



# Guidance on finance and contracting arrangements for H1 2021/22

March 2021

## Overview

1. This document sets out the details of the finance and contracting arrangements for the six-month period from 1 April 2021 to 30 September 2021 ('H1 2021/22' or 'H1'). These arrangements are supported by an additional £8.1bn of funding provided by government, of which £7.4bn is available over the first half of 2021/22 to reflect the on-going impact of COVID-19.
2. In addition, the government has provided £1.0bn for elective recovery and £0.5bn for mental health recovery across 2021/22. Full details of these are included in the Elective Recovery section of the H1 implementation guidance, and Appendix 1 of this guidance.
3. The H1 arrangements are:
  - System funding envelope, comprising adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities.
  - Block payment arrangements will remain in place for relationships between NHS commissioners (comprising NHS England and CCGs) and NHS providers (comprising NHS foundation trusts and NHS trusts). Signed contracts between NHS commissioners and NHS providers are not required for the H1 2021/22 period.
  - H1 block payments with NHS providers should be amended to reflect the changes to system funding envelopes, eg application of inflation and distribution of additional funding. Block payments with CCGs outside the system ('inter-system') and NHS England contracts for directly commissioned services (specialised and other directly commissioned services) will be uplifted by 0.5%. National approval will continue to be required to action changes to these contracts.
  - Payment timelines will return to pre-COVID timelines as set out in the NHS Standard Contract terms; the payment for April 2021 will be due on 8 April 2021.

- Where non-NHS providers are being commissioned to provide services (other than core primary care) from 1 April 2021 onwards, a written contract in the form of the 2021/22 NHS Standard Contract must be in place and signed. This includes putting in place contracts for acute independent sector (IS) services which were covered by the national IS contract during 2020/21.
- Through the H1 financial regime, systems will have access to the following additional growth funding:
  - i. acute services – access to additional funding through the Elective Recovery Fund
  - ii. mental health services – additional CCG programme funding and service development funding (SDF) to enable delivery of the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) priorities
  - iii. primary medical care services – additional primary care growth has been issued in line with the 2021/22 published CCG primary medical care allocations and additional agreed allocations as outlined in this document
  - iv. community services – funding for demographic growth has been included within system funding envelopes. Access to additional non-demographic growth will be available through SDF for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home.
- In recognition of the impact of the COVID-19 pandemic on services funded through non-NHS income streams, we will be issuing additional fixed income support in H1 2021/22 through the COVID-19 allocation. The COVID-19 allocation will continue to be distributed to the lead CCG for the system and transacted to NHS providers, where relevant, through amendments to their block payment arrangements. The funding provided will represent the totality of funding available for systems in relation to non-NHS income support. With this income, systems will be expected to fully recover their positions.

- The financial arrangements include efficiency requirements for NHS and non-NHS providers. For non-NHS providers of services within the scope of the National Tariff Payment System (NTPS), an annualised efficiency requirement of 1.1% has been set in the NTPS 2021/22 consultation prices.
- For NHS providers, a general efficiency requirement of 0.28% for the six-month H1 period has been applied to the growth in NHS provider block payments and feeds through to CCG programme envelope growth and inflation on the system top-up and COVID-19 allocation. In addition to the general efficiency factor applied to all NHS providers, targeted reductions in system top-up funding will be applied to those systems with carry-forward 2019/20 financial trajectory gaps which were funded through the H2 2020/21 arrangements. Through this mechanism, we will begin to recover the positions of those systems funded in excess of a sustainable position and support overall financial recovery. There will be a continued efficiency requirement into the second half of 2021/22.

## H1 financial planning process

4. NHS England and NHS Improvement have nationally calculated CCG and NHS provider organisational plans for the H1 period as a default position for systems and organisations to adopt. The intention in calculating these is that organisations have a starting point for budget management without needing to complete an extensive planning process.
5. Default organisational plans have been generated based on Q3 2020/21 actuals. Q3 actuals generate affordable positions for most systems and therefore minimise the extent of local planning required to set affordable organisational-level budgets. We have not actioned adjustments to organisational positions to reflect 2021/22 new items, ie no adjustment has been made for inflation or distribution of growth funding. Systems will need to plan collaboratively to determine the distribution of these resources.
6. By generating organisational positions based on Q3 actuals, the plans will implicitly assume the continuation of the Q3 distribution of system funding (comprising allocations, system top-up, COVID-19 allocation and SDF) to organisations and will not include the distribution of new funding.

7. Systems, by mutual agreement and on a net neutral basis within their system funding envelope, will be able to amend the default organisational positions, to reflect an alternative distribution of current resources and the impact of new resources, pressures and policy priorities. These changes should be reported on the system plan template.
8. All systems will be expected to report a balanced position on the system plan template. Those systems where the aggregate organisational plan position based on Q3 actuals is a deficit will be required to submit a system plan template showing an improvement to a breakeven position. If a system does not submit a balanced position, regions will be asked to assess the causes and will work with systems to develop a balanced plan.
9. As part of setting plans, CCGs are advised to set aside a contingency of up to 0.5% of their allocation to support risks to expenditure that may not otherwise be mitigated. Where setting of a contingency fund is neither considered affordable nor required – for example, where financial risks are fully mitigated – it is allowable to not set a contingency; this will be subject to regional assurance.
10. Where the submitted system plan template shows a change to an organisation's surplus/deficit position for the period (referred to as Local Organisation Contribution in the system plan template), we will action a one-line adjustment to the nationally generated organisational plan such that the final position reconciles to the system plan template.
11. In constructing organisational plans, we will assume an equal profile across each month. NHS providers will have the opportunity, during a short window in advance of M2 reporting, to make net neutral amendments to their plans to reflect an alternative distribution between detailed plan categories and an alternative monthly profile to the default position. However, the plan surplus/deficit for the period must remain consistent with the system plan template.
12. Organisations will be monitored against the final positions reported on the system plan template, including any agreed amendments.

## H1 system envelope and organisational plans

13. System funding envelopes comprise adjusted CCG allocations, system top-up and COVID-19 fixed allocation.
14. The system top-up and COVID-19 allocation will be distributed to a lead CCG for the system. By mutual agreement within a system, changes in funding should be transacted to NHS providers through amendments to their block payment arrangements.
15. Further detail on the construction of H1 system envelopes and organisational plans, including further information on the inflation and efficiency calculations, will be available through regional teams.
16. Except for the items identified in this section, system funding envelopes and block payment arrangements with CCGs outside of the system and NHS England commissioners, represent the totality of NHS funding available in H1 2021/22.
17. The following services will continue to be funded outside of system funding envelopes, and the funding terms are outlined in further detail in this document.
  - specialised high cost drugs and devices – refer to the ‘Specialised services’ section
  - specific COVID-19 services – refer to the ‘Funding for COVID-19 services’ section
  - non-clinical services contracted by NHS England and NHS Improvement that are transacted via invoicing – refer to the H2 2020/21 guidance<sup>1</sup>
  - allocations of national SDF – refer to the ‘National service development funding’ section.
18. In addition, systems will have access to elective recovery funding. Full details are set out in the Elective Recovery section of the H1 implementation guidance.

<sup>1</sup> <https://www.england.nhs.uk/publication/contracts-and-payment-guidance-october-2020-march-2021/>

## Contracts

19. Signed 2021/22 contracts between NHS commissioners and NHS providers (NHS trusts and NHS foundation trusts) are not required for the H1 2021/22 period. Where services continue to be provided, the nationally mandated terms of the NHS Standard Contract for 2021/22<sup>2</sup> will apply from 1 April 2021 onwards, and a contract incorporating those nationally mandated terms will be implied as being in place between the parties.
20. Where non-NHS providers are being commissioned to provide services (other than core primary care) from 1 April 2021 onwards, a written contract in the form of the 2021/22 NHS Standard Contract must be in place and signed.
21. The national Q4 2020/21 contracts between NHS England and 14 IS providers of acute services will expire on 31 March 2021. Commissioners, NHS providers and IS providers should take action to ensure that local contracts and subcontracts are in place to meet each system's needs for IS acute capacity from 1 April 2021 onwards.
22. H1 system envelopes have been adjusted to move funding for IS services contracted by CCGs back to historical levels. All IS provision will therefore be locally managed and funded. Access to additional reimbursements from NHS England and NHS Improvement will exclusively be through the Elective Recovery Fund arrangements per the terms set out in the ERF section of the H1 2021/22 implementation guidance.
23. Systems should continue to make best use of the NHS Increasing Capacity Framework (the 'Framework'). The Framework covers over 90 providers of acute elective services at present and allows a commissioner to put in place a contract, or a trust to put in place a subcontract, with one of the identified providers, either by a direct award (in the circumstances described in the Framework documentation) or by undertaking a mini-competition. Contracts and subcontracts awarded under the Framework must always be in the form of the current NHS Standard Contract or template NHS Standard Subcontract (full-length in each case).

<sup>2</sup> <https://www.england.nhs.uk/nhs-standard-contract/21-22/>

24. The consultation notice for the [2021/22 National Tariff Payment System \(NTPS\) statutory consultation](#)<sup>3</sup> has been published. The 2020/21 NTPS remains in place from 1 April until the new 2021/22 NTPS comes into force. The NTPS should continue to be the basis of contracting and payment arrangements with non-NHS providers for services within the scope of the NTPS. NHS providers will continue to be paid under the block payment arrangements (outlined in the ‘NHS provider block payments arrangements’ section), which involve variation from the national pricing arrangements in the NTPS.
25. System funding envelopes continue to contain an allowance for low-volume activity (NCA) flows from distant CCGs and remove the need for separate invoicing to CCGs outside the block payment arrangements. We are continuing to consider changes to streamline the way in which payment is managed for low-volume activity flows after the interim framework ends.
26. There will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage. The NTPS consultation document and NHS Standard Contract propose that CQUIN will be brought within the scope of the NTPS. Block payments to NHS providers are deemed to include CQUIN. Commissioners must not withhold funding from NHS providers or non-NHS providers in relation to failure to meet CQUIN requirements during H1.
27. Further detail on contracting arrangements are set out in the technical guidance of the NHS Standard Contract. Where this contracting guidance refers to the “first part of 2021/22” this is now confirmed to be H1 2021/22.

## NHS provider block payment arrangements

28. The block payments approach for arrangements between NHS commissioners and NHS providers in England will remain in place in H1. Where there was already a signed multi-year contract in place with an NHS provider, extending into 2021/22, the payment terms of this contract must be set aside for the rollover period, and payment must instead be made in accordance with the block payment arrangements. The local variations from national pricing

<sup>3</sup> <https://www.england.nhs.uk/publication/2021-22-tariff-consultation/>



arrangements agreed last year in accordance with NTPS rules will remain in effect.<sup>4</sup>

29. All commissioner to provider invoicing has been suspended (except for specific NHS England and NHS Improvement non-healthcare activity transactions) and therefore amendments to funding must be actioned through variations to the block payments.
30. For H1, block payment values should be set based on:
  - Contracts between CCGs and NHS providers within the same system ('intra-system contracts') – systems are advised to roll over their latest intra-system contract value (subject to affordability) and uplift them by the H1 provider inflation factor (0.5%) but may opt for an alternative distribution of inflation funding based on knowledge of local pressures.
  - Contracts between CCGs and NHS providers in different systems ('inter-system contracts') –will be issued with the latest CCG inter-system contract values (based on the national contract tracker) uplifted for the H1 provider inflation factor (0.5%).
  - NHS England directly commissioned service contracts – systems will be issued with the latest contract values (based on the national contract tracker) uplifted for the H1 provider inflation factor (0.5%).
31. As with the H2 2020/21 framework, systems may, through agreement across their relevant organisations adjust the block payment values with NHS providers within their system to support matching resources to their system delivery model.
32. The H2 2020/21 process for amending block payment between organisations within different systems (inter-system and NHS England contracts) will continue to operate. This process was designed to support organisations to amend contract values while enabling NHS England and NHS Improvement to steward the utilisation of system funding which has been distributed on the basis of enabling all systems to achieve a breakeven position. Requests to change inter-system block payments should be made on the block contracts

<sup>4</sup> <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/COVID-19-NHS-contracting-and-payment-guidance-appendix-template-statement-for-block-payments.docx>

amendment template (available in the CCG portal of the lead CCG) by the lead CCG for each system. Changes should be agreed with the relevant NHS England and NHS Improvement regional teams before being submitted for national approval. Queries on this process and template submissions should be addressed to: [nhsi.blockamendments@nhs.net](mailto:nhsi.blockamendments@nhs.net).

## NHS provider other income

33. During 2020/21, NHS England and NHS Improvement provided additional income support to NHS providers to recognise the impact of COVID-19 on non-NHS income streams. In 2021/22, NHS providers need to take actions to recover their positions – either through recovery of non-NHS income streams, utilisation of capacity for NHS activity to be funded through the Elective Recovery Fund or decommissioning of costs associated with these income streams.
34. To support NHS providers to recover their positions, we will be issuing additional fixed income support in H1 2021/22 through the COVID-19 allocation. The funding provided will represent the totality of funding available for systems, and systems will need to plan for and deliver a breakeven position including this funding. No additional income support will be available.
35. NHS hospitals are required to provide free car parking for disabled people, frequent outpatient attenders, parents of sick children staying overnight and staff working night shifts.<sup>5</sup> In addition, the government committed to provide free car parking for NHS staff for the duration of the pandemic. H2 2020/21 system funding envelopes included funding for free NHS staff car parking. This funding will continue into H1 2021/22 while the policy remains in place. Additional funding has been issued in the H1 2021/22 envelopes for free car parking for the eligible patient groups.
36. Contract arrangements with NHS Wales commissioners should be rolled over into H1 with inflationary increases in line with NHS England contracts. Additional inflationary uplifts for pay agreements will be actioned during the

<sup>5</sup> <https://www.gov.uk/government/news/free-hospital-parking-for-thousands-of-patients-staff-and-carers>

financial year. Arrangements for elective recovery for Welsh commissioners are under discussion and will be communicated in due course.

37. NHS providers should agree contracts with local authorities based on the appropriate funding for services. Once the government's response to the recommendations of the pay review bodies is announced, contracts should be updated accordingly. Arrangements for the funding of core services should not overrule separate arrangements in place for the Hospital Discharge Programme and Better Care Fund (BCF).
38. Health Education England (HEE) arrangements will continue to be funded on an activity basis by reference to the healthcare education and training tariffs.

## Mental health services

39. CCGs must continue to meet the Mental Health Investment Standard (MHIS) as a minimum in 2021/22. For 2021/22, the MHIS requires CCGs to increase their spend on mental health services by at least 2021/22 published allocation growth.
40. In addition, systems must progress towards their LTP goals through use of their available SDF and additional funding secured through the Spending Review to aid recovery of services from COVID-19.
41. To support achievement of these objectives, a full-year planning process supported by full-year funding information has been initiated. Guidance on the 2021/22 financial planning process for mental health services is outlined in Appendix 1.
42. Systems should ensure that their system plan template and mental health planning return are aligned.

## Primary medical care services

43. CCG allocations will be uplifted to fund the growth between 2020/21 and 2021/22 published primary care allocations<sup>6</sup> and the additional allocations described in this section.

### **Funding for the updated GP contract for 2021/22**

44. Additional allocations for the GP contract, on top of the published primary medical allocations, will be issued to fund:

- £20m practice contract funding, continuing to fund the impact of changes in the 2020/21 GP contract
- £24m for the new QOF indicator for mental health – severe mental illness (new for 2020/21)
- £58m for the new QOF indicators for vaccinations and immunisations, previously funded from public health budgets (new for 2020/21)
- the first tranche of the Impact and Investment Fund (IIF) indicators are introduced in April, valued at £50.7m.

45. In addition to the £50.7m above, we expect to fund CCGs up to a further £99.3m for the IIF during 2021/22. The profile of this funding will be subject to further discussions on the IIF indicators. We will adjust CCG allocations to reflect the outcome of these discussions and communicate the detail of the indicators as they are agreed.

46. Allocations for Improving Access funding will continue to be transacted through the same mechanism as in 2020/21, which comprised funding already embedded in CCG core allocations and additional SDF allocations to give a total of £6 per head. This is a change from the approach previously anticipated.<sup>7</sup> They will include allocations made directly to CCGs in London and Greater Manchester.

<sup>6</sup> <https://www.england.nhs.uk/wp-content/uploads/2019/01/ccg-allocations-2019-20-to-2023-24-primary-care-medical-revised.pdf>

<sup>7</sup> <https://www.england.nhs.uk/wp-content/uploads/2020/03/update-to-the-gp-contract-agreement-v2-updated.pdf> [Section 4.8]

## Primary care network funding

47. This section details the funding available in respect of primary care networks (PCNs). In 2021/22, funding will comprise the following elements:

- £746m for the Additional Roles Reimbursement Scheme (ARRS):
  - i. published primary medical care allocations already include £415m of the total £746m funding available for ARRS
  - ii. the remaining £331m will be held centrally by NHS England and NHS Improvement. Once the PCNs in a CCG area have claimed the total of the CCG's allocated share of the £415m, and ongoing claims will cause the CCG to exceed this amount, a CCG can access additional funding based on need. The process for this was set out in the 9 October 2020 communication to commissioners<sup>8</sup>
- £134m support for PCNs, comprising:
  - iii. £91m for the £1.50 per head from published CCG core allocations
  - iv. £43m for the clinical director roles from CCG primary medical care allocations
- £55m Care Home Premium funding to support PCN delivery of the Enhanced Health in Care Homes services – to be allocated to CCGs separately
- £87m for the PCN Extended Access DES from CCG primary medical care allocations.

## Primary care system development funding (SDF) for 2021/22

48. A full analysis of the SDF funding supporting primary care transformation programmes will be issued before 31 March 2021.

<sup>8</sup> <https://www.england.nhs.uk/wp-content/uploads/2020/10/B0177-letter-to-ccgs-arrs-funding-1.pdf>

## National service development funding (SDF)

49. Schedules will be issued detailing the funding available to systems in 2021/22, including 2020/21 funding which continues into 2021/22, and separately identifying H1 and H2 funding. The schedules will outline funding split by national programme and scheme (where relevant): for example, the schedules will identify the funding related to cancer alliances and targeted lung health checks, among other schemes.
50. SDF will be funded through two routes:
  - historic SDF embedded in block payments and adjusted CCG allocations in respect of funding for 2019/20, which will remain within block payments and adjusted CCG allocations in H1 2021/22
  - additional allocations for 2020/21 and 2021/22 which will be transacted as separately notified allocations.
51. To simplify the transaction of SDF arrangements, we have actioned a net neutral adjustment to transfer historic primary care SDF embedded within adjusted CCG allocations to the separately notified primary care SDF allocations. We have processed this adjustment for primary care SDF for improved transparency of funding and because there is limited interaction with the NHS provider block payment arrangements.
52. For historic SDF embedded in block payments and recurrent SDF issued in 2020/21, the funding should continue to be utilised for the purposes for which the allocation was made (without further planning requirements or reporting processes, unless specifically notified) and commissioners should ensure that funding continues to flow to the relevant organisations to enable them to continue these activities and cover their cost base.
53. The non-recurrent additional funding for flash glucose monitors issued through SDF in 2020/21 will end. These services should continue and should be funded from system envelopes, which include growth funding for prescribing services.
54. To minimise the immediate requirements on systems during Q1, a limited number of further SDF allocations will be issued at 1 April 2021. These

instances are identified in the section below. Additional SDF allocations will be available throughout the course of the year.

## H1 2021/22 additional SDF allocations

55. Additional funding will be available from 1 April 2021 for the areas listed in Table 1 below.

**Table 1. Further areas of SDF funding from 1 April 2021**

Programme	Guidance
Mental health	Refer to the 'Mental health services' section
Primary care	Refer to the 'Primary medical care services' section
Community	Funding will be available through SDF for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home. This transformation funding will be released subject to receipt of plans to accelerate the two-hour rollout in line with planning guidance and a commitment by all community service providers to provide complete, timely and accurate data to the Community Services Dataset (CSDS) throughout 2021/22.
Long COVID services	Funding will be distributed to regions on the same basis as in 2020/21 to maintain support for the initial assessment services established in 2020/21.
Outpatient video consultation (VC)	Nationally £10m of funding is available in 2021/22 for the local procurement of outpatient VC capability, to ensure the continued and further adoption of VC to support frontline care delivery. VC is a key enabler in the delivery of the LTP objective to reduce the number of face-to-face outpatient appointments.  Regional teams are working with systems to agree procurement arrangements. Further guidance will be issued on the distribution of funding.
Learning disability and autism	To maintain progress on transformation of learning disabilities and autism services, the H1 proportion of fair share funding and agreed targeted schemes will be distributed to lead CCGs for Transforming Care Partnerships (TCPs).
Ockenden review of	More than £80m of additional SDF funding will be available to improve the safety of maternity services and to progress implementation of the Immediate and Essential Actions from

maternity services	the Ockenden Review. More detail on how this funding will be distributed is set out in the Maternity section of the H1 2021/22 implementation guidance.
Armed forces	SDF allocations will be distributed to regional commissioners.
Health and justice	SDF allocations will be distributed to regional commissioners.

## H2 2021/22

56. When we exit the COVID-19 financial framework for H2, the process of transacting SDF for the totality of funding will return to the 'usual' process. SDF allocations (covering historic allocations and additional 2021/22 allocations) will be issued as a separately notified allocation and will be transacted on a programme/scheme basis at relevant periods during the year.
57. To prepare for this change, systems should ensure that they are reviewing their contract arrangements to understand where historic SDF is embedded into block payments and how the transition back to separately notified allocations will need to be managed through amended contracting arrangements from H2.

## Better Care Fund

58. The government has confirmed that the Better Care Fund (BCF) will continue in 2021/22 and that the CCG minimum contribution will grow (in line with the planned Long Term Plan settlement) by 5.3% to £4.26bn. As part of the H1 arrangements, CCGs' envelopes include funding for growth to enable CCGs to meet their 2021/22 BCF commitments. Details of the national conditions and processes for the BCF will be set out in due course in the BCF policy and planning guidance.

## MedTech mandate

59. The MedTech Funding Mandate (MTFM) policy was published in January 2021 and is effective from 1 April 2021. This policy requires NHS providers to make four technologies available to patients: [HeartFlow](#), [Placental Growth Factor Based Testing](#), [SecurAcath](#) and [gammaCore](#). These technologies are supported by NICE guidance, deliver cost savings within 12 months, and



reduce hospital visits and clinical interventions, which is vital in the current COVID-19 pandemic.

60. Where NHS providers have already implemented these technologies, providers and commissioners should work together to ensure a continuation of service to patients from 1 April 2021 and make adjustment to contract values as may be necessary to support this. Systems will be expected to fund these technologies from within the system funding envelopes allocated and from core allocations thereafter.
61. New site implementation will need to be managed alongside pandemic activity and recovery. The [Academic Health Science Networks](#) (AHSNs) and the technology suppliers are on hand to assist systems. Details of how to contact the AHSNs and additional implementation support is contained in the policy guidance [on the NHS England and NHS Improvement website](#).

## Specialised services

62. Arrangements for specialised services will align with the H1 arrangements across the rest of NHS commissioning, with the following areas of note or exception.
63. Systems should be mindful that the system top-up is partly funded from resource which would normally have funded growth in the value of specialised commissioning contracts. This funding will remain within system funding envelopes on a non-recurrent basis during H1 except for the adjustments described below.

### Specialised high cost drugs

64. The reimbursement process for specialised high cost drugs in H2 2020/21 will continue as part of the H1 arrangements.
65. The block payments will fund a notional baseline for high cost drugs subject to cost and volume arrangements, and a single block value for other high cost drugs. The notional baselines for 2020/21 will roll into H1 2021/22 at the same level.

66. The H1 provider block payments with specialised commissioners will be updated to transfer any amounts related to the high cost drugs baseline funded in the system top-up value in H2 2020/21 to the specialised block payments. System top-ups included funding for part of the baseline where there were differences between 2019/20 M9 AoB value and rate of spend during M8-M10. This adjustment will have a net neutral impact to system funding envelopes but will simplify funding arrangements such that all funding for specialised high cost drugs will be within the specialised element of block funding in H1 2021/22.
67. Due to the delay between source data for high cost drug reimbursement and payment, prospective payments-on-account will continue as part of the H1 arrangements for Cancer Drugs Fund (CDF), hepatitis C (hep C) and other cost and volume high cost drugs. This will be based on the prospective payment-on-account for M10-M12 included in the 15 March 2021 payment run. Provider block payment values will include these values on top of the notional baselines.
68. The notional baseline for high cost drugs expenditure included in block payments will continue to be trued up based on actual drugs spend. The reimbursement of CDF, hep C and cost and volume high cost drugs will continue to depend on the provision of accurate data submitted through existing systems, ie complete and accurate information in the provider's drugs patient-level contract monitoring data submission (DrPLCM) and Blueteq if relevant.
69. There are opportunities for significant drugs savings within high cost drugs. More detail on how commissioners will work with systems to release these will be communicated for implementation in H1 where possible.

### **Specialised high cost devices**

70. The notional baseline for high cost devices expenditure included in block payments will continue to be trued-up based on actual devices spend.
71. As part of the High Cost Tariff Excluded Devices Programme (HCTED), the move to the central procurement route for high cost excluded devices was mandated for all providers by 31 March 2021. In recognition of the impact of responding to COVID-19, the programme team has allowed for slippage in these timescales. However, it is intended that there will be no reimbursement of any devices outside of the NHS Supply Chain route from 1 July 2021. Exceptions to this include the continuing work on the external fixation category,

and devices which are not currently available through the NHS Supply Chain catalogues.

72. To support this process, all providers should have agreed plans for outstanding migrations in place. Where it is believed that there are exceptional circumstances which would require an extension beyond these dates, these must be formally agreed with the national HCTED programme director via regional teams.

### **Specialised mental health, learning disability and autism provider collaboratives**

73. There are currently 10 live NHS-led provider collaboratives (PCs) for specialised mental health, learning disability and autism services in 2020/21. It is expected that more PCs will go live from April 2021. Their scope and remit will be the same as for the first set of PCs, with the extension to cover more geographies than has been the case this financial year.
74. Under these arrangements, identified lead providers take clinical pathway and financial responsibility for the delivery of in-scope services for specific populations. The lead provider (LP) for each PC going live will receive a budget to commission services for their population. Those providers who previously held contracts with specialised commissioning for services within the scope of the PCs will see a reduction in their contract value with specialised commissioning and this value will be transferred to the LP of the PC. LPs will subcontract with other providers to deliver the services in scope.
75. For PCs as they go live, the starting expectation is that LPs will subcontract with NHS providers at the same contract value as the reduction from their block payments, to maintain system financial stability through the transition, although the contract terms may differ as appropriate.
76. For all PCs, it continues to be the expectation that any commissioning intention changes will be carefully managed, jointly agreed, be in line with contractual notice requirements and pay due attention to system financial stability.
77. Any changes to NHS contract values in 2021/22 because of commissioning decisions and service changes are expected to be agreed locally. In any instance where this would materially affect an individual systems' ability to meet

their system envelope in year, this will be expected to be agreed with the relevant regional team(s) before being enacted.

### **Other specialised mental health services**

78. In line with the commitment to fund growth on CCG-commissioned mental health services, additional growth funding will be available in H1 2021/22 for specialised mental health contracts.

### **Other adjustments to specialised commissioning block payments**

79. The national and regional specialised commissioning teams will update the H1 specialised commissioning block payment values to reflect agreed values for service changes and clinical priorities, including genomic testing and complex knees services.

80. The implementation of the revised funding models for genomic testing and complex knees services in 2020/21 resulted in funding for services previously within the scope of the NTPS being transferred from system funding envelopes and funded through specialised commissioning contracts with the directly commissioned providers. In H1 2021/22, a further adjustment has been processed to update the 2020/21 adjustment for the latest estimate. Supporting information will be available to providers via regional teams.

## **Funding for COVID-19 services**

81. Systems will continue to receive a fixed system envelope for COVID-19 services.

82. Systems should continue to review the utilisation of their system COVID-19 allocation as part of determining the optimal service design for their system. Amendments to the implied distribution should be reported through the system plan template. Changes in NHS provider funding should be transacted as block payment amendments per the guidelines outlined in the 'NHS provider block payment arrangements' section.

83. A full list of the COVID-19 items which are eligible to be funded outside of the system funding envelopes in H1 will be issued. For clarity, a table of items

where eligibility has been removed between H2 2020/21 and H1 2021/22 will also be available.

84. For the Hospital Discharge Programme, Scheme 2 costs will be covered for patients discharged up to 31 March 2021 and for the first six weeks of their care, so some costs may continue into H1. Further detail will be issued in relation to the reimbursement arrangements for the Hospital Discharge Programme for patients discharged from 1 April 2021.
85. PPE will continue to be procured nationally, funded and overseen by DHSC until at least the end of June 2021. A decision will be made in April 2021 about arrangements from June 2021 and will be communicated in due course.
86. The Nightingale sites are due to close as acute care facilities. Where sites continue to be utilised in 2021/22 to deliver other COVID-19 services which are funded outside of system envelopes – for example, as part of the COVID-19 vaccination programme – the costs of these facilities should be recorded against the cost category related to their current use. Where regions and systems are approved to use sites as part of services funded from within system funding envelopes, including as part of elective recovery plans, the costs should be borne by the relevant region or system and will need to be managed within their existing funding streams.

## CCG drawdown

87. The default position for all CCGs continues to be the delivery of a breakeven position.
88. We do not expect to make any drawdown of historic underspends available during the H1 period. This position will be reviewed for H2 2021/22 and will remain subject to affordability.
89. Cumulative historic under and overspends will continue to be reported at a CCG level; however, any future access to historic underspends will additionally take into consideration the net position of the system.

## Cash regime

90. The block payment arrangements will be rolled forward for H1 2021/22. There will not be a block payment from commissioners for April 2021 in March. Instead block payments for April 2021 will be paid in April and the in-month pattern will continue with the May block being paid in May, and so on.
91. The method of payment for block payments will remain through invoice payment file (IPF) and payment requests. Detailed guidance outlining the governance arrangements for payment requests and IPF have been issued. Provider invoicing to commissioners should occur in limited instances related to NHS England and NHS Improvement non-healthcare items.
92. Commissioners will continue to pay the NHS provider block on the 15th of the month (or closest working day) until further notice, except for April when payment should be made on the 8 April to support provider cash needs.
93. For funded COVID-19 programmes, NHS providers will continue to be reimbursed in arrears by NHS England and NHS Improvement and CCGs will be reimbursed by allocation adjustment following a process of validation of reported costs.
94. The system top-up and COVID-19 allocation will be distributed to a lead CCG for the system by allocation adjustment. By mutual agreement within a system, funding should be transacted to NHS providers, where relevant, through amendments to their block payment arrangements.
95. 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.
96. 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.
97. In the context of the expected overall cash mandate for 2020/21 and H1 funding, it is expected that provider net cash borrowing requirements will remain low. Where providers do require supplementary revenue cash support,

providers will be able to apply for revenue cash support from the Department of Health and Social Care (DHSC) via the NHS England and NHS Improvement Capital and Cash team. Communication of the process to access revenue cash financing from DHSC will be issued per normal processes.

## Capital regime

98. Guidance on system capital allocations and the 2021/22 capital planning process was published on 16 March 2021.<sup>9</sup>
99. Systems should consider the revenue impacts of their capital plans when completing their system plan template, including considering the impacts of depreciation on COVID capital assets but excluding the impact on PDC dividend for COVID capital assets that are exempt from the calculation.

## Queries and FAQs

100. Unless specified otherwise, queries on the H1 financial arrangements should be directed to [NHSI.FinPlan@nhs.net](mailto:NHSI.FinPlan@nhs.net). FAQs will be issued to CCGs (through the SharePoint Planning Library) and to providers (through the additional documents section of provider portals).
101. Queries on the process to amend NHS provider block payment arrangements and template submissions should be directed to:  
[nhsi.blockamendments@nhs.net](mailto:nhsi.blockamendments@nhs.net)
102. FAQs in relation to the mental health financial planning process will be available via the [NHS Futures Collaboration Platform](#).

<sup>9</sup> <https://www.england.nhs.uk/publication/guidance-on-the-cash-and-capital-regime-for-2021-22/>

## Appendix 1. Mental health financial planning guidance

### Introduction

---

1. It is anticipated that the impact of COVID-19 will lead to a significant increase in demand for mental health services, with evidence of services already seeing increased referral rates. The NHS Long Term Plan (LTP) for Mental Health and the ambitions outlined in the [Mental Health Implementation Plan 2019/20 - 2023/24 \(the implementation plan\)](#) remain solid foundations to deliver mental health services in the context of COVID-19 and respond to the growing mental health needs of the population in the future.
2. We therefore confirm that for 2021/22:
  - **all CCGs are individually required to meet the Mental Health Investment Standard (MHIS)**
  - **service development funding (SDF) will flow in line with the implementation plan**
  - additional funding from the £500m announced at the Spending Review has been provided by HM Treasury in 2021/22 to **accelerate recovery from COVID-19** and to bring forward elements of the LTP
  - mental health support hubs for staff will continue to be funded in 2021/22 through additional SDF funding.
3. Mental health financial planning will **be undertaken once** in relation to minimum investment requirements. In undertaking the annual mental health financial planning process, CCGs and systems need to plan for the minimum investment to meet the MHIS. **Additional investment in mental health services above the minimum can be included in the wider system financial planning process for April to September 2021 (H2).**
4. In 2021/22, **all systems must invest the full amounts available to them**, recovering activity lost during the pandemic and locking in beneficial changes made throughout the COVID-19 response. Amounts allocated in this planning round **must not cover COVID-19 costs such as personal protective equipment**. Systems are encouraged to work together to **flow available**



**funding at the earliest opportunity** to enable investment to be delivered throughout the financial year.

## 1. Timeline and process

---

5. The **Mental Health Finance Planning 2021/22 template** (the template) will be issued separately. Systems are required to complete their template in accordance with this guidance and submit to NHS England and NHS Improvement . **Systems should implement their plans as soon as they have been agreed locally. Submission should be made by 6 May 2021.**
6. NHS England and NHS Improvement will seek assurance that funding is flowing to providers, to enable the greatest opportunity for investment. **CCGs should flow agreed funding to providers equally throughout the year (on a monthly basis) and not withhold funding until later in the financial year.**
7. Submissions will be reviewed against the cumulative growth in the [LTP analytical tool \(see para 25\)](#). These findings will be shared back to regional finance and mental health teams, to enable CCGs and providers to explain any major divergences, and where it is required, to establish recovery plans where investment will not deliver the commitments set out in the Long Term Plan.

## 2. Governance arrangements

---

8. ICSs/STPs are asked to lead mental health finance planning to agree an investment plan at system and CCG level. The template should be signed off by:
  - the ICS CFO
  - each CCG CFO
  - each NHS mental health provider trust CFO listed in the template.
9. By signing off the template, each party is confirming that the agreed plan is the best way to deploy the resources available within the Mental Health Investment Standard, to deliver the Long Term Plan objectives for mental health and that the SDF and Spending Review funding is being spent for the purposes for which it was allocated, as detailed in this document.

### 3. Elements of the mental health finance planning process

---

#### 3.1 Meeting the Mental Health Investment Standard (MHIS)

10. The minimum spend to meet the MHIS is based on forecast outturn at month 11 of 2020/21 from CCGs' non-ISFE returns, increased by the allocation growth for each CCG. Where a CCG is forecasting to not meet the MHIS in 2020/21, the shortfall will be added to the 2021/22 minimum. During 2021/22 the minimum spend to meet the MHIS will be reviewed and adjusted to reflect outturn and any shortfalls discovered through the independent review of 2019/20 MHIS performance.
11. Systems and CCGs should note that as the Agenda for Change (AfC) settlement has not been confirmed, CCGs should hold the amount of the minimum spend estimated for pay inflation in a tariff adjustment reserve. This is calculated within the template for each CCG and each CCG must agree to hold a reserve.
12. The categories of spend included in the MHIS are set out [here](#). While we expect some minimal growth in mental health continuing health care (CHC) and prescribing, this growth is not expected to exceed 20/21 FOT add inflation. We expect growth in core mental health services will be equal to or greater than the overall growth in mental health spend.
13. CCGs will also need to demonstrate an increase in the percentage of their total mental health spend that is spent with NHS mental health providers and non-NHS providers that provide core and specialist mental health services. Where there are exceptions to this increase, this should be agreed with ICS/STP leadership.
14. As part of the mental health LTP ambition, CYP mental health investment will increase faster than overall mental health investment and overall NHS funding.
15. Investment in learning disability, autism and dementia should **not be included** in the MHIS, unless investment is for services for mental health and learning disability where the primary aim is to treat someone's mental health condition.
16. From 2021/22, most physical health checks for people with SMI and follow-up actions should take place within primary care, and these will be funded via the

GP Contract and the Quality Outcomes Framework (QOF) incentive scheme for primary care. Any MHIS spend noted here should be on top of national level investment into QOF to support PH SMI checks.

### **Supporting Information to meet the MHIS in 2021/22**

17. To support with planning the following information is provided:

#### *Indicative CCG funding profile for 2021/22*

18. A supporting schedule will be provided to regional finance teams, which will provide each CCG with an indicative breakdown of investments across each mental health programme area to maintain progress on the LTP in 2021/22.

19. This profile has been calculated by first providing pay and non-pay growth on 2020/21 outturn. The remaining proportion of each CCG's allocation growth has then been apportioned based on the programme breakdown provided by the LTP analytical tool. This funding profile should provide a blueprint for how MHIS funding could be spent where systems may not have the usual capacity to undertake a full financial planning process but will always need local review as it is based on national assumptions.

#### *The LTP analytical tool*

20. The [LTP analytical tool](#) provides an indicative baseline increment for programmes where the LTP has committed further investment and should be used as a check against local plans. This is particularly relevant for community SMI where CCGs should continue to invest CCG baseline MHIS funding growth in 2021/22 in community mental health services broadly in line with the LTP analytical tool, with funding flowing to providers as soon as possible.

21. CCGs may be starting from different points in terms of level of investment, which will affect investment decisions, but a large variance from the analytical tool may indicate a problem and should be investigated to be sure that local plans will deliver on the LTP ambitions:

- Amounts detailed in the LTP analytical tool may differ from those in the 'Indicative CCG funding profile for 2021/22' as the LTP analytical tool sets out the indicative cumulative baseline growth from the start of the LTP.

- The LTP analytical tool nationally apportions LTP growth using target allocations. STPs'/ICSSs' resource will vary depending on distance from target, previous mental health spending and other priorities.
- The new and expanded services being introduced as outlined in the [Mental Health Implementation Plan 2019/20 - 2023/24](#) have been assumed to cover all demographic and non-demographic growth for mental health, including on services in the pre-2019/20 baseline.

22. FAQs in relation to the mental health financial planning process will be updated and made available via the [NHS Futures Collaboration Platform](#).

### 3.2 Service development funding and Spending Review funding

#### Service Development Funding (SDF)

23. In 2021/22 allocated SDF funding **is** included in the **mental health finance planning template** (separately to the MHIS). Funding that has been agreed as part of SDF or transformation funding **does not contribute towards delivery of the MHIS**.

24. SDF (and Spending Review funding) has been allocated to all programmes **excluding** the following:

- MHST 2021/22 sites wave 5 and 6 (MHST2021/22)
- rough sleeping 2021/22 sites
- problem gambling – 2021/22 sites
- specified sites for community SMI and perinatal MMS (new sites for 21/22)
- children and young people (four-week wait sites), Spending Review only.

25. The allocation process for these programmes will be **undertaken separately** to allow release of funding from July 2021.

26. The funding for Department for Work and Pensions (DWP) employment advisors in IAPT services is **pass-through from DWP to CCGs**. There are

memorandums of understanding in place between DWP and CCGs which detail the values. Allocations will be included in the template as notified by DWP.

27. We will review CCGs' delivery of submitted plans over the first half of the year with regional teams. Where performance is poor and there are no plans to ensure recovery to full delivery, further SDF funding may not be released in full during quarters 3 and 4.

### **Spending Review funding**

28. CCG Spending Review allocations have been included where these are on a fair share basis across CCGs. This funding does **not** contribute towards the delivery of the MHIS; where the Spending Review investment allows an early start on investments planned for 2022/23, these will be included in the MHIS in 2022/23, when they become recurrent. CCGs will need to allocate this funding to providers as part of the mental health finance planning process and include in the total provider contracts.

### **3.3 NHS provider contract summary**

29. CCGs are required to show NHS providers which they are contracting with as part of the minimum spend to meet the MHIS, SDF and Spending Review investments where total investment is £500,000 or greater. The planning template calculates a monthly amount expected to flow from CCGs to NHS providers, with investment expected to be made equally throughout the year.

### **3.4 Mental health community realignment**

30. Significant investment from CCG baselines is expected as part of the community transformation (about £1 billion by 2023/24). The MHIS categories were updated in 2020/21 to align them better to the mental health LTP and capture this investment. Community and crisis outturn for 2018/19 and 2019/20 should now be recategorised, at CCG level, to enable historical comparison.
31. CCGs and STPs/ICSs may need to work with their mental health providers to recategorise contracted services in 2018/19 and 2019/20. CCGs are **only** expected to recategorise adult community and crisis categories that are no longer in use to the 2020/21 adult community and crisis categories. If

necessary, spend against old categories can be recategorised against other MHIS categories, but it is expected that this will only happen by exception.