced informally in 2020/21. This would involve a provider's host commissioner paying on behalf of more distant commissioners for services where the annual value of the activity flow is less than a set figure (eg £0.2 million), with adjustments made to CCG allocations to compensate.

# 3. Other policy areas

55. Introducing the blended payment approach discussed in Section 2 would have significant implications for the operation of the NTPS. However, there are other aspects of the tariff that we have been working on and are considering proposing in the statutory consultation on the 2021/22 NTPS. In this section we provide an overview of these key areas.

56. It should be noted that, as the potential blended payment approach would involve funding the vast majority of activity through locally agreed fixed payments rather than national prices, the range of activity affected by price-specific policies and national variations (such as MFF and specialist top-ups) could be greatly reduced.

57. While the 2020/21 NTPS was not published until the second half of 2020, and providers and commissioners largely used the financial arrangements introduced as part of the response to COVID-19, on publication the 2020/21 NTPS became the tariff in effect. The 2020/21 block payment arrangements operate as local variations/departures from the tariff's local pricing and blended payment rules. This means that the policies contained in the 2020/21 NTPS form the baseline for proposals for 2021/22. They would not be consulted upon again unless they are explicitly covered by a policy proposal for 2021/22.

## Setting prices for 2021/22

58. Implementing the blended payment arrangements discussed in Section 2 would have a significant impact on the operation of the NTPS. While we would continue to calculate and publish prices, the majority of these would be unit prices to be used for services outside the scope of blended payment, rather than national (ie mandated) prices.

59. We are considering setting 2021/22 national prices and unit prices by rolling over the 2020/21 NTPS prices and currency design. This would mean that the 2020/21 prices would be used as the starting point and would then be subject to adjustments for efficiency, CNST and inflation. There may also be changes as a result of DHSC's review of the PDC dividend charge rate. The structure

of payments for CNST contributions, as well as the inflation and efficiency factors to be applied, will be confirmed in the statutory consultation in light of the government's 2020 Comprehensive Spending Review.

60. There would be a very small number of changes to some treatment function codes (TFCs) to reflect changes in outpatient activity.

61. We appreciate that the 2020/21 prices were themselves a rollover of the 2019/20 prices. This would mean that the proposed prices for 2021/22 would be based on cost and activity data from 2016/17. However, we feel that recalculating prices based on more recent data, including using patient-level costs (PLICS) instead of reference costs, risks introducing volatility into the prices. This is a particular concern as currently there is little capacity for clinical review of price relativities so we would not be able to confirm that any new prices are clinically appropriate.

62. Feedback from clinicians on the price relativities for 2019/20 and 2020/21 has supported them as a robust reflection of the relative cost of clinical activity. We recognise that this does not reflect changes to services and costs as a result of COVID-19, which are likely to impact in different ways on different services. However, we think that it may be more effective to reimburse COVID-related costs separately (see 'Adjusting prices to account for COVID-19 costs' below) until more data is available. As such, it seems appropriate to stay with the clinically endorsed price relativities from 2020/21.

63. As a new set of prices is not being published as part of the engagement, organisation-level impact analysis reports are not being produced.

64. We welcome feedback on the published 2020/21 tariff prices and particularly any potential illogical relativities (where, for example, the price for a less complex procedure is higher than that for a more complex one).

## Adjusting prices to account for COVID-19 costs

65. COVID-19 has changed the way care is delivered and, in some cases, has decreased activity levels or increased costs – for example due to additional infection prevention and control (IPC) requirements.

66. We are considering whether these changes should be reflected in the prices published as part of the 2021/22 NTPS. Given that robust cost data is not currently available and there are variable costs across different geographies and time periods, we think it may be appropriate to produce a guidance framework for making local adjustments to prices, rather than setting a standard national approach.

67. We welcome feedback on what guidance would be most useful and any views on what should be included in the framework.

## Market forces factor

68. The blended payment arrangements would mean the majority of activity is funded through locally agreed fixed payments rather than national prices. In this context, the market forces factor (MFF) would have less bearing on individual reimbursements, but should be considered as part of agreeing the fixed element. MFF values would continue to be applied to prices used for activity outside of the scope of blended payments and for some activity below the threshold for blended payments.

69. The 2019/20 NTPS revised the method and source data used to calculate MFF values. Given the impact on some providers, the changes are being introduced over a five-step glidepath. The MFF values for 2020/21 were the second step on this glidepath.

70. For 2021/22 we are considering moving values to the third step of the MFF glidepath. This would continue the journey towards target MFF values, which gives providers and commissioners a more accurate allocation of financial resources compared to the legacy values based on out-of-date data.

71. We have been discussing further potential updates to the MFF calculation method, following feedback from stakeholders over the last two tariff development cycles. We have particularly been considering changes in regard to operating leases, facilities management costs and the land index. However, given the rollover of price relativities and other changes elsewhere in the NTPS, we are not sure that it would be appropriate to introduce further volatility by moving away from the previously published MFF glidepath values for 2021/22.

## Centralised procurement

72. Also in the 2019/20 NTPS, a policy was introduced to reduce prices to reflect the arrangements for central funding of the overhead costs of Supply Chain Coordination Ltd (SCCL). The total reduction (£204 million) was taken out of commissioner allocations, with tariff prices being lowered accordingly. The aggregate reduction was unchanged for the 2020/21 tariff

73. The pricing team are working with SCCL to understand the changes in their overhead costs since 2019/20. The exceptional additional costs relating to procurement of PPE are largely being borne by the commercial directorate and government departments and so would not be expected to be covered by the amount removed from tariff.

74. We are considering whether it would be appropriate to propose making no changes to the amounts for 2021/22. If there were any changes proposed, these would be reflected in adjustments to national prices and the unit prices which could be used for services outside the scope of blended payment.

## Complexity adjustments and specialised top-ups

75. As a result of the move to prescribed specialised services (PSS) designation of specialised services in the 2017/19 tariff, a transition path was implemented to limit the impact of the changes in a single year. This transition path was paused for the 2020/21 tariff to allow the pricing team to undertake further work to understand issues around reimbursement of complex activity under the tariff.

76. For 2021/22, we are considering keeping the transition path on hold at 50%. The top-up payment rates are also expected to remain the same as 2020/21. These adjustments were made for the 2020/21 prices and so would be reflected in 2021/22 national prices and unit price for services outside the scope of blended payment. We expect the approach to complex knee revision surgery introduced in 2020/21 to continue. We have also been working with specialist paediatric providers to ensure that prices more accurately reflect complex and specialised care.

## High cost exclusions

77. As described in Section 2, we welcome feedback on the proposal to continue with the approach to high cost drugs introduced in the second half of 2020/21, with different categories reimbursed in different ways but with the fixed payment covering CCG-commissioned drugs and those that are not expected to be volatile in uptake or require additional incentives or data to support commercial arrangements. However, we would continue to publish the high cost drugs and devices lists as part of the tariff.

78. To establish the contents of these lists, for each new tariff, high cost drugs and devices steering groups meet to discuss items that could be added or removed. In addition, there is usually a web portal for people to submit nominations for the lists, as well as a horizon scanning exercise to identify new items that might be expected to come onto the list.

79. However, the steering groups for 2021/22 have not been able to meet until late in the year and neither the horizon scanning process or web portal have been run. As such, the steering group's view is that – particularly in the context of the rollover of prices and the uncertain impact of COVID-19 – it would not be appropriate to make significant changes to the lists of high cost drugs or devices for 2021/22.

80. Nominations can be sent to us during this tariff engagement period – please contact pricing@improvement.nhs.uk. All submissions will be considered in the context of the price rollover and COVID-19, as described above.

81. We intend to update our process so that high cost drugs and devices nominations can be submitted all year round, with defined cut-off dates for nominations to be considered in future tariffs.

82. We will review the lists for any items that have not come on the market and so should be removed. We also intend to update the lists to indicate, where possible, which commissioner would be responsible for paying.

83. We will also work with the innovation team to review the innovative products list that was included in the 2020/21 NTPS. The MedTech Funding Mandate that was planned for 2020/21 has been delayed until 2021/22.

# 4. Future payment system

84. As mentioned in the introduction, we want the proposals for the 2021/22 NTPS to be consistent with development of a reformed payment system.

85. We are working to ensure the payment and contracting system supports:

- more efficient allocation of resources, including a focus on health maintenance and prevention activities
- collaborative system behaviours and collective management of system financial resources
- a focus on patient value, high quality care and good patient outcomes
- transparency and accountability to provide assurance that resources are being put to best use.

86. While our potential proposals for 2021/22 move towards some of these goals, it is likely that the payment system will need to evolve further in future years. For example, we need to ensure that moving to fixed payments does not reduce accountability and visibility over how resources are spent locally, or reduce systems' ability to allocate resources effectively.

87. We have been engaging with a range of stakeholders to understand how best to enhance and develop the payment and contracting approach in the longer term. From these discussions, the following key priorities have emerged:

- Further enhancing the whole system approach to payments, contracting and incentives, taking into account the impact of potential legislative change.
- Developing the building blocks (such as costing and currency data for non-acute services) to support a whole system approach to payment and enable the fixed payment to better reflect care models and actual costs of delivering care.
- Enhancing data infrastructure and exploring ways to use existing data in innovative ways.
- Retaining and enhancing the role of clinicians in payment decisions.

- Exploring other approaches to calculating the fixed payment, such as drawing on pathway or year of care approaches for certain patient groups.
- Considering how to align incentives for primary care and social care with those of the wider system.
- Refining quality incentives to further align them with collaborative system working and the LTP objectives.
- Supporting uptake of innovative contractual models, such as alliances and the ICP contract, where there is local appetite to adopt these approaches.

88. We welcome views on these priorities – and suggestions for how they may be developed. If you would be interested in getting involved with our work on the future payment system, please contact pricing@improvement.nhs.uk.

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.


Publication approval reference: PAR0099