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# Revenue finance and contracting guidance for 2022/23

April 2022

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## Introduction

1. This document sets out further guidance in relation to the revenue and contracting frameworks for the 2022/23 financial year (1 April 2022 to 31 March 2023). In addition, there is further guidance in respect to [technology funding](#), covering both revenue and capital. This document should be read in conjunction with the [2022/23 priorities and operational planning guidance](#) and the [Capital guidance for 2022 to 2025](#).
2. The planning assumptions set out in this document are based on the current drafting of the Health and Care Bill, and so remain subject to the passage of the proposed legislation. As such, this document includes the following references which should be interpreted as:
  - **Integrated care boards (ICBs)** – where this document refers to actions for ICBs (planning, contracting or other activity) that are required to be completed before the passage of the Bill, these actions should be completed by clinical commissioning groups (CCGs) working with designate ICB leaders.
  - **Systems** – for the purposes of this guidance, ‘systems’ are defined to be the ICB and partner NHS foundation trust and NHS trust organisations.
3. The [2022/23 priorities and operational planning guidance](#) confirms a target date of 1 July 2022 for statutory arrangements to take effect and for ICBs to be legally and operationally established. This raises several questions on how proposed financial arrangements for 2022/23 will be applied and how NHS England and NHS Improvement intend to approach key financial impacts from the delay. [Appendix A](#) gives initial information on some key finance issues.

## Financial planning process

### Planning

4. As established in previous planning processes, systems will continue to be the key unit for financial planning purposes. The resource use of NHS trusts and foundation trusts (referred to collectively in this guidance as trusts) are individually fully mapped to a single system and their planned financial positions should be only included within that single system’s plan, with trust positions reflecting the contract arrangements agreed with commissioners outside the

system their resource use has been mapped to. All systems have a breakeven requirement.

5. The system plan template has been updated to reflect the changes to commissioning structures proposed in the Health and Care Bill. A summary of the key changes to plan templates and links to key technical planning guidance, including submission guidance, are included on the cover of each plan template.
6. The system plan submission will be the source of information for ICB budget uploads and for trust income and expenditure, bottom line performance and capital.
7. Trusts will continue to be required to submit organisational plans and these plans must be in line with their system plan submission including the key categories listed above. Where trust plans are not consistent with their system position, the trust and system returns will both be rejected and their alignment and immediate resubmission requested. The trust financial plan collection has been simplified to include summarised accounting statements, capital and efficiency plans only.

## Reporting

8. Final plan submissions will form the basis of in-year financial monitoring. Plan templates will collect a monthly profile of key data to facilitate in-year monitoring. Reporting collections are continuing to be developed and further guidance will be issued outlining the in-year reporting requirements.

## Revenue allocations

### Overview

9. During 2020/21 and 2021/22, systems were also established as the key unit for financial allocations. In 2022/23, this approach will continue to support greater collaboration and collective responsibility for financial performance.
10. This section sets out further detail on the following funding components:
  - ICB programme allocation
  - ICB elective services recovery funding

- ICB primary medical care allocation
  - ICB running cost allocation
  - other primary care services allocation (ICB or regional depending on agreed voluntary delegations)
  - ICB COVID allocation
  - NHS England specialised services
  - NHS England other directly commissioned services
  - service development funding (ICB and NHS England).
11. ICBs would be able to make use of new flexibilities to manage NHS resources and guidance has already been published on [FutureNHS](#) to support place-based partnerships and provider collaboratives. An allocation tool will be published to support systems to understand relative need in different places. This tool could help ICBs looking to allocate budgets at place or service level, and to target NHS resources towards reducing inequalities.
12. ICB [allocations and supporting technical guidance](#) will be published alongside this guidance. The allocations technical guidance will include fuller detail on the construction of allocations. The sections below include key messages and should be read alongside the allocations technical guidance.

## ICB programme allocations

13. The COVID-19 pandemic necessitated the introduction of an interim allocations approach to ensure that systems had sufficient resource to respond to the pandemic. From 2022/23, the allocations methodology will be reset to move systems back towards a fair share distribution of resource at the levels affordable within the SR21 settlement.
14. ICB programme allocations are based on annualised system funding envelopes (comprising CCG allocation and system top-up components) for the second half ('H2') of 2021/22 (ie H2 x 2), with the following adjustments:
- **Baseline normalising adjustments** – to adjust H2 to be the right recurrent future baseline, eg removing H1 back-pay funding and reflecting recurrent transfers of funding from the Service Development Fund (SDF) into allocations.

- **Net growth for 2022/23** – uplift to reflect an assessment of demographic and non-demographic activity requirements, inflationary pressures and a general efficiency requirement of 1.1%.
  - **Convergence adjustment towards fair share allocations** – in addition to the general efficiency requirement, a differential convergence adjustment is applied to both reduce overall resource consumption to SR21-funded levels and move ICBs towards a fair share funding distribution. The convergence adjustment differs by ICB and depends on their distance from target allocation. Systems consuming more than their fair share will have a greater convergence ask.
15. The convergence adjustment replaces the previous CCG pace of change (PoC) and trust Financial Improvement Trajectories (FIT) methodologies. From 2022/23, distance from target allocation will become the single measure of under- or over-consumption of resource relative to fair share distribution. In 2022/23, the convergence adjustment will include consideration of the full trust cost base to better reflect the opportunity for efficiency delivery.
  16. Prior to the pandemic, NHS England and NHS Improvement allocated significant sustainability funding to trusts directly, to support the finances of essential NHS services. The NHS Long Term Plan made a commitment to reduce the size of this funding over time and during the pandemic this funding has been issued through the top-up funding element. ICB allocations will continue to include the total value of sustainability funding to further support the move towards reflecting a fair share of NHS resources (based on ICB target allocations). This allows us to take overall system resource consumption into account when setting future years' budgets.

### ***Fair share ('target') allocations***

17. The formula that determines fair share ('target') allocations will be updated in line with the recommendations of the independent Advisory Committee for Resource Allocation (ACRA) and policy updates. The ACRA recommendations include refreshing the model for general and acute hospital services, updating the existing adjustment for health inequalities and unmet need, and estimating baseline populations using GP registrations for a single month to manage the impact of COVID-19 on annual data.

18. In addition to this, fair share ('target') allocations include an updated approach, using a nationally consistent methodology, to reflect the excess financing costs of historical private finance initiative (PFI) contracts on trusts. As part of the temporary financial framework, any historical PFI support payments have already been moved into the system funding envelopes and, as set out above, these costs remain in the starting point for 2022/23 ICB allocations.

## **ICB elective services recovery funding**

19. Funding for elective recovery will operate on a different basis to that in 2021/22. As we have moved out of the emergency COVID block payment arrangements and back to local contracting and commissioning, the initial flow of funds for elective recovery will revert to a commissioner basis, not a provider basis.
20. In total, additional elective funding has been allocated to commissioners to deliver 104% of 2019/20 levels of value-based activity across elective ordinary, day case, outpatient procedures with a published tariff price and first and follow-up outpatient attendance activity for acute specific TFCs. The additional elective funding allocation will be adjusted up or down if actual activity delivered is above or below the 104% baseline value (adjusted by 75% of the tariff value both ways).
21. Systems, working with their providers, are asked to agree activity plans based on the total allocated funding for both ICB and specialised activity. Payments from commissioners to providers should follow the rules set out in the [National Tariff Payment System](#). This involves the agreement of a fixed payment to fund the level of elective activity providers have agreed with their commissioners. For elective activity that differs from plan,  $\pm 75\%$  of the difference is earned/deducted. Note that this is a change from the tariff consultation of a variable rate of  $+75\%/-50\%$ .
22. Further details, including the treatment of independent sector and outpatient follow-up activity are set out in separate [elective technical guidance](#).

## **ICB primary medical care services**

23. ICB allocations for delegated primary medical care services will be [published](#) alongside this guidance. The allocations have been updated to take account of changes above the previously assumed levels. There have been no changes in policy to the calculation of the target formula for delegated primary medical care



allocations. Instead, updates to the target formula relate to refreshing inputs for the latest data, such as population and registration rates.

## **ICB running cost allocation**

24. ICB running cost allocations will be [published](#) alongside this guidance. We will require that ICBs do not exceed a running cost allocation, which will be published as part of the ICB allocations. ICBs are asked to maintain spending on a broadly flat cash basis against the 2021/22 running cost allocation of their former CCGs, which means that running costs will fall in real terms. This is before an adjustment is made for the impact of the Health and Social Care levy on employer national insurance contributions by ICBs.
25. ICBs must ensure they are planning for and taking actions to manage management costs during 2022/23, as they implement their establishment and new legal framework. CCGs should have been operating on an integrated care system (ICS) basis by the end of 2021/22, and most will be transferring from one CCG to one ICB.

## **Other primary care services**

26. The Health and Care Bill allows for the delegation of NHS England commissioning functions for pharmacy, dental and general ophthalmic services to ICBs, by agreement. Allocations for these services will be set at regional and ICB level. Where, subject to legislation, ICBs are taking on delegations in 2022/23, they will receive the allocation to commission the delegated services. Where ICBs are not taking on delegations, NHS England regional commissioners will continue to receive the allocation, including funding for regional staffing budgets.
27. Where services are to be delegated, ICBs should assume that the responsibility for paying for primary care services will be determined in the same way as it is currently, but based on the ICB geographical footprint rather than the regional geographical footprint. Work is ongoing with regional teams and those ICBs taking on delegated primary care functions, to ensure there is a good understanding of the delegated responsibilities for commissioning and paying for pharmacy, dental and general ophthalmic services.

## Service Development Fund (SDF)

28. Systems will continue to receive SDF allocations to support the delivery of the NHS Long Term Plan commitments. Operational requirements are set out in the relevant sections of the [2022/23 priorities and operational planning guidance](#).
29. SDF allocation schedules and technical guidance will be separately issued alongside planning templates to regional teams and ICBs. The schedules will set out the total available SDF allocation for each system by programme and scheme. The associated technical guidance will outline any access conditions to the funding, including the detail of delivery criteria. Systems should develop plans based on the total SDF allocations and delivery expectations, assuming full delivery of access criteria.
30. The technical guidance will identify where allocations for programme/schemes have not yet been confirmed. Systems should not assume funding or expenditure in their planning submissions for unconfirmed areas. Funding confirmations and delivery expectations for these areas will be issued as soon as possible in the financial year.
31. For information purposes only, the issued schedules will include details of SDF allocations that have been transferred recurrently into or out of ICB allocations. The programmes to which this applies are primary care, mental health and maternity services (funding to support implementation of the Ockenden recommendations).
32. Where allocations have been confirmed and are annual allocations, these will be issued at the start of the financial year, for the full year. Allocations with access criteria will be issued on a periodic basis during 2022/23, linked to the reporting timeline of the relevant access criteria.
33. NHS England and NHS Improvement will seek to confirm SDF funding for 2023/24 and 2024/25 as soon as possible. To provide clarity, the SDF schedules will identify the recurrent and non-recurrent nature of funding. For schemes that are identified as recurrent, systems should plan on the basis of indicative funding for future years continuing at the level of 2022/23, pending confirmation of 2023/24 and 2024/25 allocations.

34. The full detail of SDF allocations is set out in the separately notified schedules and technical guidance. However, systems should particularly take note of the following updates:

- **Ockenden maternity recommendations** – funding to support the implementation of the recommendations of the Ockenden review will be issued recurrently through ICB programme allocations in 2022/23.
- **Long COVID** – funding of up to £90million will be distributed to maintain support for Long COVID assessment services and paediatric hubs through the SDF.
- **Personalised care** – from 2022/23, allocations will be issued on a fair share basis.
- **Workforce** – funding will continue for [staff mental health and wellbeing hubs](#).

## Specialised commissioning

### *Allocations and integration*

35. In 2022/23, NHS England regional commissioners will maintain ownership of the commissioner allocation and commissioning for specialised services. Contracting with providers will continue on a host regional basis as per historical arrangements.

36. To support readiness for potential future delegations to ICBs, NHS England and NHS Improvement will seek to strengthen joint working through:

- Issuing **shadow ICB population-based allocations** – these allocations are built from the same baseline as the 2022/23 regional commissioner allocation but the funding will be mapped to the ICB where the patient is registered rather than provider footprint (per regional allocations), to provide clarity on future delegation funding.
- Developing **joint collaboration arrangements** between regions and systems – these arrangements will enable integrated planning and reporting so that regions and systems start to gain the benefits of population-based management approaches and develop governance and processes to pave the way for future delegation of specialised services. We expect to publish

further detail on these arrangements and the financial aspects that support them early in the 2022/23 financial year.

- Developing **system-level reporting** – in-year financial performance reporting for specialised services on a population basis to track this against the population-based allocation.

37. A needs-based allocations formula for specialised services is being developed for implementation in future financial years. The formula is being developed along the same principles as the ICB target formula and will be implemented using an aligned convergence ('pace of change') approach.

### ***Payment arrangements***

38. Specialised service funding to trusts is currently on block inflows calculated based on M9 2019/20 agreement of balances, with the balance of funding to support system breakeven within the system top-up.
39. As part of the 2022/23 financial arrangements, commissioners and trusts will re-establish local responsibility for payment arrangements for all commissioning areas. This is important for specialised services in the context of integration of services with ICBs and establishing the right baselines for future delegations. The contracts and payments terms will be consistent with the guidance outlined in the [Contracts and payment approach](#) section of this guidance.
40. NHS England and NHS Improvement will maintain centrally held budgets for investment in service and clinical priorities. These budgets will be allocated to regions in-year, as decisions are made on investment. As a result of nationally driven procurement exercises, there may be a requirement in-year to make agreed adjustments to the fixed element of a trust's contract to reflect material service changes or transfers.

### ***Specialised high cost drugs***

41. Expenditure on drugs relating to the Cancer Drugs Fund (CDF) and Hep C will continue to be funded on a 100% cost and volume basis from a national allocation. Reimbursement will be based on provider reported data and will depend on the submission of accurate data, to ensure only the cost of the drug is being reimbursed.

42. Trusts will continue to receive payment directly through the national payment process, with the provider data supporting this payment verified by regional teams (led by regional CDF teams in the case of CDF).
43. For the remaining tariff-excluded high cost drugs, regions will contract with providers on the following basis:
  - drugs categorised as 'block' (that is, not volatile in terms of uptake) will be added to the fixed element of the contract
  - drugs categorised as 'cost and volume' will be given a notional baseline (based on M6 2021/22) in the fixed element of the contract with under or over-performance subject to variable payment.
44. New National Institute for Health and Care Excellence (NICE)-approved drugs will continue to be reimbursed on a 100% cost and volume basis based on actual reported data. Where deemed appropriate, treatment costs relating to new NICE approvals (such as CAR-T therapy) will also be funded on a cost and volume basis from a national allocation.
45. The strong emphasis on reported data will be continued, as this will be linked to financial reimbursement, and further strengthened for other missing data fields to support data improvement, including capturing drug information using SNOMED (dm+d).
46. Regional commissioners will be required to plan for local re-investment of a portion of any planned drug savings in a managed way.

### ***Specialised high cost devices***

47. Phase II of the devices programme will continue to focus on delivering price savings from national commitments and value-based procurement. There are further opportunities to deliver wider system savings from improving the uptake of certain products, eg remote monitoring of implantable cardioverter defibrillators (ICDs) and pacemakers.
48. From 2022/23, all national tariff excluded high cost devices funding for trusts in England and formally managed service arrangements with non-NHS providers will be managed on a national basis, outside contract baselines. The national finance team will manage the monthly transactional process and reimburse trusts

directly. Information will continue to be shared with regional teams, building on the current processes in place. Under this model, savings from national commitment pricing will be paid back to systems via gain share agreements with the relevant ICB and invested in centrally procured value-based devices to enable local system efficiencies to support additional capacity. The direct reimbursement for devices to non-NHS providers or the devolved nations will continue to be managed locally by regional teams.

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

49. There are currently 47 live NHS-led provider collaboratives for specialised mental health, learning disability and autism services (MHPCs). Two more are due to go live in April 2022.
50. MHPC funding is constructed on a population basis. Regional commissioner allocations will be adjusted to reflect the funding due to MHPCs within their geographies.
51. The funding will be distributed from the regional commissioner to the MHPC's lead provider (LP) to deliver services within the commissioned scope of the MHPC. LPs subcontract services from other providers – both NHS and non-NHS – as appropriate to their service model. For those MHPCs that went live during 2021/22, a full year effect adjustment will be actioned to reflect the annualised budget.
52. During 2020/21 and 2021/22, LPs were asked to subcontract with trusts at the same value as their historical contract to support financial stability. In 2022/23, MHPCs can choose to change commissioning arrangements and are encouraged to establish service models that treat patients closer to home. Where such service changes result in material changes to funding flows between the LP and a subcontracted provider, the LP and impacted provider(s) should work together to agree the appropriate phasing of service and funding changes.
53. There is potential for the scope of services covered by MHPCs to be extended during 2022/23 to cover other specialised mental health services. These changes are not planned to be made until part way through the financial year and should not be included in 2022/23 plans, unless specifically notified otherwise.

### ***Clinical networks***

54. Specialised commissioners invest significant funding in trust-hosted specialised services clinical networks. This was previously linked to CQUIN achievement but from 2022/23 it will be funded from baseline allocation funding. The value of funding for networks will be required to be separately identifiable within trust contracts.
55. Funding for specialised services clinical networks will in future be reconfirmed annually based on the network ensuring that:
  - Robust governance systems are in place.
  - An annual workplan is agreed within the network and with commissioners. This will normally include both nationally and locally agreed objectives and deliverables.
  - Data to track progress is routinely collected.
  - Progress reports (against the annual workplan) are provided to the network board and the relevant commissioning lead at regular agreed intervals. Where necessary these reports will also include agreed remedial actions to ensure continuing progress towards delivery of the annual plan.
  - Publication of an annual report demonstrating delivery of the annual workplan and the impact and value of the network's work.

### ***Specialised excess treatment costs (ETCs)***

56. During 2021/22 an established financial assurance process for specialised commissioning clinical trials was developed. The assurance process confirms the cost of each specialised clinical trial, breaking down the costs into: routine charges (eg chemotherapy delivery); pass-through costs (eg relevant high cost drugs) and excess payable costs (eg additional pathology tests). Trials are continually starting and ending, so routine costs should be embedded in 'business as usual' processes. Pass-through costs for excluded high cost drugs and devices that are not being provided free of charge will be reimbursed in line with existing processes. This leaves the excess payable costs subject to a separate process.
57. For 2022/23, a national specialised commissioning budget is being established to fund these excess payable costs via a top slice from regional allocations, with the

reimbursement to trusts managed nationally. The national team will provide regional teams with a schedule of assured trials and payments made on a quarterly basis. The top slice will be set each year but is expected to be relatively stable year-on-year.

58. The top-slice will also include funding for the net increase in any exceptional high cost routine charges (eg peripheral blood stem cell transplants) where a provider/system would be disproportionately impacted by participating in a clinical trial. Payment will be subject to a reconciliation of total activity for the specific procedure against the 2019/20 baseline.

### **Other directly commissioned services**

59. As set out in [July 2021](#), NHS England will continue to commission healthcare in relation to Section 7A Public Health and Health and Justice services in 2022/23, and regional commissioners will be issued with allocations to commission these services. The intention is to establish mechanisms through 2022/23 that strengthen joint working and support the transition to future delegations.
60. NHS England will continue to commission healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services.
61. More detail on the policy and operational requirements of the 2022/23 flu campaign will be communicated in the annual flu letter following agreement with government.

### **COVID-19 system allocation**

62. Systems will continue to receive a fixed system allocation for COVID-19 services based on their provider and commissioner footprints. The COVID-19 allocation will reduce from H2 2021/22 (annualised) levels. This reduction is in line with the SR21 settlement, and includes a transfer of resource from the COVID-19 allocation to elective recovery funding to reflect that a proportion of the 2021/22 allocation was being utilised to support delivery of elective recovery. Elective recovery is funded separately through the elective services recovery allocation (refer to the [ICB elective services recovery funding](#) section above).



63. During 2021/22, systems received additional funding to compensate for the impact of the COVID-19 pandemic on services funded by non-NHS sources. No further income support is available in 2022/23 and systems will need to take action to recover their positions, through recovering non-NHS income sources, utilising clinical capacity to support NHS service recovery funded through the elective recovery fund and taking action to reduce costs.
64. Further detail on COVID-19 items eligible for funding outside allocations are outlined in the [Other planning assumptions](#) section below. Commissioners and trusts should continue to monitor monthly guidance to ensure they follow the most up-to-date information.

## System business rules

### Limits

65. Under the proposed legislation, each ICB and its partner trusts must exercise their functions with a view to ensuring that, in respect of each financial year:
  - **local capital resource** use does not exceed a limit set by NHS England and NHS Improvement
  - **local revenue resource** use does not exceed a limit set by NHS England and NHS Improvement.
66. Furthermore, NHS England and NHS Improvement intend to use additional powers in the legislation to set a financial objective for each ICB and its partner trusts to deliver a financially balanced system, namely a duty on break even.
67. ICBs will also have a duty to deliver financial balance individually. This is to promote careful financial management and to reflect legislation that requires NHS England and NHS Improvement and ICBs to manage within a fixed budget. Where an ICB considers it necessary to deliver overall system financial balance but with a deficit in the ICB itself, NHS England and NHS Improvement should be notified at the earliest opportunity.
68. Where a trust is a formal partner of more than one ICB, and for at least 2022/23, its revenue resources will be fully apportioned to a principal system. Trusts that are formal partners of more than one ICB are required to confirm that their

operational and financial plans are compatible with and aligned to all relevant system plans. The relevant ICBs are expected to work together and with those trusts to ensure full alignment, including by making use of flexibilities to agree local arrangements. Systems can still agree local risk sharing arrangements and consideration will be given where local partners have agreed to do this, while recognising the statutory duties required.

## **Risk management approach**

69. Risk management remains a vital part of system planning. System plans, which must be agreed by ICBs and trusts, should show how financial risks will be managed. Where systems consider it appropriate to support risks to expenditure that may not otherwise be mitigated, the ICB should set aside an appropriate local contingency. While there will be no nationally mandated contingency requirement, regional teams will play an important role in supporting systems to assess the appropriateness of the risk management approach.

## **ICB under and overspends**

70. Given the proposed requirement for ICBs to deliver a breakeven position each year, they should not plan for any in-year surplus or deficit. Any ICB that is overspending will be expected to take significant steps to correct its underlying rate of expenditure.
71. In the event ICBs deviate from plan and deliver an in-year under or overspend, this will be carried forward and maintained as a cumulative position, as is currently the case with CCGs. Cumulative overspends will be subject to repayment as set out below. Access to any surplus for non-recurrent expenditure will be aligned with performance through the System Oversight Framework, and subject to national affordability.
72. CCGs are currently required to hold a cumulative underspend of the higher of 1% of allocation (excluding delegated co-commissioning) and the amount carried over from the previous financial year. As part of the establishment of ICBs, this rule will be replaced with a requirement to maintain the higher of a cumulative breakeven position and the amount carried over from the previous financial year.

## Debt regime

73. To create a more balanced debt approach, if ICBs overspend in a given year, and in consideration of the wider system position, an additional interim efficiency (equal to the prevailing Public Dividend Capital (PDC) rate for trusts) will be required for a minimum of one year, or until the ICB has reduced spend to within its allocation limit.
74. As set out in the Reforms to the [NHS Cash Regime effective from 1 April 2020](#), trusts revenue support will be available for exceptional short-term cash flow requirements and longer-term revenue support for providers in financial distress. This support will be provided as PDC, which does not require principal repayment but carries a dividend payable at the current PDC rate. This reflects the opportunity cost to the taxpayer of diverting finance to unplanned cash requirements.

## Treatment of historical cumulative CCG underspend and overspend

75. The establishment of ICBs requires consideration of the approach to historical CCG surplus and deficit positions. NHS England and NHS Improvement will aggregate the net position of each constituent CCG, and then adjust for the 1% cumulative historical surplus requirement to provide the opening cumulative position for each ICB. Where the resulting brought forward balance for the ICB is a:
  - **Net historical overspend** – the balance will be frozen and, as long as the system and ICB achieves break even for each of the following two years, will then be written off. ICBs would therefore be established with no outstanding obligation. ICBs failing to deliver this requirement will have this obligation re-instated at the end of the two-year period.
  - **Net historical underspend** – the balance will be retained as a system surplus, held by the newly established ICBs, for future non-recurrent investment, subject to affordability and national approval.
76. Separately to this, any historical agreements guaranteeing CCG drawdown will be honoured through transfer of the original agreement to the relevant ICB.

## ICB opening balance

77. ICBs will have a single brought-forward balance, which will be derived from any net historical CCG underspend plus, as set out in the [Guidance on finance and contracting arrangements for H2 2021/22](#), any CCG under or overspend in 2021/22.

## Contracts and payment approach

### COVID-19 emergency payment arrangements

78. In response to the COVID-19 pandemic, the NHS adopted emergency payment arrangements from the start of 2020/21. Under these arrangements, trusts moved to block contract payments; in the first instance these were nationally calculated, but local variations have been subsequently permitted within controlled parameters.
79. As the NHS moves beyond the initial emergency response period, changes will be made to the emergency payment arrangements to support the transition back towards local agreement of contracts under the National Tariff Payment System (NTPS). For 2022/23, a simplified payments system will remain in place for NHS commissioner and trust payment arrangements to support the process of agreeing contract values and ensure that resource can be optimally focused on operational priorities. This section sets out a summary of the NTPS payment arrangements and supporting guidance for commissioners and trusts to adopt these arrangements under simplified terms.

### National tariff payment system

80. The [2022/23 National Tariff Payment System \(NTPS\)](#) came into effect on 1 April 2022.
81. The 2022/23 NTPS continues to use the aligned payment and incentive (API) approach for almost all activity in scope of the tariff. This is largely the same as the approach introduced in the 2021/22 NTPS. API arrangements apply to almost all secondary healthcare services commissioned between organisations that are members of the same system, provider–commissioner relationships with an annual value of over £30m and all NHS England and NHS Improvement

specialised commissioning contracts. This includes acute, community, mental health and ambulance services.

82. Providers and commissioners will be asked to agree a fixed element, based on funding an agreed level of activity. [Further guidance](#) is set out in the following section to support commissioners and trusts to transition from the current emergency payment arrangements towards the API contract terms. We are not expecting or encouraging providers and commissioners to re-price activity using the new tariff prices for the purposes of agreeing fixed payments.
83. Alongside the fixed element, a variable element will further support the recovery of elective services by operating a volume-related payment for actual activity delivered. The funding for the agreed level of elective activity should be included in the fixed element and where actual elective activity delivered differs from this agreed level, the variable element either pays the provider more, or deducts funds from the provider, at a rate of 75% of the tariff price. The actual achievement of best practice tariff (BPT) and CQUIN criteria, as well as the advice and guidance services delivered will also be reflected in the variable element. As set out in the [ICB elective services recovery funding](#) section, commissioners can access additional funding for elective activity above the agreed plan.
84. CQUIN will begin to operate again from 1 April 2022 for API contracts. For 2022/23, CQUIN remains part of the NTPS. To reflect this, providers and commissioners on API terms need to ensure that their fixed element includes CQUIN funding of 1.25% of the contract value. Where the starting point for setting the fixed element is the emergency payment values for 2021/22, CQUIN funding will already be included. However, if another approach is used, providers and commissioners will need to consider if the 1.25% is included. Either way, the fixed element should be set on the assumption that providers will fully attain CQUIN metrics. An assessment of actual performance should take place at the end of the financial year. If, following the end-of-year assessment, actual CQUIN indicator attainment is below the maximum threshold, payments should be deducted from the provider as part of the variations to the fixed payment. [Combined CCG/ICB and PSS CQUIN guidance](#) has been published.
85. For other provider–commissioner relationships, those between organisations in different systems and with an annual value of less than £30m, payment

arrangements will be via local agreements. However, trusts and commissioners are encouraged to adopt a fixed payment (plus a variable elective component) where doing so would not add excess burden and to follow the NHS England and NHS Improvement guidelines to calculating fixed payments.

86. Activity contracted for under the NHS Increasing Capacity Framework will continue to be subject to the tariff's unit prices rather than the API approach. Activity subcontracted by trusts to other providers is also excluded from API and subject to tariff prices.
87. Tariff prices have been recalculated for 2022/23 and are based on the 2018/19 PLICS data. There has also been a further move towards the market forces factor (MFF) target values. Full details are shown in [Annex A of the 2022/23 NTPS](#).

## Guidelines to support establishing contract values

88. Commissioners and trusts are advised to adopt the following guidelines in establishing their 2022/23 contract values for all NHS England arrangements and all ICB relationships above the low value activity (LVA) threshold of £500,000:
  - **Contract value baseline** – the contract value baseline should be the annualised H2 2021/22 contract value, with the exception of NHS England specialised services contracts which have been adjusted on a net neutral basis to transfer specialised services growth included in system funding envelopes to specialised services contracts (further detail of the adjustments are available through regional teams). The 'Contracts' tab of the financial planning templates will be pre-populated with the baseline contract values for inter-system and NHS England contracts. Intra-system contract baselines should be agreed locally based on the agreed payment arrangements for core services in H2 2021/22.
  - **Application of 2022/23 funding and efficiencies against the contract value baseline** – commissioners and trusts should agree adjustments to the baseline contract value for 2022/23 items based on the guidelines set out in the table below. These items mirror the inputs of the 'Contracts' tab of the financial planning template.

Item	Guidance
<b>Service changes from 1 Apr 2022</b>	<p>The cost of service changes from 1 April 2022 should be reflected in amendments to the contract value, for example, cessation of non-recurrent funding where the associated service/requirement is no longer commissioned and changes to the scope of screening services. The value of such changes should be locally agreed based on a reasonable phasing of expenditure changes.</p> <p>This input should also be used to reflect Specialised Mental Health Provider Collaborative 'go-lives' from October 2021 where these are not already recognised in the contract baseline values.</p>
<b>Growth: capacity funding</b>	<p>Commissioner allocations include growth funding for 2022/23. This funding has been issued on a population basis to commissioners and therefore should be applied against relevant intra-system, inter-system and NHS England contract arrangements.</p>
<b>Growth: Inflation net of general efficiency</b>	<p>By default, commissioners and trusts should uplift contracts by the 'Cost uplift factor' and 'Efficiency factor' set out in the national tariff guidance, unless a locally agreed view of inflationary pressures and efficiency requirements has been established. Since the starting point for setting the fixed element is the emergency payment values, CQUIN funding will already be included and therefore the payment value does not need to be further uplifted by the 1.25% set out in the NTPS.</p>
<b>Additional efficiency (convergence adjustment) (applies to intra-system contracts only)</b>	<p>In 2022/23, an additional efficiency ('convergence adjustment') has been applied to allocations to reduce resource towards affordable, fair share levels. This efficiency is calculated against the full cost base of the system. Due to the calculation and distribution method of the convergence adjustment, additional efficiency requirements (ie efficiency greater than national tariff levels) should only apply to intra-system contracts. Inter-system and NHS England contract values should not include an efficiency requirement greater than that set out in the national tariff.</p>
<b>Elective recovery fund (full value)</b>	<p>The baseline contract value should not include the value of 2021/22 elective recovery funding (ERF), the total value of 2022/23 ERF should be applied on top of the baseline contract value in line with the agreed activity plan.</p>

Item	Guidance
	In 2022/23, ERF is distributed to (a) systems on a population basis for ICB services and (b) to specialised commissioners on a hosted provider basis for specialised services. ERF funding should flow into the relevant contract value, in line with the agreed activity plan, with subsequent adjustments processed in-year in line with the variable element of API terms.
<b>Service development funding (full value)</b>	The baseline contract value should not include SDF funding; therefore, the total value of 2022/23 SDF should be applied on top of the baseline contract value.
<b>Specialised excluded drugs and devices funding (full value)</b>	The baseline contract value should not include pass-through funding for specialised excluded drugs and devices. Funding for 2022/23 expenditure will be issued in line with specialised services payments guidance.
<b>COVID-19 funding (full value) (generally <u>applies</u> to intra-system contracts only)</b>	The baseline contract value should not include distribution of COVID-19 funding; therefore, the total value of non-recurrent COVID-19 funding should be applied on top of the baseline contract value. The COVID-19 allocation is distributed to systems on a host commissioner and provider basis; therefore, systems are advised to apply the funding against intra-system arrangements but alternative local arrangements can be agreed.

89. In advance of issuing allocations for 2023/24 and 2024/25, NHS England and NHS Improvement will undertake an exercise with commissioners and trusts to understand contract baselines. For 2022/23, we have sought to simplify the contracting process by retaining the 2021/22 block payment values as the baseline for 2022/23 contract values. No changes to contract values should be actioned in 2022/23 as a consequence of this exercise.
90. By default, 2022/23 contract values should be assumed to fund 2019/20 activity levels plus relevant activity growth funded through core commissioner allocations for the intervening years, with adjustments for agreed recurrent service changes and non-recurrent suppression of activity due to the impact of COVID-19. Commissioners and trusts should work together to unwind the impact of COVID-



19 on activity performance as the associated constraining factors change; for example, changes in infection prevention and control (IPC) measures.

## Payments for low volume activity

91. A revised process for ICBs and trusts will be implemented from 1 April 2022 to streamline the financial processes for managing low volume activity (LVA) flows from ICBs to trusts in other systems. This revised process has been developed following positive feedback from the Standard Contract Consultation and Pricing and Finance engagement, and the transactional benefits realised through the temporary COVID-19 financial arrangements.
92. Under the COVID-19 financial arrangements, LVA funding was transferred to the system top-up of the host system for the relevant trust. The lead CCG transferred funding to the relevant trust through block payment arrangements. From 2022/23, LVA funding will be transferred back to the relevant ICB to maintain the integrity of population-based allocations and ease the attribution of LVA expenditure against business rules (eg MHIS). However, payments will continue to be made in line with a national payments schedule ('LVA payments schedule') and no invoicing should take place outside this payment.
93. The new arrangement being introduced for LVA relates to trusts only and takes effect from 1 April 2022. Non-NHS providers will continue to operate under the existing non-contracted activity arrangements, as set out in the [Contract technical guidance](#). For those trust–commissioner relationships not covered by the LVA payments schedule, commissioners and trusts must agree and sign a written contract.
94. The revised process covers all clinical services (acute, mental health and community) provided by trusts with the exception of inpatient out-of-area placements for mental health services where these are directly arranged by commissioners. Where the LVA arrangements apply, ICBs must therefore pay each trust identified on the LVA payments schedule the amount identified on the schedule. Trusts should, in addition, invoice the responsible ICB for any mental health inpatient placement that the ICB (or its predecessor CCG) has directly arranged and the ICB must pay such an invoice. This is important to ensure that financial flows continue to support the [NHS Long Term Plan](#) commitment to eliminate out-of-area placements.

95. The LVA payments schedule, available through the PFMS portal, identifies those relationships where, on the basis of historical activity, the annual value of activity between the ICB and the trust for 2022/23 is expected to be below £500,000. The values have been calculated as follows:
- **Acute services** – three-year average based on SUS activity from 2017/18, 2018/19 and 2019/20 priced at 2022/23 tariff prices. Some ICBs have agreed in principle (on establishment) to take on delegated responsibility for commissioning secondary care dental services. The impact of this has not yet been built into the LVA payments schedule. NHS England and NHS Improvement are reviewing this with the aim of incorporating secondary care dental services as soon as possible and will, at that point, publish an updated version of the schedule.
  - **Mental health and community services** – as these services are not included fully within SUS, three-year average finance payment data has been used and increased in line with allocation growth.
96. ICBs should pay the amount included on the LVA payments schedule to the trust in quarter 2 2022/23. No further payments or amounts should be transacted during 2022/23 with the exception of inpatient out-of-area placements for mental health services (as set out above). The values will be refreshed in advance of the start of each financial year and issued as part of the annual planning process.

## Contracts

97. In 2020/21 and 2021/22 the mandated requirement for signed contracts with trusts was relaxed. As the NHS moves away from the temporary COVID-19 financial framework it is important, from a governance perspective, that properly documented contracts are put in place in all cases. It is the expectation therefore that signed contracts must be in place, covering the full financial year, between commissioners and all providers (that is, with both trusts and non-NHS providers).
98. Contracts for all commissioned healthcare services, other than core primary care services, must be in the form of the NHS Standard Contract. NHS England and NHS Improvement have published the NHS Standard Contract for 2022/23. The NHS Standard Contract, which is applicable to contracts between 1 April 2022 and 31 March 2023, is available on the [NHS Standard Contract webpage](#), and

further detail about NHS contracting more generally is set out in the contract technical guidance.

99. Contracts should therefore be negotiated and signed by CCGs. On ICB establishment, signed contracts will then transfer from CCGs to ICBs under the nationally arranged transfer schemes provided for in the Health and Care Bill; further guidance on these schemes is available on [FutureNHS](#). There will be no need for CCGs and ICBs to arrange novation of contracts. It is important that commissioners continue to collaborate in their contractual arrangements with providers, with multiple commissioners often signing the same single contract with a large provider; a model Collaborative Commissioning Agreement is available on the [NHS Standard Contract webpage](#) to facilitate this.
100. The NHS Standard Contract has three sections – the General Conditions and Service Conditions, which set out nationally-mandated terms that cannot be varied, and the Particulars, which include the schedules for local completion and agreement. It is important to agree which schedules are relevant to each contract and the key schedules to be prioritised; not all schedules will need to be populated in every case. Further details on this are set out in the contract technical guidance.

## **System relationships, behaviours and disputes**

101. System working is now well established across the NHS, and commissioners and providers are urged to build on the collaborative behaviours that have developed during the pandemic and approach 2022/23 in the same spirit of partnership. NHS England and NHS Improvement have set out guidelines for agreeing the fixed value of API arrangements to support NHS organisations to confirm arrangements. In this context, NHS England and NHS Improvement are not proposing to put in place a formal process for arbitration between commissioners and trusts where they cannot agree a contract by 31 March 2022. Rather, there will be a reliance on local NHS leaders to work together to ensure issues relating to contract agreement are resolved locally and in a timely manner. Regional teams will track local progress and will mediate where necessary.
102. The model System Collaboration and Financial Management Agreement (SCFMA) will continue to be published alongside the NHS Standard Contract, but recognising that under the Health and Care Bill, ICBs and their local partner trusts will be under a new joint legal duty to seek to achieve system financial

balance – and local systems may well have developed or be developing ICB governance arrangements (in the form of subcommittees or joint committees) through which the aspirations set out in the model SCFMA can be delivered. The model SCFMA is therefore non-mandatory for 2022/23, for use at the discretion of local NHS bodies.

## Who Pays? rules

103. Passage of the Health and Care Bill would bring changes to the arrangements for establishing the responsible NHS commissioner. NHS England and NHS Improvement's expectation is that the new rules would, in practice, be closely aligned to the position in the current August 2020 version of Who Pays?, and this should help deliver a seamless transition. There would need to be one significant change. At present, the default rule in Who Pays? is that responsibility falls to the CCG of which the patient's current registered GP is a member. GPs will not be members of ICBs in the same way. Instead, NHS England and NHS Improvement will publish a comprehensive list of general practices associated with each ICB, and the default rule will be that responsibility will fall to the ICB with which the patient's registered GP is associated. The mapping of general practices to ICBs would be based on the historical CCG membership of each practice (subject to any boundary changes), so there will be continuity with current arrangements.

## Efficiency and productivity

104. Clinical transformation will be crucial to the delivery of the efficiency and productivity challenge over the next three years; for example, continuous improvement in theatre productivity to address elective backlogs and maximisation of opportunities for outpatient transformation and optimisation through advice and guidance and patient initiated follow-up.
105. This section sets out further information on the programmes available to support systems working together to deliver cost improvement plans and reduce unwarranted variation. Further to this, with the support of the Finance Innovation Forum, NHS England and NHS Improvement will also share specific programmes and innovations implemented by systems or trusts that have delivered efficiency and productivity benefits locally and are of wider benefit. Systems should review these examples of innovation, determine the subset they intend to implement

locally and feedback on the impact so evidence continues to be collected around specific interventions.

## Reducing expenditure on NHS agency staff

106. The NHS Long Term Plan outlines the national strategy to continue improving on workforce productivity and reduce the reliance on agency workers. Trusts should take action to reduce their agency staff bills, encourage workers back into substantive and bank roles, and move back towards compliance with [agency controls](#). NHS England and NHS Improvement will monitor progress to re-instate controls, including price cap compliance.

## Commercial medicines

107. Medicines are a growing area of spend as new innovations are developed and approved for use. There continue to be significant opportunities to support patient access to the latest innovative and most clinically effective medicines and treatments, and at the same time, deliver maximum value for the NHS and taxpayers. Systems should ensure the necessary infrastructure is in place to optimise the use of medicines, to maximise the value they receive from their spend on medicines, and to support surety of medicines supply through:

- leveraging the value of national procurements and population health agreements across primary and secondary care, and adhering to commercial medicines frameworks and contract management guidance
- utilising benchmarking tools
- tackling health inequalities by identifying and addressing unwarranted variation in the use of medicines
- implementing recommendations from national guidance relating to medicines, including encouraging and supporting a shared decision-making approach to care
- adopting digital information systems such as electronic prescribing and medicines administration systems to improve efficiency and patient safety
- continuing to improve data relating to medicines (including full implementation of [dm+d](#) taxonomy for medicines) and improvements in outcomes data collection

- standardising the approach to aseptically produced medicines to support patient safety and ensure appropriate use of resources
- utilising pharmacy networks to share learning and support and to align mechanisms for achieving better value from medicines across systems
- promoting sustainable use of medicines by reducing waste and implementing initiatives to reduce the carbon footprint associated with medicines

## Procurement target operating model

108. Systems should carry out a diagnostic exercise to establish the scale of opportunity and an implementation plan that demonstrates how implementation will be done at pace. The diagnostic exercise should include the implementation of the procurement target operating model (PTOM; a methodology to support improving the procurement of products and services not covered by the NHS Supply Chain) and associated application of best practice in transactional procurement. Plans should in addition consider:

- **Digital category transformation** – the digital and IT landscape across the NHS is characterised by a high level of fragmented buying. Systems should utilise the NHS England and NHS Improvement tools available to identify recommendations to rationalise routes to market, including frameworks to support vendors and buyers on their procurement journey.
- **Data and technology** – the NHS [Spend Comparison Service](#) provides price benchmarking and spend analytics on procurement data from all trusts in England, including acute, ambulance, mental health and community trusts. Trusts are required to submit their purchase order and accounts payable data to support this service. Trusts should utilise these tools to identify procurement opportunities and reduce unwarranted price variation.
- **NHS Commercial Standards** – revised standards were issued in May 2021 and all trusts will be transitioned to their new level descriptors (Good, Better and Best). NHS England and NHS Improvement are working with a cohort of trusts to develop a set of system-wide commercial standards and further guidance will be made available to support adoption.
- **Sustainable procurement** – the [net zero supplier roadmap](#) sets out the key requirements of NHS suppliers through to the end of the decade and

establishes the adoption of Procurement Policy Note 06/20 and the Cabinet Office Social Value Model, which requires NHS organisations to include a minimum 10% weighting on net zero and social value in all NHS procurement decision-making.

## Corporate services target operating model

109. Corporate services transformation represents a significant opportunity for the NHS. Systems should develop a plan for corporate services transformation and, where appropriate, consolidation. These plans should seek to maximise collaborative opportunities to achieve benefits and economies of scale, and reflect the fact that systems will be asked to develop service support plans in 2022 indicating the commissioning support unit (CSU) services they will be buying in 2022/23 and 2023/24. Plans should include considerations of:

- **Legal** – NHS organisations should standardise and streamline their legal services processes and contracts. In particular, where organisations deliver an ‘in-house’ legal services model, systems should review how this expertise may be deployed for greater benefit to the wider system.
- **Finance back office** – contracts for functional software/IT systems and financial services should be reviewed to ensure interoperability, standardisation and optimisation of automation opportunities.
- **Payroll** – payroll contracts and arrangements should be reviewed to ensure service quality and value for money. Where payroll contracts expire within 12 months or are not in contract, plans should incorporate system collaboration at a minimum.
- **Staff bank** – systems should have collaborative staff bank arrangements in place to enable more flexible use of staff and to minimise agency costs.

## Key financial commitments

### Mental health services

110. The Mental Health Investment Standard (MHIS) will apply to ICBs and continue to be subject to an independent review. For 2022/23, the MHIS requires ICBs to increase spend on mental health services by more than ICB programme allocation base growth (prior to the application of the convergence adjustment).

MHIS requirements by ICB are set out in supporting MHIS schedules. The growth is a core part of funding the NHS Long Term Plan for mental health. Local system leaders, including the nominated lead mental health provider, should review each ICB's investment plan underpinning the MHIS to ensure it represents a credible plan to deliver the mental health activity commitments and the related workforce. Any concerns on the development of plans should first be discussed and agreed between system partners with any escalation to the regional teams only taking place after this. Where an ICB fails to deliver the mental health investment requirements, NHS England and NHS Improvement will consider appropriate action.

111. The NHS Long Term Plan makes recurrent commitments on mental health services. While currently issued as non-recurrent SDF allocations, they are recurrent within the NHS mandate and therefore systems will continue to be funded to deliver these beyond the current planning period, at Long Term Plan funding levels (subject to efficiency). Efficiencies applied to MHIS-related expenditure should be re-invested in mental health services such that systems continue to meet their MHIS requirements. Further guidance will be published in April 2022 to set out how and when SDF will move into ICB baselines.
112. The use of re-categorised data is provisional and where material reductions are being made, regional and national teams will confirm that they are supported by appropriate evidence.
113. Further information in respect to mental health capital is set out in the [Capital guidance for 2022 to 2025](#).

## **Primary medical and community services**

114. The NHS Long Term Plan commits to increasing investment in primary medical and community services (PMCS) by £4.5billion real terms investment growth (£7.1billion investment growth in cash terms) by 2023/24.
115. For 2022/23, ICBs will continue to support progress towards meeting this commitment through their allocations for:
  - primary medical care – both delegated and non-delegated expenditure. Non-delegated spend includes locally enhanced services, out-of-hours and



extended access schemes but excludes general practice prescribing costs. Investment and Impact Funding (IIF) should be included

- community services
- continuing healthcare (CHC) including funded nursing care (FNC)
- regional and national expenditure delivering or supporting the above.

116. In addition, plans should take account of forecast SDF spend, including:

- funding to support workforce initiatives in primary care (including GP fellowship, New to Partnership payments, GP retention, flexible staffing pools and the Supporting Mentors Scheme)
- Extended Access and Improving Access
- digital first initiatives
- Additional Roles Reimbursement Scheme (ARRS)
- funding to support ageing well.

117. As part of the plan assurance process, there will be a review of planned investment in PMCS at system level.

### ***Transforming community services***

118. In 2021/22, £200m of funding for transforming community services was issued via the SDF on a fair share basis. For 2022/23, this funding has been issued on a recurrent basis through an adjustment to the 2021/22 ICB programme allocation baseline.

### ***Implementation of virtual wards***

119. To support the implementation of virtual wards in 2022/23, £200m of funding will be made available to systems on a 'fair shares' basis, through the SDF, to deliver the national ambition of 40 to 50 virtual ward beds per 100,000 population by December 2023. For 2022/23, the funding will be subject to local in-year progress and systems will be asked for monthly reporting on year-to-date and forecast outturn spend. System-level plans must be established on the delivery of virtual ward bed coverage and where plans demonstrate a shortfall in delivery, excess funding will be recovered. Further information on accessing 'fair shares' funding

for 2022/23 for the implementation of technology enabled remote monitoring is available in the [technology funding section](#).

120. After this initial period, the expectation is that funding will move to a match-funding basis (ie SDF to match local spend up to an agreed limit) in 2023/24, with virtual wards expected to be embedded in baseline provision from 2024/25.

## **Better Care Fund**

121. The Better Care Fund (BCF) will continue in 2022/23. Government will publish a policy framework in due course. For the purposes of final plans, ICBs should assume a minimum contribution to the BCF and the minimum BCF contribution to social care will rise by 5.66%<sup>1</sup> on average. Further communications on this will be issued following government guidance, after which the detailed allocations showing the contributions required from each ICB will be published.

## **Other planning assumptions**

### **Inflation**

122. The NTPS guidance sets out the basis for the inflation assumptions included in the cost uplift factor applied to tariff prices and allocations, including relevant pay and non-pay assumptions.
123. Government has committed to fund the direct cost impact to the NHS relating to the employer costs of the [Health and Social Care Levy](#). Allocations and tariff prices will be uplifted to reflect this additional funding. Further detail on the construction of the inflation calculations will be available through regional teams.

### **NHS pension employer contribution rate**

124. The transitional approach that has operated since 2019/20 for employer contributions will continue in 2022/23. For 2022/23 an employer rate of 20.6% (20.68% inclusive of the administration charge) will apply; the NHS Business Service Authority will continue to only collect 14.38% from employers and is the basis on which organisations should plan. Employers should ensure that their

<sup>1</sup> This rate has increased from the original assumption shared for draft plans (from 5.3% to 5.66%)

payroll provider continues to apply an employer contribution rate of 14.38% from 1 April 2022. Central payments will again be made for the remaining 6.3%.

## **NHS 111**

125. Systems must continue to have regard for all providers of urgent and emergency care (UEC) when agreeing appropriate allocations of funding. 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.
126. In line with the letter, dated 23 November 2021 and titled 'NHS 111 single virtual contact centre', systems should move to a regionally networked model of NHS 111 call handling, using the single virtual contact centre model, to improve productivity and resilience in the NHS 111 service. The required cloud telephony technology has been made available to support this development. Regional teams will work with systems and NHS 111 providers to implement the model and support demand and capacity planning across each region. A lead ICS (or lead CCG) must ensure these arrangements are in place from April 2022 onwards.
127. In H2 2021/22 additional SDF funding was issued to CCGs to support capacity in NHS 111 call handling and clinical services. In view of continued increased demand for NHS 111 services during the pandemic, £50m of funding will be made available in 2022/23 as SDF, to continue to support additional NHS 111 capacity. Funding will be allocated to lead commissioning ICBs for each NHS 111 area. Drawing on this and existing ICB funding, systems must fund NHS 111/integrated urgent care providers (call handling and clinical services) appropriately in the context of their overall UEC systems, and in co-ordination with regional teams and other systems in their regions as part of the move to regionally networked call handling.

## **Diagnostics**

128. Subject to government approval, we expect systems with community diagnostic centre (CDC) programmes of work or capital business cases will, once these have been agreed, be able to access additional revenue funding to support the set up and running of CDCs. Funding should not be assumed in plans until confirmed by NHS England and NHS Improvement. Where confirmed, revenue

will be separately allocated and align with the programmes of work or capital business cases.

## **All-age continuing care**

129. A sustainable social care provider market is essential to support hospital discharge and maintain services for individuals receiving care. ICBs should locally, and in conjunction with their integrated care partnership (ICP), consider the sustainability of the local social care provider market and the challenges faced by these providers. To support sustainability of the social care provider market, ICBs should negotiate and agree reasonable contract uplifts that considers general price inflation.
130. The ICB and social care providers must together engage constructively with the 'local prices' approach for all-age continuing care. CQUIN no longer applies to contractual relationships outside the scope of API. This means that it no longer applies to smaller providers of NHS-funded services like those that deliver care home and or domiciliary care services (social care providers) to all-age continuing care.
131. ICBs should have CHC management systems in place that comply with the Information Standard and Data Set Specification in advance of the conformance date of April 2022, to ensure full preparation for the new data collection.
132. We expect Government will announce the FNC rate for 2022/23 shortly.

## **Car parking**

133. As part of government's manifesto commitment, 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. Funding for this policy is included recurrently in ICB programme allocations.
134. As part of the COVID-19 emergency response during 2021/22, trusts were funded to provide free car parking at their sites for NHS staff, in line with Government policy. Government has announced that, from 1 April 2022, free car parking for NHS staff will end and that trusts should re-introduce charging in line with their local policies. Although free hospital car parking for all NHS staff will end on 31 March 2022, NHS staff working night shifts will still be able to access

free hospital car parking as part of the Government's commitment to providing this for those in greatest need.

135. The car parking guidance for trusts has been amended and is available on the [DHSC website](#).

## **MedTech funding mandate**

136. The [MedTech funding mandate \(MTFM\) policy](#) published in January 2021 became effective on 1 April 2021. The policy requires trusts to make the technologies supported by the policy available to patients. Technologies included in the policy are supported by NICE guidance. The final list of technologies to be included in the MTFM 2022/23 policy guidance will be published later this winter.
137. Technologies should deliver cost savings within three years, and reduce hospital visits and clinical interventions, which is vital to recovery from the pandemic. Details on the technologies that meet these criteria can be found on the [MTFM webpage](#). It is important that eligible patients can access the technologies to ensure equity in healthcare provision and tackle health inequalities.
138. Following consultation with clinicians, providers and commissioners, it was determined that payment for eligible technologies should be excluded from the API arrangements until they are fully established at system level, when they will be added to the fixed element of the API. Therefore, for 2022/23, MFTM will remain a 'pass-through' payment approach, where commissioners are required to pay for the cost of MTFM technologies from existing allocations on a 'cost and volume' basis. The MTFM technologies will be excluded from national prices.
139. Work is ongoing with [NHS Supply Chain](#) to make these technologies available without the need for individual contracts. The Academic Health Science Networks (AHSNs) and the technology suppliers will assist systems to adopt these technologies.

## **Medical examiners**

140. The [medical examiner system](#) is currently being rolled out across England. Since June 2021, medical examiner offices have started putting measures in place to extend medical examiner scrutiny to non-coronial deaths across all non-acute sectors.

141. The Health and Care Bill includes provisions for medical examiners to be put on a statutory footing. Subject to the parliamentary process, we do not expect the statutory system to be introduced before summer 2022. Further guidance will be made available when the statutory system is confirmed. Until this point, trusts with medical examiner offices should continue to plan based on the current [guidance](#).
142. During the COVID-19 pandemic, the requirement for completion of the form Cremation 5 was suspended along with the associated fee income by the emergency Coronavirus Act, which expired on 24 March 2022. The Ministry of Justice have confirmed that the form [Cremation 5 will not be re-introduced](#), so medical examiner offices will not have income from these forms. NHS England and NHS Improvement recently published [information for medical practitioners](#) confirming this.
143. NHS England and NHS Improvement will write to trusts to confirm the funding arrangements for medical examiner services in 2022/23. Trusts with medical examiner offices should continue to work in partnership across systems to optimise capacity within the total funding available.

### **Initial healthcare services for asylum seekers**

144. NHS England and NHS Improvement will continue to provide SDF funding to ICBs providing initial health assessment services for destitute asylum seekers in Home Office commissioned initial accommodation centres, with further detail of funding arrangements to be made available in the SDF technical guidance. In addition, we will continue to reimburse ICBs for additional costs that are incurred in supporting access to primary care services, including initial health assessments, for destitute asylum seekers in other initial temporary accommodation used by the Home Office. These arrangements will continue to be reviewed during the financial period and organisations should refer to the latest cost reporting guidance during the year.

### **ICB Clinical Negligence Scheme for Trusts (CNST) contributions**

145. NHS Resolution has notified CCGs, and will contact designate ICBs in due course, of the confirmed 2022/23 [CNST](#) contributions, which are intended to be charged to newly established ICBs. ICBs will be charged a £1,000 administrative fee, as has been the case with CCGs. The costs of claims raised against ICBs in

future, or falling back on ICBs through their commissioning contracts, will however be charged to them in future CNST contributions. While we do not expect this to cause a financial pressure in the current planning round, ICBs should ensure they are undertaking necessary due diligence when agreeing contracts, ensuring that providers have appropriate indemnity cover in place, in line with the requirements of the [NHS Standard Contract](#).

## Revenue support for capital investments

146. Pressures created by depreciation, PDC dividend charges or other short-term revenue costs can sometimes inhibit necessary capital investment. This is especially the case where associated efficiency or productivity gains accrue over a longer time period. National capital programmes will therefore be allocated a specific revenue support fund to assist with some of the short-term costs of capital.

## External income

### *Other government income*

147. Training placements will continue to be funded by Health Education England (HEE) on an activity basis by reference to the healthcare education and training tariffs. The [education and training tariff arrangements for 2022/23](#) have been published separately by the Department of Health and Social Care (DHSC).

148. Trusts should agree contracts with non-NHS commissioners, eg local authorities (LAs), based on the appropriate funding for services, including inflationary uplifts. Once the government's response to the recommendations of the pay review bodies is announced during 2022/23, contracts should be updated accordingly. The non-recurrent funding provided in H2 2021/22 to fund the 2021/22 inflationary pay pressures on LA contracts has been recurrently included within ICB allocations; locally agreed contract values should reflect that this is included within NHS funding streams.

149. Government has confirmed arrangements for the [Local Authority Public Health Grant \(LAPHG\)](#). Providers should ensure these costs are reflected in local contracts as appropriate.

150. Under the previous emergency arrangements, contracts between NHS Wales and English trusts were on block payment arrangements. From 1 April 2022,

contract terms will revert back to 'locally determined' arrangements, comprising either payment by results (based on national tariff prices) or establishing API contracts. It is important that waiting list parity is maintained between English and Welsh patients. Due to the variation in the monetary value of the cross border agreements and the services commissioned, agreeing contracting baselines for 2022/23 and additional elective recovery activity will therefore be locally determined on an individual commissioner and trust basis.

### ***Commercial and overseas visitor income***

151. Trusts should continue to actively explore and develop opportunities to recover and, where appropriate, grow their external (non-NHS) income. Whilst continuing the focus and priority on core NHS service delivery, it is expected that the NHS will return to working towards securing the benchmarked potential for commercial income growth, overseas visitor cost recovery and private patient services. In developing such income opportunities, trusts should ensure that processes are continually refined and focus also placed on the recovery of such non-NHS income ('making sure the NHS gets paid'). Following the launch of the NHS Export Collaborative in 2021, throughout 2022/23 NHS England and NHS Improvement (along with partners [HCUK](#)) will also work with trusts to identify and scale-up NHS export opportunities and support appropriate development of opportunities to generate revenue and provide benefits for NHS staff and local patients and services.
152. Since 2020/21, the CCG allocations adjustment for charge exempt overseas visitors (CEOV) activity and the risk-share arrangements between trusts and CCGs for chargeable overseas visitors (COV) activity have been suspended. These arrangements will continue to be suspended in 2022/23. There will be further engagement with ICBs and trusts during 2022/23 to develop the arrangements for 2023/24 and beyond.

### **COVID-19 separately reimbursable services**

153. A summary of key changes from 2021/22 (H2) (at the time of publishing this document) and updates on key programmes is set out below. Where funding is provided through central cost reimbursement, it should be reported in line with the relevant COVID-19 cost reporting guidance, to be published for the start of 2022/23. The following services will continue to be eligible for separate reimbursement:



- **COVID-19 testing services** – the Government has announced the revised staff and patient testing regime for NHS services from 1 April 2022; the detail of which is set out in the NHS England and NHS Improvement communication '[Living with COVID-19 – testing update](#)' dated 30 March 2022. 2022/23 plans should reflect the revised testing regime requirements. For the purposes of developing 2022/23 plans, delivery organisations should assume that the current reimbursement mechanism remains in place, that the guidelines for reimbursable costs remain as-is and that procurement responsibilities are unchanged. For example, Lateral Flow Devices (LFDs) should be assumed to be centrally procured by UKHSA and no costs should be included in NHS plans in relation to these items. Any potential decommissioning costs arising from the changes to the NHS testing regime should be identified separately. Further guidance will be issued in due course confirming the funding arrangements.
- **COVID-19 vaccination programme** – a separate NHS England and NHS Improvement communication '[Next steps for the NHS COVID-19 vaccination programme planning and delivery](#)' was issued on 23 February 2022, alongside a document setting out 'Planning parameters for 2022/23'. These communications set out the basis on which systems should develop detailed operational plans for the next six months, and provisional plans to provide autumn boosters should the NHS be instructed to do so. 2022/23 financial and operational plans should be updated to reflect the requirements for the first 6 months of the year only and should not include the provisional arrangements for the second half of the year. Current financial and contractual processes and principles, for the initial planning period, remain in place up to the end of September 2022.

154. For additional clarity, the following items have been removed from separate reimbursement:

- **Hospital Discharge Programme** – as outlined in the H2 2021/22 planning guidance, the Hospital Discharge Programme will end in March 2022, and funding for related costs will not continue into 2022/23.
- **Dental support** – commissioners should assume a normal level of dental income in their planning returns, and should not assume a benefit from variable cost adjustment. NHS England and NHS Improvement will write to commissioners if this changes. Commissioners are reminded that clawback

should be accounted for in the year to which it relates by including an accrual, and not accounted for on a cash basis.

- **International quarantine** – the central funding for international quarantine costs for staff will not continue into 2022/23. This will be reviewed in-year should there be a significant change in international travel measures and quarantine costs.

## Personal protective equipment

155. Personal protective equipment (PPE) will continue to be procured centrally, funded by DHSC and delivered by SCCL until the end of March 2023 or until IPC guidance is either withdrawn or significantly amended, whichever is sooner. During the financial period, if PPE requirements change, for example if IPC requirements are adapted, then the arrangements will be reviewed and therefore may be subject to change. The operating model for 2023/24 and beyond is being reviewed.

## Cash regime

156. NHS England and NHS Improvement will issue ICBs with an annual cash drawdown limit as part of the overall commissioning group cash mandate. This will be reviewed during the course of the year with a view to ensuring each ICB receives its fair share of the cash mandate allocation. This is similar to the current arrangements with CCGs.

157. It is anticipated that trusts will continue to have sufficient cash resource during 2022/23 to meet working capital requirements without the need for further borrowing. This will support prompt payment for goods and services received. In the very few instances where trusts may need revenue cash support, the principles remain as set out in the [Reforms to the NHS Cash Regime effective from 1 April 2020](#). The guidance confirms that revenue support is available in exceptional circumstances via the issue of PDC. However, efficient transacting with systems should ensure that requirements are kept to a minimum.

158. There will be a continued focus throughout 2022/23 on ensuring that prompt payment targets are achieved for both ICBs and trusts. Payment performance for organisations will be monitored on a monthly basis and late paying NHS organisations will be contacted to agree a rectification plan.

159. Commissioners will continue to pay providers on the 15th of the month (or closest working day), which will maintain the efficient flow of cash.
160. The primary method of payment for transactions from NHS commissioners to providers will remain invoice payment file (IPF), with limited use of invoices and payment requests. Further detailed transacting guidance will be issued in due course, based on the best practice protocols currently in use.

## Technology funding

161. [Who pays for what](#) sets out that from 2022/23 technology funding will begin to be allocated directly to systems before the start of the financial year rather than asking organisations to bid for it. This will allow systems to plan technology spending and investments alongside their wider planning activity. Systems will need to agree how technology funding is to be allocated between their partners and this should be reflected in the relevant section of the financial planning template.
162. Although systems will agree how funding is allocated, the existing funding flows and mechanisms will remain; capital funding will flow from DHSC to trusts and revenue funding will flow to ICBs, which will then be able to pass it to trusts and other organisations.
163. Central funding for 2022/23 will be prioritised for creating a minimum level of digital maturity across the NHS, and digital transformation to help with elective recovery. Systems should plan using the initial allocation of central funding summarised in the table below, with further details in the ‘technology funding frequently asked questions’ available through [FutureNHS](#).

Priority area	Allocation method	Funding value (£m)
Existing Frontline Digitisation commitments	Existing funding agreements, as previously agreed	£68m capital
Critical cybersecurity infrastructure risks	Trust operating expenditure	£12m capital
Funding for digital implementation teams, based in systems, to support digital transformation (details below)	Weighted capitation	£20m revenue

164. Digital implementation teams should focus on the implementation of technology enabled remote monitoring to support people at home in one or more of the following areas:

- virtual wards (not subject to match funding). Further information on virtual ward implementation funding is here.
- mental health care e.g. annual physical health checks
- care sector remote monitoring
- long term condition management

165. Further funding for 2022/23 and indicative allocations for 2023/24 and 2024/25 will be provided later in 2022 to inform the finalisation of digital investment plans. Additional revenue and capital for 2022/23 is expected to be available to:

- level-up digital maturity, ensuring all systems have a core level of digital maturity
- allow data to flow appropriately and safely (platforms for population health, planning)
- support the adoption of digital social care records and acoustic monitoring or equivalent 'falls prevention' technologies
- support the adoption of digital pathways in cancer, cardiology, dermatology, perioperative services and ENT.

At this stage, ICBs and trusts should not include any technology PDC relating to this additional funding in their 2022/23 operational plans.

166. Unless otherwise agreed, systems must provide 50:50 match funding (either revenue or capital, cash or in-kind) for all central technology funding. This does not necessarily need to be provided in the same year as the investment. Trusts and systems must plan for the revenue consequences of any capital funding they receive.

167. Systems should discuss their planned investments with their regional director for digital transformation, regional directors of finance and NHS Digital security lead (where relevant) at an early stage and ahead of the submission of draft plans.

168. ICBs may retain funding if they intend to implement a solution at a system level. Any funding not allocated to trusts or retained by ICBs without a specific purpose may be re-allocated centrally to other systems in spring 2022 and funding may be reallocated in-year if investment is off-plan and not expected to recover.
169. All of the technology funding (as described above) is subject to HM Treasury approval of programme business cases (PBCs), which will be managed centrally. Individual organisations that receive central technology funding will be required to follow the appropriate digital business case approvals process. ICBs and trusts should speak to their regional teams before developing a business case for digital investment to ensure the correct processes are followed.
170. Funding is also subject to letters of agreement with the receiving ICB or trust, which will set out the terms and conditions of payment. Relevant ICBs and trusts will be contacted following the submission of draft operational plans to make arrangements for letters of agreement.

## Queries and FAQs

171. For queries on the financial arrangements relating to:
- revenue funding and template completion: [england.finplan@nhs.net](mailto:england.finplan@nhs.net)
  - capital funding: [nhsi.capitalcashqueries@nhs.net](mailto:nhsi.capitalcashqueries@nhs.net)
  - technology funding: [feedback.wpfw@nhsx.nhs.uk](mailto:feedback.wpfw@nhsx.nhs.uk).
172. FAQs will be issued on a regular basis to ICBs and trusts (through [FutureNHS](#) and the PFMS portal).

## Appendix A: Financial arrangements for the new target of July 2022 for establishing integrated care boards

### Financial framework and allocations

1. NHS England and NHS Improvement are responsible for determining allocations of financial resources to clinical commissioning groups (CCGs) and will be responsible for the same duties for ICBs, subject to the passage of the Health and Care Bill. To meet these obligations, full year financial allocations will be produced for both CCGs and ICBs in 2022/23. The CCG schedules will be a disaggregation of the ICB values to ensure that system-level funding remains the primary focus.
2. Systems (on ICB footprints) will be required to plan and deliver a net financial balance in 2022/23, which is based on aggregating relevant CCG and ICB positions over the period.
3. CCGs will receive an allocation from 1 April 2022 and ICBs will be established with the remaining amounts for the financial year. In practice this means the aggregate full-year ICB allocations will be reduced by the amount of resources the relevant CCGs have consumed. NHS England and NHS Improvement will issue CCG-level allocations where relevant to do so. As part of the planning process, CCGs will have the opportunity to request amendments to these allocations on a net neutral basis within their overall ICB allocation.
4. The CCG disaggregation methodology is summarised in the table below:

Revenue allocation	CCG distribution method	CCG distribution methodology
<b>Programme allocations</b>	Distributed to all CCGs	CCGs proportion of the system's H2*2 baseline applied to the final 2022/23 ICB allocation. Lead CCGs will have a higher proportion of H2 funding and therefore receive a larger share of the ICB allocation.
<b>Primary medical care services</b>	Distributed to all CCGs	2021/22 H2 proportions applied to the final 2022/23

		ICB allocation.
<b>Running cost allocation</b>	Distributed to all CCGs	2021/22 H2 proportions applied to the final 2022/23 ICB allocation.
<b>Service development fund (SDF)</b>	Distributed to the lead CCG	100% to the lead CCG, or distributed based on local planning submissions
<b>COVID-19 system allocation</b>	Distributed to the lead CCG	100% to the lead CCG
<b>Elective recovery funding</b>	Distributed to the lead CCG	100% to the lead CCG

5. Financial commitments on the Mental Health Investment Standard (MHIS) and minimum contributions to the Better Care Fund (BCF) will be required and monitored at the ICB level on a full year basis.
6. A few CCGs have planned changes to their boundaries and these will also be implemented on 1 July 2022. Support and guidance is being provided directly to those systems affected by this, to help them understand and manage any potential risks and issues.
7. On 1 July 2022 NHS England and NHS Improvement intends to delegate pharmacy, general ophthalmic and dental services to ICBs who are willing and able to take on this delegation, and to remaining ICBs in April 2023. This will be underpinned by a delegation agreement signed by NHS England and NHS Improvement and the ICB. For the delegation occurring on ICB establishment, as with other programme budgets, ICBs will receive their full-year allocation minus resources already consumed in relation to these functions prior to their establishment.
8. NHS England and NHS Improvement regional commissioners will maintain ownership of the commissioning allocation and functions for specialised services in 2022/23. Contracts will continue to be hosted on a regional basis with providers and commissioners as per historical arrangements. We will seek to strengthen joint working during 2022/23 to support readiness for the potential future delegation of specialised services to ICBs, planned from 2023/24 onwards. This includes issuing shadow population-based ICB-level allocations, and

developing system-level financial reporting and joint collaboration arrangements between regions and systems.

9. Running cost allowances will be set for CCGs and their spending against these limits will reduce the remaining allowances for ICBs on their establishment. The delays in establishing ICBs may cause an unintended pressure on CCG administrative budgets in Q1 2022, for example where ICBs being formed from multiple CCGs are required to run additional shadow arrangements (from 1 April 2022). CCGs at risk of exceeding their administrative limits due to delayed ICB establishment should notify their regional team.
10. Capital allocations and planning will continue as planned, as these are not impacted by any ICB delay. New proposed duties and powers in the Health and Care Bill related to capital will not come into force until ICBs have been established. Further information is set out in the [Capital guidance 2022 to 2025](#).

## **Planning and reporting**

11. System planning continues to be the primary planning requirement. Financial system-level plans in the published templates will be collected for the full 2022/23 financial year. These templates include extra sheets to capture CCG-level information that shows how ICB plans are split between individual CCG plans for the full year and Q1.
12. The required CCG-level planning data will be minimal and restricted to that required to assure CCG ledger budget uploads and allocations.

## **Contracts and payment approach**

13. Contracts will need to be agreed between CCGs and providers. When ICBs are established, these contracts will transfer to the relevant ICB through a nationally agreed transfer scheme. For ICBs established from multiple CCGs, consistent local contractual terms are needed to ease the transition to a single ICB contract.
14. We advise CCGs and trusts to establish aligned payment and incentive (API) terms for all relationships (between an NHS commissioner and a trust), other than for low volume activity (LVA). Fixed payments covering full-year LVA flows will be set nationally, to reduce the number of separate invoices and transactions. These should be actioned by each ICB, once established, during in Q2.



15. We strongly recommend that collaborative contracting arrangements are re-established and therefore trusts sign a single contract with all relevant CCGs (excluding those covered through LVA arrangements). The finance schedule in the contract should set out the value to be paid by each CCG and how these aggregate to ICB level.

## **Financial accounts**

16. CCGs should complete annual accounts for 2021/22 as planned and financial audits will need to be undertaken for the 12 months to 31 March 2022. Accounting arrangements continue as currently from 1 April 2022 and until ICBs are established.
17. Financial ledgers will not be created to transact system plans during the extension period and should continue to operate through individual CCGs, even where multiple organisations are due to merge into one ICB. Financial accounts will be required for CCGs for the period up to ICB establishment, however the arrangements for this are still to be confirmed, and subject to discussion with audit firms and agreement with the National Audit Office (NAO). This will cover both CCG and ICB accounts during the financial year and be completed formally by ICBs.
18. Further detail on how financial accounts should be prepared will be provided in due course.

## **Cash drawdown**

19. Cash drawdown should be for payments required while a CCG continues to operate and will continue to be monitored against the annual cash drawdown requirement (ACDR).
20. Prior to ICB establishment, CCG drawdown will be paid into current CCG bank accounts. On ICB establishment, drawdown will then be paid into the relevant ICB bank accounts (namely the identified lead CCG bank account).
21. CCGs are encouraged to keep cash balances low but sufficient to cover committed outflows, to ensure opening consolidated ICB cash balances are at acceptable levels. Accurate cash forecasting remains important.

22. The focus on ensuring that prompt payment targets are achieved will continue. CCGs are encouraged to promptly review and pay historical and current invoices to limit the liabilities transferring from CCGs to ICBs.

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