Classification: Official

Publications approval reference: C1406

Guidance on finance and contracting arrangements for H2 2021/22

Version 1, 30 September 2021

Overview

1. This document sets out the detail of the finance and contracting arrangements for the six-month period from 1 October 2021 to 31 March 2022 (H2 2021/22 or H2). It outlines additional information or changes from the H1 regime and should be read alongside the H1 2021/22 guidance.

2. As we move into the second half of the financial year, it is important that there remains a continued focus on restoration and recovery of services, with additional funding available to support this, and recovering finances back to a sustainable footing. H2 envelopes include an increased efficiency requirement from H1, and the ask will continue to increase into 2022/23. Where systems are able to go further to prepare for 2022/23, they should take action to do so with any savings re-invested in supporting non-recurrent recovery initiatives.

3. As we move towards the creation of statutory integrated care boards ('ICBs'), the NHS financial framework will continue to enable system collaboration. National guidance has been published to support the implementation of the changes required and we will be publishing further information on financial governance and the management of NHS resources by ICBs in due course.

4. The H2 arrangements are broadly consistent with a continuation of the current H1 framework, and are summarised as:

    - System funding envelopes, containing adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of the pay award, and increased efficiency requirement.
    - Block payment arrangements remaining 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 2021/22 financial year.

H2 financial planning process

5. Systems, working collaboratively with their constituent CCG and provider organisations, will be required to submit a planning return ('System Plan Template') outlining their utilisation of H2 resources.

6. H1 and H2 will be treated as a single financial period. Where systems in aggregate, or their constituent organisations, are exiting H1 in a surplus position against H1 funding, this funding will be retained by the system into H2. Any surpluses generated in H1 should be utilised appropriately to manage winter demands and go further on elective recovery, while ensuring that the system and its constituent organisations are exiting 2021/22 with an affordable underlying run-rate and have taken action to recurrently deliver the necessary efficiencies. Where systems in aggregate, or their constituent organisations, are exiting H1 in a deficit position against H1 funding, they are expected to take action to deliver a balanced position for the full financial year.

7. System plans for H2 should appropriately consider their carry forward position from H1 and ensure that this balances across the full period. H2 system planning forms will include the H1 position, to provide the full view of the financial period. The H2 planning templates have also been updated to request information on the underlying position to support understanding of the exit run-rates.

8. For H2 planning, we will not set default organisational plan positions. Providers will be required to submit organisational plans and these plans must be in line with their system plan. Where provider plans are not consistent with the system position, the relevant provider will be asked to re-submit.

9. CCGs should put in place a plan that includes suitable mitigations of known risks. Where CCGs consider it appropriate to support risks to expenditure that may not otherwise be mitigated, we advise to set aside a contingency of up to 0.25% of their H2 allocation.

H2 system funding envelope

10. As in H1, system funding envelopes contain adjusted CCG allocations, system top-up and COVID-19 fixed allocation. The system top-up and COVID-19

allocation will continue to be distributed to a lead CCG for the system. By mutual agreement within a system, distribution of this funding should be transacted to NHS providers through amendments to their block payment arrangements.

11. Further detail on the construction of H2 system envelopes, including further information on the inflation and efficiency calculations, will be available through regional teams. A summary of the key changes is outlined below.

Pay

12. Government has announced a 3% pay award uplift for NHS staff covered by the remits of the NHS Pay Review Body (NHS PRB) and the Review Body on Doctors' and Dentists' Remuneration (DDRB). Staff groups covered by the review bodies' 2021/22 remit are: Agenda for Change, career and staff grades, consultants and specialty and associate specialist (SAS) doctors not switching to the new contract. The pay award will be backdated to 1 April 2021 for relevant staff groups.

13. Doctors and dentists in training and SAS doctors moving onto new contracts are not covered by either the DDRB recommendations or the government announcement as those groups are already covered by multi-year pay deals. Government has accepted the DDRB recommendation to freeze consultant clinical excellence award (CEA) values.

14. System funding envelopes will be uplifted to account for the additional recurrent costs of the pay award uplift as well as a non-recurrent adjustment for back pay. Further detail on the construction of the inflation calculations will be available through regional teams.

15. Pay award funding in the H2 uplift includes provision for the implementation of the reformed specialty doctor contract and those SAS doctors remaining on existing terms and conditions.

16. Funding will also be provided to systems to support the pay pressures on those parts of providers' cost base which would usually be covered by local authority (LA) and Health Education England (HEE) income.

17. Consistent with our communication in H1, the CCG running cost allowance (RCA) for 2021/22 is fixed and there will be no amendments to the allocation for in-year pay awards.

Efficiency

18. For NHS providers, a general efficiency requirement of 0.82% for the six-month H2 period has been applied to the growth in NHS provider block payments. The H2 efficiency requirement feeds through to CCG programme envelope growth and inflation on the system top-up and COVID-19 allocation.

19. As in H1, 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 based on their distance from their 2021/22 Financial Improvement Trajectory (FIT) funding envelope. Further detail on the application of this requirement is available through regional teams.

20. The COVID-19 fixed allocation has additionally been reduced and systems should ensure that they are continuing to take action to implement infection prevention and control (IPC) requirements optimally.

21. For providers not in receipt of the block payment arrangements, an annualised efficiency requirement of 1.1% is set out in the published NTPS guidance.

Capacity

22. Systems will have access to the following capacity funding:
    - **Non-elective services (including maternity services)** – additional funding has been issued into H2 system funding envelopes on a commissioner footprint and should be transacted into block payments, including relevant out-of-system arrangements.
    - **Elective services** – access to additional funding is through the Elective Recovery Fund (ERF) and Targeted Investment Fund (TIF) (refer to Appendix 1).
    - **Mental health services** – the H2 envelopes will reflect the remaining element of the full-year funding notified at the beginning of H1.
    - **Primary medical care services** – the H2 envelopes will reflect the remaining element of the full-year funding notified at the beginning of H1.

Additional resources will also be made available as set out below (refer to the Primary Medical Care Services section).

- **Community services** – in line with the H1 approach, funding for demographic growth has been included in system funding envelopes. Access to additional non-demographic growth will be available through the Service Development Fund (SDF) for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home.

Services funded from outside the envelopes

23. Except for the items identified in this section, system funding envelopes and block payment arrangements with CCGs outside the system and NHS England commissioners represent the totality of NHS funding available in H2 2021/22.

24. The scope of services funded outside of system funding envelopes is consistent with H1 and comprises:

    - specialised high cost drugs and devices
    - specific COVID-19 services – refer to the COVID-19 section
    - elective recovery funding – subject to meeting the conditions of the ERF set out in Appendix 1
    - separately notified SDF allocations
    - non-clinical services contracted by NHS England and NHS Improvement that are transacted via invoicing – refer to previous guidance.

Contracts

25. Signed 2021/22 contracts between NHS commissioners and NHS providers (NHS trusts and NHS foundation trusts) are not required (for the H1 or H2 periods). Where services continue to be provided, the nationally mandated terms of the NHS Standard Contract for 2021/22 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. It is the expectation that signed contracts will be required for 2022/23 and therefore organisations should

ensure a common understanding of existing service requirements leading into 2022/23.

26. 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 continue to be in place and signed.

27. The 2021/22 NTPS was published alongside the H2 planning guidance and will take effect from 1 October 2021. As confirmed at H1, 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 its scope. 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.

28. System funding envelopes continue to contain an allowance for low-volume activity flows from distant CCGs and remove the need for separate invoicing to CCGs outside the block payment arrangements.

29. There will be no 2021/22 CQUIN scheme (either CCG or specialised). Under the 2021/22 NTPS, CQUIN now only applies to those providers in scope of the Aligned Payment and Incentive (API) rules. For those providers to whom CQUIN would normally apply, under the API rules:

- block payments to NHS providers are deemed to include CQUIN;
- CQUIN must be paid at the full level of 1.25% to non-NHS providers
- commissioners must not withhold CQUIN funding from NHS providers or non-NHS providers in relation to failure to meet CQUIN requirements during 2021/22.

30. For those providers to whom CQUIN does not now apply under the API rules, national and unit prices published as part of the 2021/22 NTPS have been uplifted by 1.25% to compensate. For contractual relationships governed by local prices (rather than by national prices, the API rules or mandatory unit prices, as for example under the Increasing Capacity Framework), those local prices are a matter for local negotiation. Our expectation is that, as a starting

position before other adjustments are considered, local prices should also be uplifted by 1.25%; this will mean that the change to the applicability of CQUIN will not result in a cost pressure for providers.

31. Further detail on contracting arrangements are set out in the technical guidance of the NHS Standard Contract.

NHS provider block payment arrangements

32. The block payments approach for arrangements between NHS commissioners and NHS providers in England will remain in place in H2. As set out 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, and payment must instead be made in accordance with the block payment arrangements. The local variations from national pricing arrangements agreed last year in accordance with NTPS rules will remain in effect.

33. H2 block payments with NHS providers should be amended to reflect the changes to system funding envelopes, eg application of additional inflationary and growth funding and distribution of efficiency requirements.

34. For H2, 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 H2 provider inflation factor (1.16%), but they 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)** – contract value (incorporating those changes approved by NHS England and NHS Improvement nationally) should be uplifted by the H2 provider inflation factor (1.16%).
- **NHS England directly commissioned service contracts** – contract values will be uplifted by the H2 provider inflation factor (1.16%).

35. In addition to the general uplifts described above, NHS provider block payments (including where appropriate distribution of system top-up and

COVID-19 funding) should be uplifted non-recurrently by 10.5% (using the block payment values before the 1.16% inflation factor is applied) in Month 7 only, to fund providers for back pay associated with the 3% pay award uplift. This means Month 7 provider block payments should be uplifted by 11.66% before reverting to 1.16% from Month 8. CCG programme funding has been increased to fund the element of this which would be paid from core allocations, as well as any other system pressures associated with the pay award uplift. For payments between commissioners and providers within the same system, systems may, through agreement across their relevant organisations, adjust the block payment values to reflect local knowledge of pay pressures.

36. Payments for MHIS-related services should continue in line with the full-year plan agreed at the beginning of the financial year, adjusted for the general uplifts outlined above. Efficiencies applied to MHIS-related expenditure should be reinvested in mental health services such that systems are continuing to meet their MHIS requirements. CCG MHIS targets will be adjusted to reflect the higher pay award, and these will be communicated in time for Month 9 non-ISFE.

37. National approval will continue to be required to action changes to inter-system CCG block payments, except for application of the inflationary uplifts described above which should be applied to all inter-system block payments. Requests to change inter-system block payments should be made on the block contracts amendment template by the lead CCG (and available in their portal) 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.

NHS provider other income

38. In recognition of the impact of the COVID-19 pandemic on services funded by non-NHS sources and the associated stranded costs, we will continue to issue additional fixed income support in H2 2021/22. H2 income support will be 75% of the H1 income support, reflecting improvements in income recovery throughout H1 and the ongoing requirement for systems to take actions to utilise capacity for NHS services funded through ERF, recover income

streams or mitigate cost impacts. The funding provided represents 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.

39. 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. In addition, Trusts should continue to provide free car parking at their sites for NHS staff for the duration of the pandemic, in line with the Government's policy, alongside providing free parking for those eligible groups above. Funding to Trusts for these policies was included in H1 envelopes and has been rolled over in to H2 envelopes.

40. Contract arrangements with NHS Wales commissioners should be rolled over into H2 with relevant adjustments in line with NHS England contracts. Inflationary uplifts for pay agreements should be actioned, with the impact back dated to 1 April 2021. NHS Wales will separately communicate further information to their commissioned providers, including the detail of elective recovery funding.

Mental health services

41. CCGs must continue to meet the Mental Health Investment Standard (MHIS) as a minimum in 2021/22. For mental health services, a full-year planning process, supported by full-year funding information, was initiated at the start of H1. Systems should be continuing to deliver against those plans. H2 system and organisation plan submissions should incorporate and be consistent with the notified full-year mental health plan submissions.

42. For H2, while we expect mental health services to make efficiencies in line with the overall NHS efficiency requirement and recover deficit positions, efficiencies made on MHIS-related expenditure should be reinvested in mental health services such that systems are continuing to meet their MHIS requirements. As such, the total expenditure on mental health services should not reduce from the notified full-year plan, adjusted for the impact of the higher pay award.

43. A further £29m of funding will be made available in H2 to support timely discharge and should be used to reduce long lengths of stay and out of area

placements in mental health inpatient services, as well as long waits in A&E for mental health patients. This will be issued through the SDF directly to systems on a non-recurrent basis.

Urgent and emergency care

44. The capacity funding included in system envelopes is to fund the entirety of the UEC pathway. In addition to this, we have set out specific further funding for 999 and NHS 111 (see below) and primary care (see Primary Medical Care Services section). Separate national funds for 111 First in H1 will, as communicated previously, not continue in H2 and 111 costs will need to be managed within the overall available funding.

45. A national fund of £55m for 2021/22 has been announced to fund additional 999 call handlers, crews and clinicians to work in control rooms. It will also cover the recruitment and retention of liaison officers who manage the handover of patients between ambulances and hospitals.

46. A further £75m of funding for NHS 111 to support additional capacity and performance will be issued in H2 through the SDF. Systems should work with lead commissioners of NHS 111 services to agree appropriate allocations of this additional funding to providers, for call handling and clinical assessment services, in the context of overall system urgent and emergency care provision.

47. Systems must continue to have regard for all providers of urgent and emergency care when agreeing appropriate allocations of system funding, including the distribution of COVID-19 allocations. For services that cover wide geographical areas, such as providers of NHS 111 services and ambulance trusts, systems must work together to develop a shared understanding of pressures and appropriate utilisation of resources.

Primary medical care services

48. As notified in H1 guidance, CCG allocations were uplifted to fund the growth between 2020/21 and 2021/22 published primary care allocations, along with details of the additional allocations. The growth included additional funding for

the GP contract, PCN Care Home Premium, new QOF indicators and Investment and Impact Fund (IIF) funding.

49. Systems are asked to support practices with access challenges so that all practices are delivering appropriate pre-pandemic appointment levels, including face-to-face care as part of a blended access model. We will shortly set out details of continued investment in H2 to support general practice capacity and improve access.

50. A summary of all the GP contract financial implications to date was published in a letter on 9 July 2021. This letter details the additional £257m for general practice in 2021/22.

Dental services

51. Restrictions on dental activity due to COVID-19 mean that patient charge income is lower than would normally be expected. It is expected that commissioners will take steps to minimise this loss of income and as services are recovered that income support will be withdrawn. Regions will be reimbursed for actual lost income only, net of any adjustments for variable costs not incurred. If activity requirements change after September, regions will be notified as soon as possible.

Service Development Fund (SDF)

52. Additional SDF allocations will be issued for delivery of the notified priorities. Schedules will be issued detailing the funding available to systems in H2 2021/22. Allocations where previously communicated will be transacted in Month 7 (or prior notified month) and any further allocations will be issued as soon as is practicably possible with the aim of finalising all allocations by Month 9 (where possible).

Better Care Fund

53. As part of the H1 guidance, we set out that system envelopes included funding for growth to enable CCGs to meet their 2021/22 Better Care Fund (BCF) commitments. Government published the 2021 to 2022 Better Care

Fund policy framework on 19 August 2021. The minimum contributions to the BCF by each CCG for 2021/22 are published alongside the BCF planning requirements on the NHS England website.

Specialised services

54. Arrangements for specialised services will align with the H2 arrangements across the rest of NHS commissioning. Areas of note or exception, which will continue into H2, are set out in the H1 guidance and updates to these are set out below.

55. As highlighted in the H1 guidance, the system top-up captures funding for CCG and NHS England commissioned services. This means that regional commissioners do not have separate allocations to fund growth, cost pressures or investments over and above those which organisations and systems are funded for through the block values and system top-up, with the exception of a limited list of new national service development initiatives.

56. By exception a limited number of adjustments to specialised block values are being transacted nationally for H2, with associated adjustments to corresponding system top-ups where relevant.

Specialised mental health, learning disability and autism provider collaboratives

57. There are currently 24 live NHS-led provider collaboratives for specialised mental health, learning disability and autism services (MH PCs). It is expected that up to 23 more MH PCs will go live from October 2021.

58. Funding for MH PCs is paid to the lead provider (LP) of the MH PC through their block payment. LPs subcontract services from other providers – both NHS and non-NHS – as relevant. As MH PCs go live, subcontracted NHS providers will see an adjustment to their block payment to transfer the relevant funding to the LP of the MH PC. The starting expectation is that LPs will subcontract back with NHS providers at a value equivalent to the reduction in their block payments, to maintain system financial stability through the transition, although the contract terms may differ as appropriate. For non-NHS

providers, the lead contractor for arrangements will change to the LP of the MH PC.

High cost drugs

59. The reimbursement process for specialised high cost drugs in H2 2021/22 will continue in line with the H1 arrangements. The notional baselines will roll into H2 at the same level as in H1. Prospective payments-on-account will continue in H2, as they did in H1, for Cancer Drugs Fund (CDF), Hepatitis C (Hep C) and other cost and volume high cost drugs. The H2 payments-on-account values will be based on 2021/22 YTD Month 2 data (as at end of July 2021).

60. The notional baseline for high cost drugs expenditure included in block payments will continue to be trued up based on YTD actual drugs spend up to the end of 2021/22. 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.

61. Full reimbursement of CDF spend is also contingent on receiving data submission that allows the regional CDF team to complete price check validation. We reserve the right to stop the monthly payments-on-account advance payments to providers who do not improve data quality to the required standard. This will be reviewed following receipt of CDF data at the end of September 2021.

62. A more detailed FAQ document on high cost drugs reimbursement, updated for H2, will be available through regional commissioning teams.

High cost devices

63. For H2, and in line with H1 guidance, all remaining pass-through charges issued by providers for high cost devices that are available through the High Cost Tariff Excluded Devices (HCTED) programme will not be reimbursed by Specialised Commissioning unless by exception. Providers must discuss any exceptions with the Regional Specialised Commissioning Team before explicitly agreeing any exceptions with the Programme Director for HCTED.

Funding for COVID-19 services

64. Systems will continue to receive a fixed system allocation for COVID-19 services. An additional efficiency has been applied in H2 to the COVID-19 allocation. Systems should continue to review the distribution and utilisation of their COVID-19 allocation, alongside reviewing the optimal configuration of COVID-19 related services and indirect resource impacts as the COVID-19 pandemic changes. Looking ahead to 2022/23 and further tapering of the COVID-19 allocation, systems should ensure that they understand the additional costs they are incurring due to COVID-19 and begin establishing plans to release these costs, recognising that implementing elements of these plans will depend on changes to national policy and local circumstances.

65. A full list of the COVID-19 items eligible for funding outside the system funding envelopes will be available through monthly reporting guidance. Commissioners and NHS providers should continue to monitor monthly guidance to ensure they follow the most up-to-date information.

66. A summary of key changes from H1 (at the time of publishing this document) and updates on key programmes is set out below:

    - **Hospital Discharge Programme** – Government will continue to fund the first four weeks of post-discharge recovery and support services where this is provided on or before 31 March 2022 for those with new and additional care needs. The scheme will end on 31 March 2022 and will not fund care delivered after this date - consequently no costs for care delivered in 2022/23 will be funded by this scheme. Working together, health and social care systems are asked to ensure that the Hospital Discharge and Community Support policy and operating model is fully implemented. This will ensure that more people are discharged home and that the length of stay for people in acute care (particularly over 21 days) is reduced. CCGs can continue to claim reimbursement for costs associated with delivery of the service outlined in COVID-19 Hospital Discharge Service Requirements.
    - **Personal protective equipment (PPE)** – will continue to be procured nationally, funded and overseen by the Department of Health and Social Care (DHSC) until at least the end of March 2022.

- **Long COVID services** – full year funding was confirmed to regions and systems during H1. Regions and systems should be continuing to deliver against agreed plans, aligned to the published Long COVID plan.

CCG business rules and access to drawdown

67. The default position for all CCGs continues to be the delivery of a breakeven position. Any CCG under or overspends in 2021/22 will carry forward into 2022/23.

68. We do not expect widespread access to drawdown in H2; however, if systems are able to make a case for additional non-recurrent funding in H2, and this supports the aims set out in the H2 planning guidance, we will consider these on a case by case basis.

69. Further details with respect to historical CCG cumulative under and overspends will be made available as part of the wider Integrated Care Board Financial Framework.

Other planning assumptions

70. NHS Employers has published guidance setting out further information in relation to the ongoing calculation of holiday pay (Flowers) under Agenda for Change Terms and Conditions. This guidance sets out some of the practical options available to local employers to ensure compliance with their legal obligations from 1 April 2021 in the absence of a full ESR system solution. Employers should have reviewed this guidance and be already taking the relevant action to ensure they have considered and are upholding their contractual obligations to employees, the costs of which should be included in 2021/22 financial reporting.

71. Pending the confirmation of the annual leave carry over policy for the current year, organisations should hold their annual leave accrual at the current level and not assume any benefit to the bottom line in their H2 2021/22 plans.

Cash regime

72. The cash payment approach for H2 is consistent with H1; CCGs and providers should refer to the H1 guidance for further detail.

73. It remains important that providers and commissioners pay promptly (to terms) during this time, so that cash flow for NHS and non-NHS suppliers of goods and services does not become a barrier to service provision. All organisations will be monitored on a monthly basis and late paying NHS organisations will be contacted to agree a rectification plan.

74. In the context of the expected overall cash mandate, it is expected that provider net cash borrowing requirements will remain low. Where providers do require supplementary revenue cash support, they will be able to apply for revenue cash support from DHSC via the NHS England and NHS Improvement Capital and Cash team.

Queries and FAQs

75. Unless specified otherwise, queries on the H2 financial arrangements should be directed to 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).

76. Queries on the process to amend NHS provider block payment arrangements and template submissions should be directed to nhsi.blockamendments@nhs.net

Appendix 1: Elective Recovery Fund and Targeted Investment Fund guidance

Introduction

1. We are making two funds available to support elective recovery during H2:

    - a **Targeted Investment Fund (TIF)** worth up to £700m to enable regional teams, with national support / scrutiny, to target investment at systems or individual providers in return for specific delivery commitments
    - an **Elective Recovery Fund (ERF)** worth up to £1bn to support activity above the level funded within system financial envelopes.

Targeted Investment Fund

2. The TIF is a flexible revenue and capital fund. At least £500m of the fund must be spent on capital, with half of this (£250m) ringfenced for technology that enables elective recovery. Funding is only available in 2021/22. The fund will support:

    - systems that can go further on elective recovery with greater financial certainty
    - systems that require additional financial support, but where the commitment, ambition and a credible plan to deliver is in place
    - propositions from individual providers with a proven track record of delivery
    - schemes which will support delivery beyond the second half of this financial year.

3. We are asking systems, working with regional teams, to propose by 14 October 2021 a shortlist of targeted investments that can be delivered in year, and have a material impact on activity or demand management in their region, either in 2021/22 or in future years. Each region should have a digital lead supported by the wider taskforce to develop their technology proposals, with support from NHSX where necessary. Any investment will be linked to approval of a sufficiently ambitious, credible plan for elective delivery. Investments should be

included in financial and activity plans only once final approval has been given following 14 October 2021 submission. Investments pending approval should not be included in submissions. There will be an opportunity to update existing capital plans to reflect investments once these have been approved.

4. Proposals should focus on delivering the highest priority elective recovery reforms, and / or on systems and providers facing the greatest challenges in restoring activity to pre-pandemic levels. This could include:

   - Additional day surgery units/day theatres to maximise activity and minimise length of stay, or upgrade works to allow for increased amount of surgical work
   - Additional permanent and modular theatres to rapidly increase throughput, and surgical hubs to improve productivity in specific pathways
   - Additional critical care capacity to facilitate greater elective throughput and increase resilience
   - Investment in outpatient space to deliver more productive outpatient clinics
   - Reconfiguration or refurbishment of existing clinical spaces that currently have a negative impact on clinical productivity
   - Estates optimisation to improve clinical workflow and logistics (adjacencies) and the mix of clinical and administrative space to improve productivity
   - Imaging investment such as compressed sense upgrades to MRI, mobile breast screening units, digital pathology
   - Surgical equipment and interoperative diagnostics, such as scopes, to allow for shift into different settings
   - Investment in digital, IT or technology that delivers productivity savings, reduces pressure on waiting lists, helps with the management of patients out of hospital, reduces length of stay or enables patient initiated follow up care
   - Other proposals that deliver productivity savings in the system more widely which can be re-invested in additional activity or enable separation of elective and diagnostic capacity (‘green’ / ‘cold’ site facilities) through winter and for the future.

5. The technology fund should be invested in productivity-enhancing innovations, from the list below which has been agreed by NHSX and national clinical teams in consultation with the frontline, that can be drawn down from existing national procurement frameworks:

   - home based pre-surgical support including virtual surgery schools, patient information packages, digital pre-assessment, digitally enabled preoperative rehabilitation and consenting
   - digital tools that help with active waiting and personalised optimisation such as supporting increased activity, weight loss and smoking cessation
   - patient facing tools for communications, including patient held records, that enable patients to select when they want a follow-up appointment (digitally enable personalised follow-up), staff to provide guided self-management, and/or asynchronous clinical triage supported by patient self-assessment
   - deployment of robotic process automation to reduce the administrative burden on staff and improve the efficiency of clinical processes
   - real time operational data or population health management tools that helps systems to visualise performance to best balance capacity and demand, reducing waiting times as rapidly as possible
   - use of digital innovations that support early discharge and home rehabilitation, including virtual wards and remote monitoring licenses
   - digital tools and operational data that support the deployment of enhanced recovery after surgery (ERAS) approach, leading to improved patient outcomes, faster patient recovery shorter patient stays and reduced post-surgical complications
   - access to evidenced digital solutions that support people at home on alternative pathways - for example establishing digital offers for those patients in need of support with their mental health or pain management avoiding the need for hospital based care
   - other digital tools that present a clear benefit to productivity or access.

6. We are adopting a streamlined business case approvals process. Systems, working with their regional team, will be asked to complete a provided short form business case template for all proposals in their region by 14 October 2021. In addition, by 29 October 2021 we will require:

- for **all technology fund proposals**: details of the proposed solutions in which investment will be made and the approach to implementation
- for all other schemes with capital values of:
  - **£5m-£15m**: a summary of the 5-case model (replacing the outline business case and full business case) and a value for money (VfM) template
  - **£15m and above**: a summary of the 5-case model (replacing the outline business case and full business case) and comprehensive investment appraisal (CIA) model.

7. We expect these plans to clearly set out the proposed costs and benefits, and make use of national frameworks/procurement models, where applicable, to speed up delivery.

8. Any proposals of £50m or above will be subject to HM Treasury approval.

Elective Recovery Fund

9. A second fund worth up to £1bn will support activity above the level funded within system financial envelopes. For H2 this will be focussed on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity which was used in H1. The thresholds for the scheme have been recalculated so that they are on a comparable basis to the 95% threshold for the ERF in Q2.

10. Systems that achieve completed referral to treatment (RTT) pathway activity above a 2019/20 threshold of 89% will be able to draw down from the ERF. Part of the ERF will also be used to centrally fund systems for independent sector (IS) activity above 2019/20 levels.

11. System level RTT pathway activity performance against the 89% threshold will be calculated by weighting performance at treatment function code (TFC) level, split between admitted and non-admitted pathways.

12. Where systems deliver completed RTT pathway activity above the 89% threshold, additional activity will be funded at 100% of tariff between 89% and 94%, and 120% of tariff over 94%. This will be applied to the ERF baselines for October to March which were issued in H1.

13. For example, if a system delivers:
    a. 91% against the 89% threshold in a month and had an ERF 2019/20 baseline value of £20m for that month, then the system would earn an additional £0.4m (2% x £20m x 100%).
    b. 95% against the 89% threshold in a month and had an ERF 2019/20 baseline value of £20m for that month, then the system would earn an additional £1.24m (5% x £20m x 100% + 1% x £20m x 120%).

14. Systems will be issued with their weighted completed RTT pathway baselines which will be used to monitor performance against the 89% threshold.

15. Weekly RTT data will be used to make an initial assessment of performance and payment and, as per H1, 90% of the funding will be released on that basis with final adjustments made when the final monthly RTT data is released.

16. The scheme will again operate at a system level, covering both NHS and IS providers and any funding earned will be allocated to lead CCGs. The distribution of any funding earned within a system will be subject to local agreement.

17. Separately, we will hold funding to pay for any locally commissioned IS activity above 2019/20 levels. This activity will be funded even if the system does not deliver above the 89% threshold for completed pathways. Where a system does earn funding for activity above the 89% threshold, any IS payment (from this fund) will be made at 100% of tariff and netted off to avoid any double payment.

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.

© NHS England and NHS Improvement 2021

Publishing approval reference: C1406