Context for finances and payment for 2022/23

3 September 2021

NHS England and NHS Improvement

About this webinar

- This webinar is part of our engagement on potential policies for 2022/23.
- It is intended to support the series of engagement workshops that are running throughout September.
- It is focussed on providing context for 2022/23 – it is not discussing the financial arrangements that will be in place for 2021/22.
- You can ask questions using the chat box and we will address as many of them as we can.
- The session will be recorded and will be available to view after the event.

Speakers:

- Paul Healy, Head of Strategic Finance – Financial considerations for 2022/23
- Sam Stringer, Senior Payment Policy Manager – Developing the payment system

Financial considerations for 2022/23

The Health and Care Bill

Health and Care Bill

► Integrated Care Partnerships

- Would be established as a **joint committee** by the Integrated Care Board and each responsible local authority which falls wholly or partly in the same area
- Would be required to prepare and publish an **integrated care strategy** setting out how the needs of the local population will be met by the relevant functions, which bodies would have regards to

► Integrated Care Boards

- Would be established from **abolished Clinical Commissioning Groups**, including the transfer of all property, rights and liabilities
- Would be required (with its partner NHS trusts and foundation trusts) to prepare and publish a **five year strategic plan**, as well as an annual capital resource use plan before each financial year

► NHS England

- Would be required to **establish Integrated Care Boards** and could publish rules on the people for whom they have responsibility for
- Would have new powers to direct Integrated Care Boards to exercise its functions, including **delegating direct commissioning** functions

Health and Care Bill

► Other relevant clauses

- NHS England, Integrated Care Boards, NHS trusts and foundation trusts would be required to have regard to all likely effects of decisions in relation to the **Triple Aim**, which NHS England could produce guidance on
- NHS England could impose **capital expenditure limits on foundation trusts** for a defined period, which would be published after consultation. NHS England must published guidance on how this power would be used
- NHS England, Integrated Care Boards, NHS trusts and foundation trusts have a new power to allow any **functions to be exercised by or jointly with any other statutory bodies or local authorities**. Regulations may limit where this power could be exercised or else impose conditions
- NHS England could publish **guidance on joint appointments** between Integrated Care Boards, NHS trusts, foundation trusts and local authorities, which the relevant NHS body must have regard to
- NHS England would have new powers to set **rules for the NHS payment scheme**, including setting formulae, referencing groups of services, making different provision for different services and making different provision for the same service by reference to circumstances or other relevant factors

Health and Care Bill

► Financial duties

- New **joint financial duty** on the Integrated Care Board and its partner NHS trusts and foundation trusts to ensure they collectively exercise their functions in a way that **does not consume more than their agreed share of NHS resource** (set by NHS England)
- NHS England could set directions on what capital and revenue **resources should be attributed** to local resource use
- NHS England could set directions to **apportion capital and revenue resources** of NHS trusts and foundation trusts to one or more Integrated Care Boards
- The Bill would also **strengthen the duty on NHS bodies to cooperate**, whereby guidance give organisations greater clarity about what this means in practice

ICB Financial Framework

ICB Financial Framework

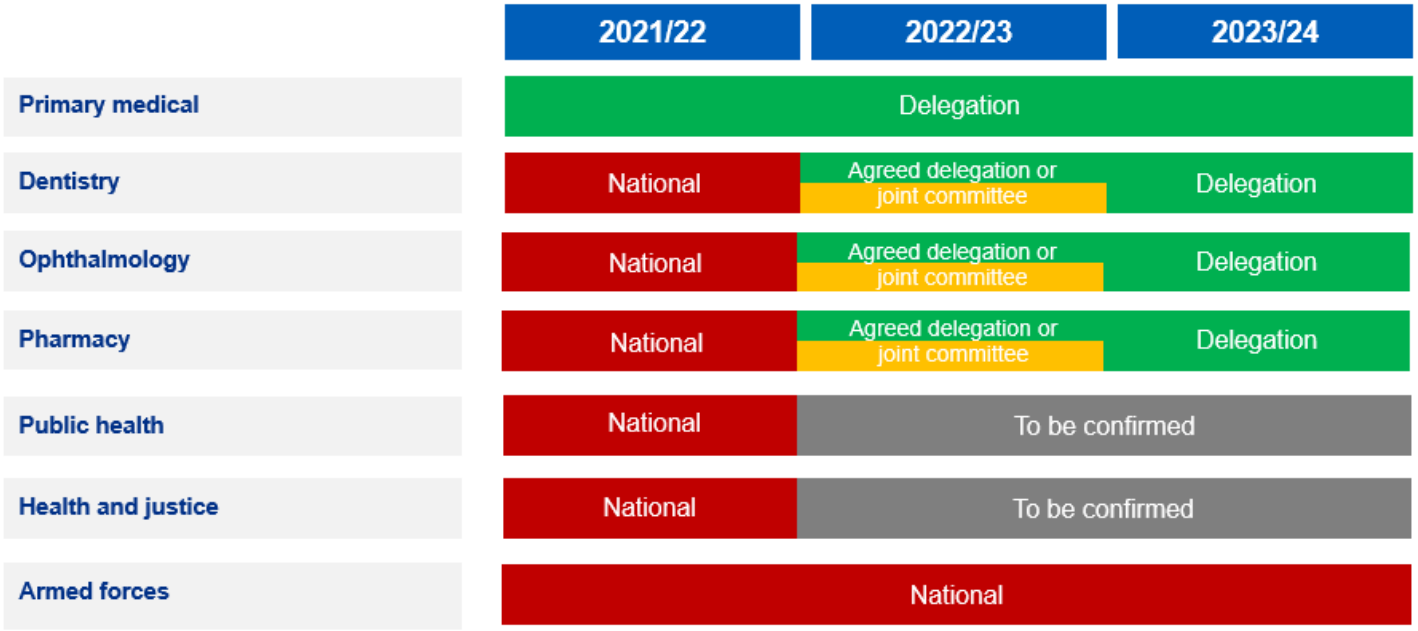
► Transition to ICB allocations

- NHS England would make **financial allocations to the Integrated Care Board** in 2022/23, which would include budgets for:
  - Services currently commissioned by CCGs, including primary medical services;
  - Newly delegated functions agreed with NHS England, in line with plans set out; and
  - A running cost allowance set at the same level and distribution as for CCGs in 2021/22
- ICB allocations would be based on longstanding principles on equal opportunity of access for equal needs and informed by the independent Advisory Committee on Resource Allocation (ACRA).
- Money would flow from the Integrated Care Board to providers **largely through contracts**, which could be managed by Place Based Partnerships or Provider Collaboratives
- We are working to have ICB allocations released as soon as possible, following an outcome from the Spending Review. This would allow systems as the time needed to plan for the year ahead, in the context of the settlement agreed.

ICB Financial Framework

► Transition to ICB allocations

Plan for delegation of NHS England functions (other direct commissioning)



Functions retained by NHS England nationally:

- Responsibility for some specialised services that need to be centrally commissioned
- Identifying national priorities, setting outcomes, and developing national contracts or contractual frameworks
- Maintaining national policies and guidance that will support ICBs to be effective in their delegated functions
- Delivering support services.

ICB Financial Framework

► Managing ICB NHS resources at place

- **Models for Place Based Partnerships** in Integrated Care Boards include:
  - A consultative forum
  - A committee of the Integrated Care Board
  - A joint committee with other statutory bodies
  - Delegated authority to an individual executive or staff employed by the Integrated Care Board
- Integrated Care Board could **also contract a lead provider** to manage resources via sub-contracts
- NHS England **would not set central allocations to place**, but could adapt existing allocation tools to support an understanding of target allocation at place

► Managing ICB NHS resources at scale

- All acute (non-specialist) and mental health NHS providers would be part of **one or more Provider Collaborative**
- Options for Integrated Care Boards to **contract with Provider Collaboratives** include:
  - Contracting with and **paying providers individually**, which could agree how to use resources for shared objectives through a Provider Collaborative
  - Contracting with and **paying a lead provider**, which could agree sub-contracts and payment arrangements through a Provider Collaborative

ICB Financial Framework

► Place-based partnerships and provider collaboratives

2022/23

- Beginning the process of developing provider collaboratives and place-based partnership as a significant focus for collaboration across all systems
- Payment flows are to remain between the legally defined entities (e.g. ICB to provider)
- The ICB would mostly lead on the commissioning process, delivering these functions as part of arranging services for the local population
- SCFMA and risk sharing agreements could form the basis of agreements for provider collaboratives
- Section 75 partnership agreements could form the basis for governance of place-based partnerships

2023/24 and beyond

- Deeper collaboration, with more formal arrangements
- Commissioning functions more significantly delegated to place and provider collaboratives, e.g. through lead providers or ICB committees, informed by population need
- Fixed payments for collaborative activity informed by PLICS and shared governance arrangements
- Expectations and responsibilities for fixed payment within these arrangements will need to be clarified
- Network arrangements across ICB boundaries considered to ensure sufficient flexibility and guidance

ICB Financial Framework

► Recent

June 2021	ICS Design Framework	Future ambitions for ICBs
June 2021	Guidance on the employment commitment	What commitment means in practice
July 2021	NHSE direct commissioning functions	Confirming plans for 2022/23 and beyond
August 2021	Guidance on provider collaboratives	Minimum expectations for providers working together
August 2021	ICB functions and governance	Expected governance requirements for ICBs
August 2021	HR framework to support people change	National policy ambition and practical support
August 2021	People function and operating model	Builds on the priorities set out in the People Plan
August 2021	ICB Readiness to Operate Statement	Template for ROS and accompanying checklist
August 2021	Due Diligence guidance	Due diligence process underpinning legal transfers

► Key documents soon

Guidance on place-based partnerships	Guidance on involving people and communities
Guidance on professional and clinical leadership	Supporting information on managing ICB resources
Guidance on ICB and VCSE sector	ICB financial governance guides

ICB Financial Framework

► FutureNHS Collaboration Platform

- FutureNHS will host the latest information, guidance and tools produced by NHS England to support ICB implementation and development
- An ICB Guidance workspace will be regularly updated with documents across a range topics, including the ICB Financial Framework
- To access this, register on http://future.nhs.uk and join the ICB Guidance workspace on http://future.nhs.uk/ICSGuidance/grouphome
- We plan to upload an updated Frequently Asked Questions (FAQ) document each month on this platform, which would capture questions received through engagement in one place

Developing the payment system

Case for payment system reform

- The NHS Long Term Plan committed to reform of the payment system, with the aim of moving from activity-based to population-based payment for all services.
- Activity-based payment (payment by results (PbR), then national tariff) was initially introduced to reduce waiting times, support patient choice, reward efficiency and quality, and focus provider and commissioner discussions on quality rather than price. While it has proved successful at delivering these objectives, the context and what the payment system needs to achieve has evolved.
- The primary driver for improvement within activity-based approaches is competition. However, in the context of ICSs, the emphasis is shifting to collaboration and how the payment system can support system partners to work together.
- In addition, the pre-Covid payment system – largely a mix of activity-based payments for acute services and block contracts for non-acute services – was sometimes being seen to get in the way of innovation and integration, with different payment approaches promoting different incentives, behaviours and risk allocations, and sometimes coming into conflict.
- Even before Covid-19, local areas were increasingly varying away from national payment policy defaults and using block contracts, “aligned incentive contracts” (AIC) and other payment approaches.

Covid-19 and payment

- The NHS response to Covid-19 meant nationally-set block payment arrangements were put in place for 2020/21 and 2021/22, rather than using an activity-based payment approach.
- The block payment arrangements have significantly simplified the payment system in operation, but have also moved much decision making to national rather than local level. These block arrangements also offer little transparency as to the efficacy and efficiency of payments in-system.
- As the pandemic has progressed, providers have needed support to deliver increasing levels of non-Covid activity, in addition to dealing with Covid cases. As such, in March 2021, the Elective Recovery Fund was introduced. This gives additional income to providers able to deliver higher levels of elective activity, helping to address the backlog.
- In setting the 2021/22 national tariff, funding for Covid-19 costs have been excluded from tariff prices and calculations of inflation and efficiency, with the funding to be distributed outside the tariff.
- We are aware that, in addition to direct costs, Covid-19 has had a significant impact on how care is delivered – for example, an increase in virtual appointments. Many of these changes are not yet reflected in the data used to set the tariff.
- All of these points mean that the impact of Covid-19, and the financial arrangements introduced in response, have created a different starting point for payment system development to that envisaged in 2019/20 when blended payment was first introduced.

What is blended payment?

- One of the specific commitments in the Long Term Plan is to introduce a blended payment model for almost all services. Blended payment is intended to:
    - support a more effective approach to resource and capacity planning that focuses commissioners and providers on making the most effective and efficient use of resources to improve quality of care and health outcomes
    - provide shared incentives to local system partners to deliver the optimal level of care in the right place at the right time – and shared financial responsibility for levels of hospital activity
    - fairly reflect the costs incurred by efficient providers in delivering care and generate incentives for continuous improvements in efficiency
    - minimise transactional burdens, provide financial stability and reduce barriers to support service transformation.
- Blended payment is designed as a framework, rather than a fixed design.
- It was initially introduced in 2019/20 for urgent and emergency care and adult mental health services. It was intended to then introduce it on a service-by-service basis over future tariffs, starting with outpatient and maternity services in 2020/21.

Blended payment framework

- The blended payment framework comprises:

A **fixed element**, set based on forward-looking forecasts of activity and best available cost data.

At least one of…

A **variable element** **and/or** A **risk-sharing element** **and/or** A **quality- or outcomes-based element**

Aligned payment and incentive (1)

- Aligned payment and incentive (API) is **a type of blended payment**, introduced for the 2021/22 national tariff. It was designed to support a smooth transition out of the Covid-19 payment arrangements, while also making progress on developing the payment system.
- The API model is the starting point for proposals being developed for the 2022/23 tariff.
- The API blended payment model involves:
    - providers and commissioners locally agreeing a **fixed element** to deliver an agreed level of activity
    - a **variable element** to reflect quality of care (best practice tariffs and CQUIN) and address deviations from planned activity levels used to set the fixed element.
- API arrangements cover almost all secondary healthcare services, including acute, community, ambulance and mental health.
- All NHS England Specialised Commissioning is covered by API blended payment (regardless of value). Other NHS England commissioned activity is subject to a threshold.
- Contracts under the Increasing Capacity Framework agreement for elective activity would again be exempted from the API blended payment.

Aligned payment and incentive (2)

- API applies to all contracts for secondary healthcare services between a commissioner and providers **who are members of the same ICS**.
- For providers and commissioners in different ICSs:
  - API applies to all commissioned activity **above a contract value threshold**. For 2021/22, this threshold is set at £10 million.
  - Payment arrangements for contracts below this threshold would be **determined by agreement** between the commissioner and the provider. Where agreement cannot be reached, prices published as part of the tariff are the default approach.
- The introduction of API means that most prices published as part of the tariff are no longer 'national' (ie mandated) prices, but are 'unit' prices instead. National prices remain for unbundled diagnostic imaging services.
- Unit prices are calculated in the same way as national prices but would be used in the variable element, as benchmarks, for some activity outside of the scope of API, and for independent sector activity delivered as part of the Increasing Capacity Framework.
- This means that unit prices would be used for around 5-6% of activity covered by the national tariff.

Tariff development timetable

Tariff development process
Engagement and gathering feedback on potential policies **September 2021**
Statutory consultation on proposed 2022/23 tariff **December 2021/January 2022**
Publication of final 2022/23 tariff (subject to consultation) **February/March 2022**
2022/23 tariff takes effect **1 April 2022**

Publication of 2021/22 national tariff is still planned for autumn 2021.

Payment system development

Historic payment system	Current payment system	Future payment system
Detailed specifics	High level / macro	High level framework
Based on published prices	Provides a default approach	Potential more specific defaults
Mandated (but not enforced)	Flexibility on implementation	Flexibility to be determined

What this may mean in practice
Rules – less detail; more focussed specific rules as local and national requirements evolve
Guidance – Increased need for supportive implementation guidance that describes the default approach and agreeable variations. Potential to support with case studies of successful implementation
Prices and products – less of a role for published prices in blended payment arrangements, but other products developed to support fixed element setting. Products determined and developed through engagement with the sector.

Potential change in focus?

As the payment system moves from primarily activity-based to population-based focus, its structure may need to change.

Activity-based tariff/PbR → **Blended payment**

Questions?