NHS England

Revenue finance and contracting guidance for 2024/25

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Contents

1. This guidance sets out the revenue finance and contracting frameworks for 2024/25 (1 April 2024 to 31 March 2025) and should be read in conjunction with the 2024/25 priorities and operational planning guidance and the capital guidance for 2024/25.

2. For the purposes of this guidance, NHS trusts and foundation trusts are referred to collectively as 'trusts'. 'Systems' are defined as the integrated care board (ICB) and those trusts mapped for the purposes of financial apportionment (as defined in the ICB and system finance business rules).

Financial planning and in-year monitoring

3. Systems will continue to be the key unit for financial planning purposes. Each trust's resource use should be individually and fully mapped to a single system. Its planned financial positions should only be included in that system's plan but reflect the contract arrangements it has agreed with commissioners outside the system. As set out in the ICB and system finance business rules, all ICBs and systems have a breakeven requirement as well as a duty to seek to comply with the system resource limits.

4. From the work to submit medium-term plans, ICBs and trusts should ensure that 2024/25 plan phasing is credible and realistic. Consideration should be given to bringing forward efficiency and productivity delivery to avoid plans that expect a significant amount of efficiency to be delivered in quarter 4 of 2024/25.

5. The system financial plan submission will be the source of information for system plan assurance, ICB budget uploads and in-year financial monitoring. It will also be the primary source of information on trust income and expenditure, bottom line performance, contracting, financial efficiencies and capital.

6. Trusts will continue to be required to submit organisational financial plans and these plans must be in line with their system's financial submission, including for the categories listed in paragraph 5. Trust financial submissions will be the basis of in-year financial monitoring of trust plans and will profile key data to facilitate in-year monitoring. Trust plan submissions will also be used to assess the triangulation of system and trust financial plans with system activity and workforce plans.

7. Where a trust's plan is not consistent with its system's position, the trust and system returns will both be rejected, and their alignment and immediate resubmission requested. Systems will be required to co-ordinate the completion of board approved

planning templates across their system to ensure fully aligned system and trust plans are submitted by the submission deadline.

ICB and system finance business rules

8. The ICB and system finance business rules are summarised in the table below.

Rule	ICB	System
Capital resource use		Collective duty to act with a view to ensuring that the capital resource use limit set by NHS England is not exceeded
Revenue resource use	Duty to meet the resource use requirement set by NHS England	Collective duty to act with a view to ensuring that the revenue resource use limit set by NHS England is not exceeded
Breakeven duties (achieve financial balance)	Duty to act with a view to ensuring its expenditure does not exceed the sums it receives	Objective to break even – that is, duty to seek to achieve system financial balance
Financial apportionment	Revenue and capital resources of all trusts apportioned exclusively to a principal ICB	
ICB administration costs	Duty not to exceed the ICB running cost allowance limit set by NHS England	
Risk management	Local contingency decision required to show how financial risks will be managed	
Prior year's under and overspends		Maintain as a cumulative position
Repayment of prior year's overspends		All overspends are subject to repayment
Mental Health Investment Standard	Comply with standard	
Better Care Fund	Comply with minimum contribution	

9. Further information is available in ICB and system finance business rules.

Repayment of 2022/23 system overspends

10. All system overspends are subject to repayment. To allow systems time to stabilise their spending, it was confirmed that repayments will not start until the second year following the year in which the overspends first arose.

11. For 2024/25, repayments relating to 2022/23 will be captured in the integrated care system (ICS) financial planning template through a 'repayment of prior year deficit' adjustment. The amount subject to repayment is the total cumulative system overspend. For 2024/25, that is the 2022/23 net position of the ICB and of those trusts mapped to it, adjusted for any historical clinical commissioning group (CCG) net cumulative underspend.

12. So that repayments are achieved over a sensible timescale, overspends will be repaid over a minimum 3-year period, subject to an annual cap set at 0.5% of the published 2024/25 ICB core services programme allocation.

Access to drawdown in 2024/25

13. NHS England does not anticipate widespread access to drawdown. Where drawdown is considered, this will be on the basis that it would be funded through repayments of prior year overspends and subject to national affordability.

14. For the purposes of planning, systems should not assume access to drawdown unless this has been approved in advance of plan submission. Where drawdown is approved, this will be added to the relevant system financial planning template.

ICB revenue allocations

Overview

15. In January 2023, NHS England issued ICB programme allocations for 2023/24 and 2024/25. These set out the allocations for both financial years, including the fair share ('target') allocations, base growth and convergence for each ICB. These allocations still stand but with the adjustments described in the following sections.

16. The updated 2024/25 allocation schedules, published alongside this guidance, sets out the revised allocations, including each adjustment.

17. The cost uplift factor (CUF) for 2024/25 has decreased from the 1.8% originally assumed in the 2023/24 revenue finance and contracting guidance to 1.7%, with the

general efficiency requirement remaining at 1.1%, giving a 2024/25 net CUF of 0.6%. Further information on the CUF is set out in Annex D of the 2023/25 NHS Payment Scheme (NHSPS).

18. Where ICB funding is provided on a population basis, it is important that inter-system funding arrangements recognise patient flows and that all relevant funding is included in contracts. Where funding is not provided on a population basis, this is clearly identified. Further information on the payment and contracting arrangements for 2024/25 is available in the contracts and payment approach section.

ICB core programme allocations

Baseline adjustments

19. The following recurrent adjustments have been applied to 2024/25 allocation baselines and are therefore subject to base growth and convergence:

- **Pay** funding issued in 2023/24 will be recurrently included in baselines, with the exception of funding for local authorities and research and development which was issued on a non-recurrent basis.
- **Non-pay inflation** funding as confirmed during 2023/24 will be included.
- **International Financial Reporting Standard (IFRS) 16** revenue programme funding, covering both ICBs and trusts, will be added recurrently to ICB programme allocations on a host trust basis. The current revenue impact associated with IFRS 16 relates to the combined effect on the leases in place at the application date of IFRS 16 compared to the previous accounting treatment. This effect will reduce to nil over the length of the related leases. Consequently, the additional resource has been applied to ICB allocations but is not a feature of the target quantum, and therefore will converge out of allocations over time. ICBs should distribute this resource to the trusts within their system through the API fixed element of their contracts. This should then be reviewed locally on an annual basis, with the ultimate end point of no funding in all contracts.
- **Any other recurrent allocation updates** up to and including month 7 2023/24.

20. The following adjustments have been applied in 2024/25 after base growth and convergence:

- **Ambulance funding** of £200m issued in 2023/24 has been added to 2024/25 ICB core programme allocations, including an uplift to recognise the CUF and general

efficiency requirement. In 2023/24, this funding was distributed to the lead commissioner (ICB). For 2024/25, it has been recurrently added to the core programme allocations of all ICBs, with each ambulance trust's total funding issued to its commissioning ICBs based on the weighted population of the ICBs. A separate schedule has been issued setting out the required amendments to contracts to ensure that the allocation change has a neutral impact on ambulance trust income. This funding is conditional on maintaining the required capacity and performance standards.

- **Virtual and physical urgent and emergency care (UEC) capacity, including services that specifically support admissions avoidance and timely discharge.** Recurrent funding issued in 2023/24 (updated to recognise the CUF and general efficiency requirement) has been added to the 2024/25 ICB core programme allocation schedule, bringing the total national allocation to £1bn. The 2024/25 ICB-level allocations are based on the recurrent allocations set through the 2023/24 planning process. This means that in 2024/25 some ICBs may receive more or less than their actual 2023/24 allocation, as some non-recurrent adjustments were agreed in 2023/24 to reflect the different approaches taken to increase capacity in-year. This funding is conditional on maintaining the required capacity and performance standards. This is in addition to the funding already included in ICB allocations to support timely discharge (£500m in 2024/25) that was announced in 2023/24. Further information is available in the Better Care Fund (BCF) section.
- **COVID-19 testing funding** for the commissioning of COVID-19 testing services for NHS use cases performed in a hospital setting, comprising PCR testing services and lateral flow device (LFD) hospital-based testing services. These allocations are non-recurrent and subject to change should the national testing protocol be amended. Further information is given in the COVID-19 testing section.
- **Adult Long COVID services** funding will be moved into ICB programme allocations from the Service Development Fund (SDF). For 2024/25, funding will be added based on the current (2023/24) distribution of funding to minimise disruption to funding flows. Through the allocations convergence policy, this funding will be transitioned over time to a fair share basis. To support the move from the SDF, adult Long COVID funding will be separately identified in the allocation schedule in 2024/25. Children and young people Long COVID service

funding will remain in the SDF and be distributed as in 2023/24 through a lead ICB.

- **Learning disability and autism funding transfer agreement (FTA) residual funding** has been added recurrently to ICB core programme allocations, based on the same distribution as the 2023/24 adjustment, which comprised both positive and negative adjustments for ICBs. As a consequence of the COVID framework, in 2023/24 £68m was included in ICB core programme allocations, with £15m provided through an in-year non-recurrent adjustment, bringing the total funding to £83m. For 2024/25, the recurrent inclusion of the residual funding (totalling £15m) means that the totality of the FTA funding is now included in core ICB programme allocations.

Base growth

21. Base growth has been increased by 1.0% to reflect the following ICB pressures since the original 2024/25 allocations were published in January 2023:

    - a revised gross domestic product (GDP) deflator for 2024/25
    - the Clinical Negligence Scheme for Trusts (CNST) increasing from 6.5% to 7.7% (see CNST section)
    - ongoing pressures in continuing healthcare and prescribing
    - the 2024/25 acute and ambulance capacity adjustment increasing from 0.2% to 0.6%

Convergence

22. For those ICBs over their target allocation, the convergence values have been scaled to 80% of the percentage in the 2024/25 allocations published in January 2023. The convergence adjustment applied to an ICB depends on its distance from target allocation. Systems consuming more than their fair share have a greater convergence ask and therefore a lower level of growth than the national average.

23. For those ICBs under their target allocation, the convergence remains unchanged. The purpose of the convergence methodology is to move ICBs towards a fair share distribution of resource at the levels affordable within the settlement.

Fair share ('target') allocations

24. There are no changes to the 2024/25 target formula that determines fair share ('target') allocations. Further information is available in the updated supporting technical guide to ICB allocations.

25. The allocation tool supports systems to understand the relative need at different place levels within their ICB. It can help ICBs allocate budgets at place or service level and target NHS resources towards reducing health inequalities.

ICB primary care allocations

ICB primary medical care allocation

26. ICB allocations for delegated primary medical care services are published alongside this guidance.

27. The 2024/25 published allocations have been updated to include additional funding relating to the implementation of the 2023/24 Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendations.

28. There have been no changes in policy relating to the calculation of the target formula for delegated primary medical care allocations and therefore no updates to the target formula or convergence methodology.

29. Implementation details and contractual payments for 2024/25 have not yet been published. For the purposes of planning, ICBs should assume the full increase in allocations is required to fund growth and contractual payment increases until such point that the agreed details of payment changes for 2024/25 are published.

ICB pharmaceutical, ophthalmic and dental services allocation

30. All ICBs have taken on delegated responsibility for community pharmaceutical services, general ophthalmic services, dental services (primary, secondary and community) and other primary care services (POD services) as set out in the delegation agreements. ICBs should therefore award contracts for all delegated primary care services for 2024/25.

31. The published allocations have been updated to reflect:

    - **pay** funding communicated as recurrent for the 2023/24 pay awards

- a **domiciliary optometry** adjustment to neutralise the impact of domiciliary optometry activity being charged based on provider location rather than on a population basis
- **other recurrent allocation updates** up to and including month 7 2023/24

32. As part of the Delivery plan for recovering access to primary care and as set out in the 2024/25 priorities and operational planning guidance, there is a requirement to expand community pharmacy services to deliver a common conditions service and significant increases in contraception and blood pressure monitoring (Pharmacy First). Supplementary guidance will be issued on the payment terms and pass-through funding arrangements. For the purposes of planning, ICBs should not include income or expenditure on this service in their plans.

33. The utilisation of POD allocations remains subject to the additional rule that dental budgets are ringfenced (see ICB dental ringfence section).

ICB running cost allowance

34. Pre-delegation ICB running cost allowances (RCAs) covering 2024/25 and 2025/26 have been published. As previously communicated, RCAs are subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% to be delivered in 2024/25. ICBs should continue to provide assurance on the delivery of this reduction.

35. The published figures do not include any allocation for the impact of delegation in 2023/24 and therefore ICBs will separately receive additional recurrent RCA on a population basis to reflect the 2023/24 transfer of staff. ICBs are responsible for calculating and transacting any inter-ICB adjustments to appropriately fund the agreed operating model in 2024/25.

36. For the purposes of planning, separately identifiable RCAs – namely the 2024/25 published values (pre-delegation) and the recurrent delegation staff transfer funding (on a population basis) – will be provided.

37. NHS England requires that ICBs do not exceed this combined RCA. These values should be considered a maximum and any underspends in RCA can be used as non-RCA revenue expenditure.

Service Development Fund (SDF)

38. ICBs will continue to receive SDF allocations to support the delivery of the NHS Long Term Plan commitments in 2024/25 and the national objectives set out in the 2024/25 priorities and operational planning guidance.

39. The SDF for 2024/25 will continue to be bundled into high-level groupings. These have been reviewed and, where possible, the number of individual allocations has been streamlined.

40. Separate schedules, with an accompanying SDF technical guide, will be made available to each ICB and will set out how the total funding for each bundle has been calculated and which schemes are included. ICBs must spend bundled SDF on the core set of initiatives it has been allocated for, but can choose how to distribute the funding between those initiatives, other than where specific priorities are set out in the 2024/25 priorities and operational planning guidance.

41. To provide additional clarity, NHS England will also set out schemes:

    - that are considered recurrent and that should be included in plans
    - that are considered non-recurrent and that are only to be included in plans where the scheme has been confirmed by NHS England. For those not yet confirmed, further information will be available in due course
    - that will cease in 2023/24, with funding not issued in 2024/25, and that therefore should not be included in plans

42. The SDF reporting and assurance mechanism introduced in 2023/24 will continue into 2024/25. Further details on the requirements and process for reporting and assurance are set out in the SDF technical guide.

43. The SDF is also used as a mechanism to transfer funding to ICBs that has been allocated for a specific purpose by the government. In line with the rest of the SDF, funding allocated for these categories must be spent only on the purpose for which it has been allocated. NHS England is required to return any underspends to the government and therefore corresponding ICB underspends will be adjusted for in month 12. For clarity, the following SDF categories are allocated for specific purposes by the government:

- children and young people (CYP) – early language and support for every child (ELSEC) [Department for Education]
- learning disability and autism – partnerships for inclusion of neurodiversity in schools (PINS) [Department for Education]
- mental health – talking therapies [Department for Work and Pensions]
- mental health – other inter-departmental funding [Department for Work and Pensions]
- mental health – individual placement and support (IPS) additional funding
- mental health – NHS talking therapies for anxiety and depression
- other SDF – women's health hubs

Elective Recovery Fund (ERF)

44. The ERF will operate in a similar way to how it has operated in 2023/24. The Elective Recovery Fund technical guidance for 2024/25 sets out how funding for elective services will flow for 2024/25 and the funding rules associated with commissioner allocations and provider payments.

45. The ERF baselines for 2023/24 will be rolled forward for 2024/25 without further baseline adjustments. NHS England will in due course publish individual commissioner targets and indicative targets for each provider–commissioner relationship above the low volume activity (LVA) threshold. This is intended to help providers and commissioners agree their activity targets for 2024/25. These values will form the default target values for all inter-system relationships and should be used unless explicitly agreed otherwise. LVA activity will be excluded from the scope of the ERF in 2024/25.

Allocation

46. The allocation for elective service recovery (the ERF) has been separately identified in ICB allocations and distributed on a fair share basis. NHS England will receive a proportionate share for the activity it commissions directly.

47. To maintain stability and simplicity in the context of some, but not all, ICBs taking on delegated services in 2024/25, the ERF for all activity within the scope of NHS England Specialised Commissioning in 2023/24 will operate on a host provider basis for both NHS England commissioned and ICB commissioned delegated services. NHS England

will set out further detail on this in due course, including baselines, targets and allocations.

48. NHS England will set the target elective activity that each commissioner is expected to deliver within the totality of funding made available. Where commissioners exceed their activity target, additional funding at 100% of NHSPS unit prices (plus the market forces factor (MFF)) will be provided to fund the additional elective activity.

49. A proportion of each ICB's ERF allocation will be held back and released when the necessary level of elective activity has been delivered.

Payment for elective activity

50. Almost all secondary healthcare commissioned between trusts and NHS commissioning bodies is subject to the aligned payment and incentive (API) payment approach, as set out in the NHS Payment Scheme (NHSPS) section.

51. Non-NHS providers will continue to be paid on an activity basis for services with NHSPS unit prices.

Specialised services

Delegation and joint commissioning

52. Joint committees were introduced from 1 April 2023 to allow for all specialised services in scope for delegation, as confirmed by the service portfolio analysis, to be managed jointly by NHS England regional and ICB commissioners. These joint committees have laid the groundwork to integrate the financial planning and delivery of these services with wider system planning and financial management.

53. On 7 December 2023, the NHS England board approved the delegation of suitable acute specialised services to ICBs in the East of England, Midlands and the North West regions of England from 1 April 2024. In these regions, specialised services currently out of scope for delegation will continue to be commissioned by NHS England. Further guidance and tools to support ICBs and trusts in moving to future delegation are available on FutureNHS and through NHS England regional teams.

54. As in 2023/24, NHS England regional commissioners will be required to submit their 2024/25 financial plan at individual ICB level. Prior to submission, all partners in the joint committee arrangement (NHS England and ICBs) will be required to agree and

approve the specialised commissioning services financial plan for the population-based services in scope for delegation.

55. For services suitable for delegation to ICBs but not delegated in 2024/25, the NHS England board approved one more year of statutory joint commissioning arrangements between NHS England and ICBs in the South West, South East, London and the North East and Yorkshire regions of England, building on the arrangements in 2023/24. This continues to recognise the importance of ICBs working together to commission specialised services across footprints wider than their own system.

Setting allocations for specialised services

56. In January 2023, allocations for specialised services in scope for delegation were produced on a population basis at ICB level, covering 2023/24 and 2024/25. This meant that for the first time they represented resources for the patients mapped to ICBs on the basis of their GP registration, rather than for consumption by the individual trusts mapped to that ICB on a hosted provider basis.

57. For 2024/25, the ICB-level allocations have been updated to reflect the outcome of an NHS England regional exercise during summer 2023 to update the underpinning baseline data for additional allocations and 2023/24 growth (including pay uplifts). NHS England will also introduce a needs-based target allocation formula to the ICB-level acute specialised services allocations in 2024/25. At an ICB level, a differential convergence adjustment is applied to move ICBs towards a fair share funding distribution. The convergence adjustment for an ICB depends on its distance from target as defined by the needs-based formula. ICBs consuming more than their fair share will have a greater convergence ask. This is the first time such a model has been adopted for specialised services allocations, and it is expected that this move will support equal opportunity of access to specialised health services and help reduce health inequalities. Work is ongoing to develop a similar needs-based formula to inform mental health specialised service allocations in future years.

58. Where delegation to an ICB is approved, allocations for the relevant services will be transferred from NHS England on 1 April 2024. Where full delegation is not approved, NHS England regional commissioners will retain those population-based allocations for services in scope for delegation.

59. To support the continuation of joint committee arrangements, allocations will continue to be on a population basis for specialised services that are in scope for future delegation but remain the responsibility of NHS England in 2024/25.

60. Allocations relating to services that are not intended to be delegated have been retained by the relevant regional commissioner on a hosted provider basis.

61. NHS England will retain some funding for investment in agreed national service and clinical priorities. This funding will be allocated to NHS England regional commissioners or ICBs in-year, as decisions are made on investment. As a result of nationally driven procurement exercises, mutually agreed adjustments to trust baselines may be required in-year to reflect any material service changes or transfers.

Contracting for delegation in 2024/25

62. Specialised services contracts for 2024/25, including those to be delegated, will be awarded at the outset by NHS England in its name, rather than by ICBs. This may be done under standalone contracts to which NHS England is the only party or under joint contracts with ICBs, for which the ICB will typically be the co-ordinating commissioner. Once delegation is confirmed, through signature of a delegation agreement on or after 1 April 2024, the standard approach will be that NHS England then assigns the commissioning responsibilities in respect of the delegated services to each affected ICB. This will take effect through 2 separate actions.

    - NHS England will issue a contractual notice to each ICB, confirming the detail of the services being delegated, as provided for in the delegation agreement.
    - NHS England will inform each affected provider in writing of which rights and obligations under the signed contract it is now assigning to which ICBs, and in respect of which services and populations. Assignment of this kind is permitted at the commissioner's discretion under General Condition 12 of the NHS Standard Contract.

63. Affected contracts will not need to be novated to ICBs to reflect the delegation. Similarly, variations to contracts will not be necessary but may be considered for convenience in some cases.

2024/25 payment priorities for specialised commissioning

64. Given the volume of specialised activity that is planned for delegation from 1 April 2024, NHS England intends to align reimbursement as much as possible with existing arrangements for ICBs, including low volume activity (LVA) payments. A small number of amendments to the NHSPS will apply to support delegation of services. These include:

    - introduction of unit prices for some specialist radiotherapy services
    - change to the application of specialist top-up payments, although payment of the top-ups would remain the responsibility of NHS England. Where specialised activity in 2024/25 is paid for by an ICB as a result of delegation, NHS England will pay the corresponding eligible top-up on this activity

65. Where services and payments are currently managed at a provider level (and are best managed that way), and where there are limited standardised activity or data flows, NHS England regional teams will work with a nominated lead ICB for each provider to develop ICB-level payment arrangements. NHS England will also work with the providers and nominated lead ICBs to develop currencies, data flows and guide prices over time. This includes those for specialist services such as environmental controls, perinatal pathology and prosthetics.

66. Further information on the 2024/25 payment priorities for specialised commissioning will be made available to finance leads through FutureNHS.

High-cost drugs

67. Arrangements for excluded specialised high-cost drugs will be the same as in 2023/24. This means that allocations will stay with NHS England and reimbursement against opening provider income baselines will be funded by a central reserve for all specialised high-cost drugs identified as being subject to cost and volume reimbursement arrangements.

68. As set out in the NHSPS, most specialised high-cost drugs will be reimbursed on a cost and volume variable basis according to in-year reported trust expenditure data. A small number will continue to be reimbursed on a fixed payment basis.

69. As in 2023/24, costs relating to hepatitis C and cancer drugs funded from the Cancer Drugs Fund (CDF) will be reimbursed in line with the actual expenditure trusts submit

in-year. Drugs funded from the Innovative Medicines Fund (IMF) will also be reimbursed in this way.

70. Where it has been agreed to separately fund treatment costs associated with specialised high-cost drugs, such as CAR-T treatment, NHS England will continue to pay for these. A new CAR-T tariff is in place for 2024/25 onwards, as advised by a working group of providers convened by NHS England during 2023/24. Details are being communicated directly to affected providers.

71. It is imperative that drug data, particularly for those funded by the CDF and IMF, continues to improve. Payment will only be made to providers on the basis of expenditure that passes price validation exercises. Accurate data is critical to NHS England's ability to exercise the Expenditure Control Mechanism should either the CDF or IMF exceed their annual budgets and ensures NHS resource is protected.

High-cost devices

72. The second phase of the devices programme will continue to focus on delivering price savings from national commitments and value-based procurement. Further opportunities to deliver wider system savings will come from improving the uptake of certain products.

73. For 2024/25, existing reimbursement arrangements will continue; all NHSPS excluded high-cost devices funding for trusts in England, including formal managed service arrangements, will be managed on a national basis, outside contract baselines. The NHS England national specialised commissioning team will manage the monthly transactional process and reimburse trusts directly. Information will continue to be shared with NHS England regional teams, building on the processes currently in place.

74. Trusts will be reimbursed directly for any purchases made via the NHS England central procurement process with NHS Supply Chain (the visible cost model). Any device categories or specific products not available via NHS Supply Chain will be reimbursed directly based on the device patient-level contract monitoring (DePLCM) template. Trusts will not be reimbursed for DePLCM reported expenditure for devices that should have been ordered via NHS Supply Chain, or where key data fields have not been completed or where pricing information is unclear.

75. The direct reimbursement for devices to non-NHS providers or the devolved nations will continue to be managed locally by NHS England regional teams.

Clinical networks

76. NHS England invests significant funding in provider-hosted or commissioner-led specialised clinical networks. These are funded as a separately identifiable component within NHS England regional allocations and contracts are required to separately identify the value of funding for each network. Funding for specialised clinical networks will continue to be managed by NHS England and reconfirmed annually.

Excess treatment costs

77. The process for reimbursing providers in 2024/25 for excess treatment costs (ETCs) associated with specialised clinical trials is under review. Providers should plan on the basis that the current process (as defined in the 2023/24 revenue finance and contracting guidance) remains in place. If required, any changes to the process for 2024/25 will be formally communicated.

Mental health provider collaboratives

78. All phase 1 NHS-led provider collaboratives for specialised mental health, learning disability and autism services (MHPCs) have gone live.

79. MHPCs have the flexibility to review service provision and are encouraged to establish service models that treat patients closer to home, and to make and reinvest savings locally. As in 2023/24, where such service changes result in material changes to funding flows between the lead provider and a subcontracted provider, the lead provider and impacted provider(s) should work together to agree the appropriate phasing of service and funding changes, and will be subject to the NHS England change management process.

80. The scope of services covered by MHPCs was extended in 2023/24 to include perinatal services. All MHPCs are expected to be live for perinatal services by the end of 2024/25.

81. NHS England regions will retain contracting arrangements with lead providers in 2024/25, as mental health services are not expected to be delegated until 2025/26. All finance and contracting guidance relating to the operation of MHPCs is available through NHS England regional commissioning teams.

NHS England commissioned services

Public health services

82. NHS England will continue to issue public health allocations to regional commissioners so that they can commission services that form part of the NHS public health functions (Section 7A) agreement.

83. To help strengthen joint working with ICBs in preparation for future delegation, regional commissioners will produce 2024/25 financial plans for public health services at ICB level. This information will be used to support the future development of ICB-level allocations. Supplementary guidance on the finance and payment rules for public health services has been issued to regional teams to support the generation of ICB-level plans on a consistent basis.

84. From 1 April 2024, healthcare providers of public health screening services will be required to report activity performed within standard contract monitoring to their commissioners. New service codes have been created to enable the clinical activities to be reported within the Aggregate Contract Monitoring (ACM) and Patient Level Contract Monitoring (PLCM) for submission monthly as part of routine commissioning flows. The new service codes enable a greater level of granularity than currently documented and allow for the capture of diagnostic tests routinely used by screening services.

85. Ahead of the 2024/25 planning process for public health services, regional commissioners and trusts completed a limited public health contract and allocation baseline reset exercise. The purpose of the exercise was to identify the utilisation of non-recurrent funding issued in 2019/20 that remained embedded in public health contracts to better reflect the services that are now being commissioned from this resource. Where the funding was identified as being used to support ICB commissioned services or a broader trust financial position, and not for public health services, it will be transferred to the trust's host ICB with the associated contract changes required to be actioned for 2024/25. All adjustments will be processed on a net neutral basis to the commissioner and trust. Adjustments to baseline contract values and planning allocations will be populated in planning templates. A schedule is available on FutureNHS outlining the offsetting changes to contract values and allocations. Allocation adjustments will be subject to convergence, in line with national policy, from 2025/26 onwards.

Flu and COVID-19 vaccination programme

86. The policy and operational requirements of the 2024/25 flu campaign will be communicated in the annual flu letter, following agreement with government.

87. Allocations for commissioner staffing budgets for COVID-19 vaccination services will be confirmed as part of NHS England regional allocations, and NHS England regional plans should include the use of this resource. The remaining allocations for COVID-19 vaccination services are still subject to government funding approval. This is expected to be after the financial planning process has concluded and so, for the purposes of planning, commissioners and trusts should not assume income or expenditure on COVID-19 vaccination services.

Health and justice

88. NHS England will continue to issue regional commissioners with allocations to commission health and justice services.

Armed forces

89. 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. These services will be commissioned nationally.

Other revenue

Education and training funding

90. Training placements will continue to be funded on an activity basis by reference to the healthcare education and training tariffs or local prices where agreed. The Department of Health and Social Care (DHSC) will publish the education and training tariff arrangements for 2024/25 in due course.

91. To better support the planning process, education and training income and expenditure will continue to be collected using the following categories:

- postgraduate medical and dental
- undergraduate medical and dental
- clinical (non-medical)
- other (including education support and workforce development)

92. For the purposes of planning, and to ensure there is a consistent approach, a set of assumptions will be provided for use until the 2024/25 education and training tariff is published.

Revenue support for capital

93. Pressures created by depreciation, public dividend capital (PDC) charges or other short-term revenue costs can inhibit necessary capital investment. This section sets out the support available to manage these pressures. Where funding is available, this is to help mitigate short-term revenue affordability barriers to capital investment and should be used to assist with revenue costs related to capital charges. It is intended to support short-term non-recurrent costs during the initial implementation period and up until efficiencies or productivity benefits associated with the capital investment are fully realised.

94. Further information in relation to capital investment is available in the capital guidance for 2024/25.

Depreciation and amortisation

95. Government has agreed additional revenue resources for the NHS to support depreciation and amortisation expenditure, where the expenditure is in scope of the technical ringfence as defined in the HM Treasury consolidated budgeting guidance. The purpose of this additional funding is to mitigate the risk that the cost consequences of technical items could impact on the funding available for patient care and service delivery. For the purposes of NHS expenditure, the table below defines which elements of NHS depreciation and amortisation are in scope for additional funding:

PFR subcode line description	PFR subcode	In scope for additional funding?
Depreciation: owned assets	EXP0470	Yes
Depreciation: donated and government granted assets	EXP0500	No
Depreciation: PFI/LIFT (IFRIC 12) assets	EXP0490	No
Depreciation: Right-of-use assets – leased assets	EXP0480	Yes
Depreciation: Right-of-use assets – peppercorn leases	EXP0505	No

Amortisation: Intangibles – owned assets	EXP0520	Yes
Amortisation: Intangibles – donated and government granted assets	EXP0540	No
Amortisation: Right of use intangibles – leased assets (existing IAS 17 leases only)	EXP0525	Yes

96. If a system, being the aggregate of all hosted trusts within that system, incurs expenditure on in-scope depreciation and amortisation in excess of a system-level baseline (as defined by NHS England), NHS England will fund (payable to the host ICB of the system) the excess in-scope expenditure up to a capped value. This approach is necessary because NHS England's access to the resource from government is predicated on actual spend on in-scope items only.

97. The system baseline will be calculated based on the lesser of:

- 2021/22 trust depreciation outturn (adjusted for IFRS 16) for the trusts hosted within the system plus growth funded through the CUF and allocations up to 2024/25
- 2023/24 M8 forecast outturn (FOT) on in-scope items for the trusts hosted within the system plus 2024/25 growth funded through the CUF and allocations

98. The 2024/25 funding through the CUF and allocations for the revenue consequences of capital is 2.6% (comprising 1.7% cost growth in revenue consequences of capital stated in the CUF, less 1.1% general efficiency and plus 2.0% activity). Trusts should continue to secure funding for this element of growth through their existing contractual arrangements.

99. The capped value represents the additional funding available to systems, above the base growth funded through the CUF and allocations. This will be calculated as an uplift to the baseline value. The uplift will include a uniform uplift for all systems and a targeted adjustment to reflect the incremental pressures experienced by systems, including the impact of large, nationally directed schemes.

100. Where the system as a whole meets the criteria for additional funding, additional revenue allocation will flow to the host ICB, which in turn will make any necessary

amendments to the fixed element of its API arrangement with the relevant trusts within its system.

101. System baselines and capped funding will be built into planning templates with separate schedules available on FutureNHS. Funding will populate in ICB planning templates based on plan spend inputs. However, actual allocations will be dependent on actual spend and will be monitored throughout the financial year.

102. Indicative allocations for the purposes of financial reporting will be based on plan expenditure. Final allocations will be confirmed at year-end based on actual expenditure.

103. For this approach to work successfully, systems need to come together to plan their depreciation and amortisation expenditure, and forecast effectively in-year against this plan position.

Public dividend capital (PDC)

104. New Hospital Programme schemes are eligible for Assets Under Construction (AUC) PDC dividend relief, such that trusts do not pay PDC before the asset is operational. In addition, government has agreed that this relief will be applied to a further set of limited schemes. Where this is the case, the trust will have received a letter from DHSC confirming eligibility for AUC PDC dividend relief.

Community diagnostic centres (CDCs)

105. ICBs have access to dedicated revenue funding to contribute to the set up and running costs of CDCs in 2024/25, based on activity plans already agreed with NHS England.

106. As in 2023/24, all approved CDC revenue funding will be allocated to ICBs to distribute to individual host trusts of respective CDCs. NHS England has amended the Who Pays? Rules to make clear that, until further notice, the agreed host-ICB of the trust-led CDC is responsible for paying the trust to provide the designated CDC services (regardless of which GP practice the patients attending the CDC are registered with). Further guidance on CDC finance and contracting arrangements for 2024/25 will be made available to confirm:

    - the conditions that apply to CDC revenue funding allocations from NHS England to ICBs

- ICBs must ensure that appropriate contracts are in place with trusts for designated CDC services
- the pricing and provider payment arrangements for services in designated CDCs

107. CDC pricing and payment in 2024/25 will continue to require a locally agreed adjustment to the API payment rules set out in the NHSPS, and it will be necessary for each ICB to submit the agreed adjustment request to NHS England to enable this. A model CDC variation request template is included in the separate CDC finance and contracting guidance.

Payment approach and contracts

NHS Payment Scheme (NHSPS)

108. The 2023/25 NHSPS (amended) will come into effect from 1 April 2024.

109. 2024/25 prices and LVA values are included in Annex A of the NHSPS and have been calculated by updating 2023/24 prices for inflation and efficiency (uplifted for net CUF) and adjusting for changes in CNST contributions. The updated prices also reflect a small number of amendments that were subject to consultation.

110. The NHSPS applies to all secondary healthcare – acute, ambulance, community and mental health. As in 2023/24, it includes rules for 4 payment mechanisms:

Payment mechanism	Description	Scope
Aligned payment and incentive (API)	Fixed and variable elements	Almost all trust relationships with: • NHS England for any directly commissioned services • any ICB where the relationship is not covered by LVA arrangements
Low volume activity (LVA)	Nationally set values for LVA	Almost all trust and ICB relationships for which NHS England has mandated an LVA block payment
Activity-based payments	Each unit of activity is paid for using NHSPS unit prices, with relevant adjustments (for example, MFF) applied	Services with NHSPS unit prices delivered by non-NHS providers

Local payment arrangements	Locally agreed payment approaches, subject to NHSPS rules	Activity not covered by another payment mechanism

111. The normal and expected arrangement for payment is that the provider bills the patient's responsible commissioner for their treatment, as set out in the Who Pays? Rules. ICBs operating a joint contract with a provider may agree to 'aggregate' their payments (so that one ICB makes payment to the provider on behalf of all the ICBs, with recharging between the ICBs). ICB-to-ICB recharging is only appropriate if all parties agree to this in a specific contract. It should not be used for non-contract activity payments or as a way of circumventing LVA arrangements.

112. Where transactions are needed, they should be done in the most cost-effective way, for example, invoice payment file (IPF), and their volume should be minimised.

Aligned payment and incentive (API)

113. Since the 2023/25 NHSPS came into effect on 1 April 2023, almost all secondary healthcare commissioned between trusts and NHS commissioning bodies is subject to the API payment model. Activity is excluded from an API agreement where a low volume activity (LVA) arrangement is in place or where a single specialised service is individually procured.

114. Under the API rules, trusts and commissioners need to agree a fixed element, based on funding an agreed level of activity other than for elective activity (covering most elective ordinary and day case outpatient procedures with an NHSPS unit price, outpatient first attendances, unbundled diagnostic imaging and nuclear medicine, and chemotherapy delivery). The fixed element should include funding for all expected activity other than the variable elements.

115. Additional fixed payment guidance has been created to support providers and commissioners by providing additional clarity and highlighting areas for consideration in local negotiations to agree fixed payment arrangements for the following specific service areas:

- paediatrics diabetes best practice tariff (BPT)
- advice and guidance
- cancer on-treatment follow-ups
- capsule sponge test

- Getting It Right First Time (GIRFT), Right Procedure Right Place (RPRP) programme
- wider elective pathway costs

116. Further guidance on setting the 2024/25 API fixed payment is available in Appendix A.

117. The API variable element means trusts are paid 100% of NHSPS unit price for elective activity. Some of the funding for the elective variable payments comes from the Elective Recovery Fund (ERF). The price paid by the commissioner is adjusted by the trust's MFF value and, where the relevant criteria are achieved, elective activity best practice tariffs (BPTs) must also be paid. Any applicable prescribed specialised service (PSS) top-up payments will be paid by NHS England.

Low volume activity (LVA)

118. In the 2023/25 NHSPS, almost all trust–ICB relationships with an expected annual value below £0.5m (excluding delegation) are subject to LVA arrangements, with the only exceptions being:

- services provided by ambulance trusts, including patient transport services
- non-emergency inpatient out-of-area placements into mental health services where these are directly arranged by commissioners
- elective care commissioned by an ICB to enable patient-initiated transfers of existing long-waiting patients under patient choice arrangements

119. For 2024/25, the following changes will apply:

- The LVA value of **delegated services** will be added to current LVA values so that a single payment will be made for all services. This will continue in almost all cases where a trust–ICB relationship is currently defined (in 2023/24) as an LVA arrangement, and a single payment should be made as set out in the 2024/25 LVA payment schedule. However, for a small number of relationships that NHS England defines as significant in value as a result of delegation, the ICB and trust will need to establish a contract on API terms from 1 April 2024.
- An **uplift to the values** to recognise the CUF and general efficiency requirement as provided for in the NHSPS.

120. The LVA payments schedule is published as part of Annex A of the NHSPS. To further minimise the number of financial transactions, ICBs should pay each trust identified on the schedule the calculated amount once any in-year updates have been made to reflect the impact of any agreed pay award or by the end of quarter 3, whichever is sooner.

Activity-based payments

121. The activity-based payment mechanism applies to almost all activity delivered by non-NHS providers for services with NHSPS unit prices. Providers will be paid 100% of NHSPS unit prices, with MFF applied.

122. Where the totality of the contract is based on activity-based payments, convergence as a price efficiency is not expected to be applied.

Local payment arrangements

123. Activity not covered by one of the other three payment mechanisms described in paragraph 110 is subject to local payment arrangements. This includes services delivered by non-NHS providers for which there are no NHSPS unit prices. Local payment arrangements mean that providers and commissioners locally agree an appropriate payment approach. The NHSPS rules require them to consider the NHSPS payment principles and cost uplift and efficiency factors.

Commissioning for Quality and Innovation (CQUIN)

124. NHS England will pause the nationally mandated CQUIN incentive scheme in 2024/25. This will mean that providers' income associated with CQUIN achievement is not at risk and they are not required to repay any amounts if they do not fully achieve the CQUIN criteria. CQUIN funding will continue to be included in prices. The fixed payment must continue to include the 1.25% funding previously identified for CQUIN.

Contracts

125. It is important from a governance perspective that fully populated contracts in the form of the NHS Standard Contract 2024/25 are put in place between commissioners (ICBs and NHS England) and each provider (NHS trusts, NHS foundation trusts and non-NHS organisations) covering at least the full financial year of 2024/25 and in advance of 1 April 2024.

126. Contracts for all commissioned healthcare services – other than primary medical services, primary dental services, primary ophthalmic services and pharmaceutical services – must be in the form of the NHS Standard Contract, regardless of the type of provider commissioned to provide those services. NHS England has published the final version of the NHS Standard Contract for 2024/25 to enable contracts to be agreed and signed in advance of 1 April 2024. For contracts where payment is to depend on activity volumes, opening activity plans and financial values should be set at realistic levels. This is important for providers because the monthly cashflow they receive ('on-account payments') will be broadly in line with the expected profile of costs they will incur. Further detail about NHS contracting is set out in the contract technical guidance.

127. Further information on contractual arrangements for services where NHS England is delegating commissioning functions to ICBs is set out in the specialised commissioning section.

Provider Selection Regime (PSR)

128. The Health Care Services (Provider Selection Regime) Regulations 2023 came into force on 1 January 2024. The PSR is a new regime for the procurement of healthcare services by relevant authorities (NHS England, ICBs, NHS trusts and NHS foundation trusts, and local and combined authorities).

129. Any in-scope procurement process for healthcare services that started on or after the date the PSR came into force will need to be undertaken in accordance with the new PSR regulations and guidance. The regulations will apply to all new contracts (including those awarded based on an existing framework agreement) and all new framework agreements, unless the procurement process was started before 1 January 2024. It also applies to all contract modifications (including modifications for contracts awarded or established before the PSR came into force).

130. The PSR does not have any retrospective effect on contracts or framework agreements that were entered into prior to it coming into force. In addition, procurements started prior to that date must be completed on the basis of existing procurement regulations and guidance (Public Contracts Regulations and Procurement, Patient Choice and Competitions Regulations).

131. More information is available on the PSR webpage.

Collaborative commissioning

132. To minimise bureaucracy and duplication, it is important that commissioners continue to collaborate in setting up and managing their contractual arrangements with providers, with multiple commissioners often signing the same single contract with a large provider. An updated model collaborative commissioning agreement is available on the NHS Standard Contract webpage to facilitate this.

Contract agreement

133. Agreed contracts are an essential discipline to support effective delivery. The inability to agree a contract promptly is likely a sign that a system plan is not robust. Contracts must be agreed by the start of the financial year, and local NHS leaders must work together to ensure that this is achieved.

134. Progress towards contract agreement and signature will be monitored by regional teams. Where there is a risk that a contract between a commissioner and a trust will not be agreed, the issues preventing agreement must be escalated to, and discussed by, the ICB chief executive (or for contracts involving NHS England as commissioner, the NHS England regional director) and the trust chief executive.

135. Where contracts between ICBs and trusts (whether within a region or across regional boundaries) have not been agreed by the final deadline for plan submission, the affected organisations will be required to submit a single joint statement of the issues in dispute to the relevant NHS England regional director(s) of finance. The regional team(s) will work with the ICB and trust to resolve the dispute and, where required, will have access to expertise from NHS England's national teams to clarify the application of relevant national rules and guidance.

136. In exceptional circumstances, the issues in dispute will be escalated by the regional director(s) of finance to NHS England's national teams, who will then provide binding advice to the disputing parties. The expectation is that all contract disputes between commissioners and trusts will be resolved, and all contracts signed, no later than 31 May 2024.

System Collaboration and Financial Management Agreement (SCFMA)

137. The model System Collaboration and Financial Management Agreement (SCFMA) remains available for partners within an ICS to use to manage in-year financial pressures and risks. Its use is not mandatory, and systems may now have put in place

their own local governance arrangements (in the form of subcommittees or joint committees) to deliver the aspirations set out in the model SCFMA.

Key financial commitments

Mental health services

138. The Mental Health Investment Standard (MHIS) will apply to ICBs and continue to be subject to an independent review. For 2024/25, the MHIS continues to require ICBs to increase spend on mental health services by ICB programme allocation base growth (prior to the application of the convergence adjustment). This growth is a core part of funding the NHS Long Term Plan commitments for mental health. The ICB MHIS requirements, including the calculation methodology, are set out in supporting MHIS schedules and technical guidance.

139. Local system leaders, including the nominated lead mental health provider, should review each ICB's investment plan underpinning the MHIS to ensure it is credible to deliver the mental health activity commitments and the related workforce. Any concerns about these plans should first be discussed and agreed between system partners, with any escalation to the regional teams only after this. Where an ICB fails to deliver the mental health investment requirements, NHS England will consider appropriate action.

140. The NHS Long Term Plan makes recurrent commitments on mental health services. To provide additional clarity, and as set out in the SDF section, 2024/25 SDF allocations will be identified as recurrent, non-recurrent or ceasing in 2023/24.

141. Efficiencies applied to MHIS-related expenditure should only be reinvested in mental health services such that systems continue to meet their MHIS requirements.

Better Care Fund (BCF)

142. The BCF will continue in 2024/25. The policy framework and planning requirements for the BCF in 2023 to 2025 were published in April 2023, and included growth of 5.66% in 2024/25. These allocations must be pooled into a Section 75 agreement alongside grants paid to local government.

143. The Autumn Statement 2022 confirmed that an additional £0.6bn (provided equally through NHS England and local authorities) will be made available in 2023/24 and £1bn in 2024/25 through the BCF to support timely discharge. The NHS component of this

funding (£0.5bn in 2024/25) is already included in ICB allocations and separately identified as part of published ICB programme allocations.

Reducing NHS expenditure on agency staff

Joint financial objective for ICBs and their partner NHS trusts and NHS foundation trusts

NHS England sets the following financial objective in exercise of the powers conferred by section 223L of the National Health Service Act 2006.

The agency spending of each ICB and its partner NHS trusts and NHS foundation trusts should not exceed the system agency expenditure limit set by NHS England in each financial year. For the purposes of assessing the financial objective, the agency expenditure for NHS trusts and NHS foundation trusts that are partners to more than one ICB should be mapped in accordance with the financial direction for the apportionment of the use of resources set by NHS England with respect to sections 223M and 223N (as defined in the NHS financial framework: ICB and system finance business rules).

This financial objective applies in relation to the financial year ending 31 March 2023 and each subsequent year, unless the objective is changed at a later date.

144. Government announced in the Spring Budget that it is working with NHS England to reduce the costs of agency staffing. To support this, the following measures are to be implemented in 2024/25:

- a collective duty on all trusts to seek to achieve the financial objective of systems controlling agency spending within the limit set, as set out above.
- a requirement that all trusts end the use of off-framework agency staff by July 2024.
- a requirement on trusts to comply with the agency rules in the NHS Standard Contract Service Conditions.

Setting the system agency expenditure limits

145. NHS England will continue the measures to control agency expenditure, including system agency expenditure limits. Metrics to monitor agency use are included in the

NHS Oversight Framework, and this spending is reviewed as part of the wider NHS accountability and assurance framework.

146. Agency expenditure limits for 2024/25 have been set using broadly the same approach as in 2023/24. The overall intention is to reduce aggregate agency spending for all trusts to 3.2% as a proportion of the total NHS pay bill (assuming pay inflation is in line with the current planning assumption). This builds on progress made in 2023/24, with each system set an individual 2024/25 financial limit that will be built into planning templates.

147. Each system has its own limit (in £m), which is set based on current (month 9 2023/24 forecast outturn) spending levels. All systems are expected to reduce their agency spending by at least 5%, but those systems spending above 3.2% of total pay will be set limits that would reduce spending by more than 5%. Systems with the highest excess spending are therefore required to make the biggest reductions.

148. System partners should agree the approach taken to spend within their total limit and will be collectively responsible for delivering the plans they agree. NHS England reserves the right to set lower limits where systems return a deficit plan, and an additional 10% reduction may be required from those systems in these circumstances.

149. System performance against the agency expenditure limits is monitored on a full-year basis. Spending profiles agreed as part of the planning process will give an indication of expected expenditure at different points in the year, which may then inform actions to resolve under-performance.

150. Trusts should therefore continue to take action to reduce expenditure on NHS agency staff, encourage workers back into substantive and bank roles, and achieve compliance with agency controls. This includes ending the use of off-framework providers and improving compliance with NHS agency price caps. A national temporary staffing dashboard and toolkits on the better use of substantive and bank staff have been produced to support this.

ICB dental ringfence

151. The utilisation of POD allocation is subject to the rules set out in the ICB and system finance business rules – namely the duty to break even within the resource use limit. It is also subject to the additional rule that dental budgets are ringfenced and NHS England reserves the right to direct that any unused resources are used to improve

dental access through the implementation of the dental recovery plan. Exceptionally, the unspent allocation may be returned to NHS England.

152. A separate schedule is available on FutureNHS setting out the ringfenced dental budget included in POD allocations.

Other planning assumptions

All-age continuing care

153. NHS-funded all-age continuing care can be arranged either through a personal health budget or care services delivered by a social care provider. Both of these commissioning arrangements support optimised care in the community. ICBs should locally, and in conjunction with their integrated care partnership (ICP), consider the sustainability of the social care providers and the challenges they face. The ICB and the providers must engage constructively on the provision of care services for those in receipt of all-age continuing care, using the rules for local payment arrangements as set out in the NHS Payment Scheme, and follow the NHS Standard Contract terms and conditions relating to prompt payment of providers.

154. ICBs should have a continuing healthcare (CHC) management system in place that complies with the information standard notice and dataset specification for the NHS Continuing Healthcare Patient Level Data Set (CHC PLDS). The NHS All Age Continuing Care (AACC) Patient Level Data Set is currently under development and, once approved and implemented, will replace the CHC PLDS. ICBs should create and implement a digital transformational plan that enables a system-wide approach to compliance.

155. Government have announced the NHS-funded nursing care (FNC) rates for 2024/25.

Charge-exempt overseas visitors and UK cross-border A&E and ambulance activity

156. Commissioners should continue to note their legal responsibility to commission services for charge exempt overseas visitors (CEOVs) and UK cross-border A&E and ambulance services. They should provide the appropriate level of funding to providers through their commissioning contracts, as set out in the NHS Standard Contract. Information on determining the responsible commissioner for overseas visitor and UK cross-border activity can be found in the Who Pays? Rules.

157. The Who Pays? Rules have been updated for 1 April 2024 to clarify that NHS England is responsible for paying for CEOVs accessing NHS England commissioned services, and ICBs are responsible for paying for CEOVs accessing ICB commissioned services. Current charging arrangements will continue to apply until 31 March 2024.

158. CEOV and UK cross-border emergency activity allocation redistributions have been actioned (through the planning templates) to ICB core programme allocations, on a non-recurrent basis and at the same value as the 2023/24 ICB-level adjustment (updated for CUF and general efficiency). The initial adjustment will be amended in-year based on the values reported in the spring 2024 ICB collection. Actioning the adjustment in advance of the financial year is intended to minimise the in-year change to ICB allocations.

Clinical Negligence Scheme for Trusts (CNST) contributions

159. As in previous years, the growth in contributions to the CNST is funded in commissioner allocations on a uniform basis. The overall increase in CNST contributions to NHS Resolution in 2024/25 is 7.7%. However, the change for each individual trust will reflect its relative risk factors.

160. The NHSPS sets out further detail on how nationally published unit prices have been adjusted for the change in CNST contributions. It also includes guidance for commissioners and providers on the change in API and local payment arrangements to reflect average CNST changes in different specialties. As a minimum, commissioners need to uplift the fixed element relating to maternity using the maternity CNST uplift. This should also be done for all the other service areas but, if this is too resource intensive, an average for non-maternity service areas can be applied.

161. ICBs also make a nominal contribution to NHS Resolution as part of their membership of the CNST. NHS Resolution has already confirmed to ICBs the contribution required for 2024/25.

162. The cost of claims raised against ICBs (or falling on them through their commissioning contracts) for incidents since 1 July 2022 will be charged to them in future CNST contributions. NHS England does not expect this will cause any financial pressure in the current planning round, but ICBs should ensure they are undertaking necessary due diligence when agreeing contracts, ensuring that commissioned providers have appropriate indemnity cover in place in line with the requirements of the NHS Standard Contract.

COVID-19 testing

163. ICBs will receive fixed allocations for the commissioning of COVID-19 testing services for their populations, comprising PCR testing services and LFD hospital-based testing services as set out in the ICB core programme allocations section.

164. The allocations are based on the revised COVID-19 testing protocol published in March 2023, which remains valid at the point of publication of this guidance. Unless stated otherwise in superseding guidance, ICBs and trusts should plan based on the continuity of this testing protocol. The non-recurrent funding issued in 2023/24 to support trusts to transition PCR capacity to the revised testing protocol will cease. Allocations for the capacity required for the testing protocol have been recalculated based on current demand and will be uplifted to reflect demographic and inflationary growths (see ICB revenue allocation section for detail on the CUF). The general efficiency requirement of 1.1% will also apply against this service. Payments should flow to trusts through the fixed payment element of their API contract arrangements.

165. Trusts continue to be encouraged to maximise value for money through the procurement of non-pay items (reagents, LFD kits, swabs, etc) through existing national framework arrangements.

166. Access to LFD testing for people in the community who are eligible for NICE-recommended COVID-19 treatment and have symptoms will continue to be through the community pharmacy advanced service. For the purposes of planning, ICBs should not include any income or expenditure in relation to this service.

Inflation

167. The NHSPS sets out the basis for the inflation assumptions in the CUF applied to NHSPS payments and allocations, including relevant pay and non-pay assumptions.

Pay reform offers

168. The pay reform offer for the consultant workforce has not been included in the 2024/25 CUF as it is still being voted on.

169. The consultant workforce pay reform offer includes a proposal in relation to Local Clinical Excellence Awards (LCEAs). The proposal states that the contractual entitlement to access an annual awards round will cease from 1 April 2024, with funding redeployed to support the main pay changes.

170. If the pay reform offer is implemented, systems should expect commissioner allocations to be distributed on a fair shares basis, based on national assumptions and with a corresponding increase to the CUF. Therefore, systems will need to locally manage any potential differences between the funding and local cost. Trusts should hold in reserve (and not spend) any funding relating to LCEAs until this position is confirmed. If the deal is implemented and includes ceasing new LCEAs, the fair share funding issued to commissioners would take into account the funding already within allocations for the new style LCEAs. The current national assumption is that the recycling of the funding for the new style LCEAs covers the first 1.5 percentage points.

NHS pension employer contribution rate

171. Government consulted on proposed amendments to the NHS Pension Scheme regulations. A new employer pension contribution rate will be introduced from 1 April 2024 in line with the results of the 2020 scheme valuation.

172. The consultation confirmed that the transitional approach that has operated since 2019/20 for employer contributions will continue in 2024/25. From 1 April 2024, an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply; the NHS Business Service Authority will continue to only collect 14.38% from employers and organisations should plan on this basis. Central payments will be made for the remaining 9.4%.

173. Employers should ensure that their payroll provider continues to apply an employer contribution rate of 14.38% for 2024/25 and therefore no impact from any change in employer contribution rate should be reflected in plans.

Central technology licensing arrangement

174. As in 2023/24, a funding transfer from ICB allocations for trust technology licences will be applied through a separately identified deduction. The transfer will be calculated on the same basis as in 2023/24 as the cost saved by trusts on the licences is now covered by central licensing arrangements. The deduction will be populated in the system planning template. A separate schedule will be issued setting out the associated adjustment that ICBs should make to each trust's API fixed payment value.

External income

Non-NHS commissioners

175. In 2023/24, NHS England issued additional non-recurrent funding to ICBs to contribute to the impact of the pay awards on those parts of NHS trusts' cost base that are funded through non-NHS commissioners (for example, local authorities). For 2024/25, trusts should agree contracts with all non-NHS commissioners based on the appropriate funding for services, including inflationary uplifts for 2023/24 and 2024/25 pay.

Local authorities

176. As part of the 2023/24 public health ring-fenced grant circular, DHSC published 2024/25 indicative allocation values. These values excluded the impact of the 2023/24 pay award, so DHSC has published updated public health local authority allocations 2024 to 2025 to include funding for the recurrent impact of the 2023/24 pay award. For 2024/25, NHS trusts will therefore need to secure recurrent funding relating to 2023/24 through agreed contract values with local authorities.

177. The 2024/25 local authority public health allocations include a 2024/25 assumption for pay in line with the NHSPS. Once government responds to the recommendations of the 2024/25-related pay review bodies, contracts should be updated accordingly.

NHS Wales

178. Contracts between NHS Wales and English trusts should have regard to the NHSPS CUF, appropriate activity growth assumptions and the cost of services funded on a population basis in addition to NHSPS unit prices (specifically in relation to COVID-19 testing services). Similarly, English commissioners using Welsh providers will be expected to fund equivalent uplifts. Payment arrangements should comprise either activity-based payment (based on NHSPS unit prices) or API contracts (including both the fixed and variable elements). 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 and any additional elective recovery activity will be locally determined on an individual commissioner and trust basis.

Chargeable overseas visitors

179. Providers should continue to have regard to the mandatory requirement to collect payment upfront for any chargeable patient not in need of urgent or emergency care, as set out in the DHSC guidance for NHS service providers on charging overseas

visitors in England. Systems should ensure that they have visibility of cost recovery as providers work to improve identification and cost recovery processes, as set out in Service Condition 36 of the NHS Standard Contract.

Cash regime

180. NHS England will issue ICBs with an annual cash drawdown limit as part of the overall group cash mandate.

181. ICB cash drawdown should be for payments required for the month of the drawdown and will continue to be monitored against the cash drawdown requirement (CDR). Accurate cash forecasting remains important as ICBs are encouraged to keep cash balances low but sufficient to cover committed outflows.

182. Commissioners will continue to pay providers on the 15th of the month (or closest working day), which will maintain the efficient flow of cash. The primary method of payment for transactions from NHS commissioners to NHS providers will remain invoice payment file (IPF), with limited use of invoices and payment requests.

183. NHS England expects that trusts will continue to have sufficient cash resource to meet working capital requirements without the need for further cash support. This will support prompt payment for goods and services received. In instances where trusts may need revenue cash support, the principles remain as set out in the DHSC guidance on financing available to NHS trusts and foundation trusts. This guidance confirms that revenue support is available in exceptional circumstances via the issue of public dividend capital (PDC). However, efficient transacting with systems should ensure that requirements are kept to a minimum. Alternatively, within a system where a trust has a revenue or working capital cash need, DHSC can facilitate cash transfers between trusts within that system. This mechanism enables a trust to repay PDC to DHSC. Once repaid, DHSC will re-issue that PDC to another trust. Cash funding transfers must only be transacted via PDC and not made directly between trusts.

Further advice and support

184. Frequently asked questions (FAQs) will be issued on a regular basis to ICBs and trusts through FutureNHS and the Provider Financial Monitoring System (PFMS) portal.

185. For further queries on the financial and contracting arrangements, please contact:

Financial planning process and templates	england.finplan@nhs.net
NHS Standard Contract	england.contractshelp@nhs.net
Provider Selection Regime	psr.development@nhs.net
NHS Payment Scheme	pricing@england.nhs.uk
Elective Recovery Fund (ERF)	england.erf@nhs.net
Revenue allocations	england.finplan@nhs.net
Capital and cash	england.capitalcashqueries@nhs.net

186. For any other query on the financial arrangements, please email england.finplan@nhs.net

Appendix A: Setting the 2024/25 API fixed payment

1. Commissioners and trusts are advised to consider the following guidelines in establishing their 2024/25 fixed payment values for all NHS England arrangements and all ICB relationships with trusts above the low value activity (LVA) threshold.

Item	Guidance
Opening baseline	The opening baseline should be calculated as: • **2023/24 fixed payment value** – this value should not include the value of services on variable terms as defined in the 2023/25 NHS Payment Scheme (NHSPS). It should be adjusted for any non-recurrent and full-year effect items, as well as the items stated in the baseline adjustments section (for example, IFRS 16) • **2023/24 full variable value** – this value should include the relevant proportion of the 2023/24 ERF allocation, which was incorporated into 2023/24 baselines, plus the 2023/24 planned value of chemotherapy delivery, unbundled diagnostic imaging and nuclear medicine Note that this value should not include high-cost exclusions[1] or the 2023/24 value of SDF.
Baseline reset for public health services	The limited public heath baseline contract amendments agreed through the baseline reset exercise must be applied as an adjustment to the opening baseline, such that the funding flows back through the API fixed payment to the trust on a net neutral basis and in line with the processed commissioner allocation adjustments. These adjustments should not result in any additional performance expectations. These values have been pre-populated in planning templates.
Service changes from 1 April 2024	The cost of service changes from the point of setting the opening 2024/25 baseline should be reflected in amendments to the API fixed payment. The value of such

[1] High-cost drugs, devices and listed procedures, and MedTech Funding Mandate products as set out in Annex A of the NHSPS. These are reimbursable outside of API arrangements, which means they are not included in the fixed or variable element.

Item	Guidance
	changes should be locally agreed based on a reasonable phasing of expenditure changes. For elective service changes, the value of any service change should be agreed and adjusted for in this step but will require a consistent and documented locally agreed elective activity target[2] different from the default value published by NHS England.
Growth: activity	Commissioner allocations include growth funding for 2024/25. Agreed levels of growth, including for elective services, should be applied against the opening 2024/25 baseline for relevant intra-system, inter-system and NHS England API arrangements.
Growth: inflation net of general efficiency	By default, commissioners and trusts should adjust the opening 2024/25 baseline value by the cost uplift factor (CUF), general efficiency factor and CNST, as set out in the NHS Payment Scheme, unless a view of inflationary pressures and efficiency requirements has been locally agreed.
Additional allocation funding	**Continued support to underlying capacity recovery** Commissioner allocations include funding to support the existing acute and ambulance capacity as recovery from the COVID-19 pandemic continues. All commissioners will need to reflect this in their API fixed payments value with all trusts providing acute and ambulance services (not just those within their system). The uplift should only be applied to the fixed payment value of the relevant services (for example, acute and ambulance) and not to the total value of the fixed payment where this includes other services. To minimise negotiations and expedite the flow of funding to trusts: • ICB inter-system and NHS England contract arrangements should be uplifted by 0.6% (to the value of the relevant services within that contract).

[2] While commissioner to provider targets can be locally adjusted, the overall commissioner target must remain as defined by NHS England and any service changes should still enable achievement of this target overall.

Item	Guidance
	• For intra-system contract arrangements, systems should work collaboratively to understand local service and cost requirements and flow funding appropriately. **Ambulance funding** In 2023/24, additional capacity funding of £200m was issued to ambulance trusts through their lead commissioner (ICB). For 2024/25, this funding has been recurrently added to ICB core programme allocations on a population basis. This is determined by each ambulance trust's total funding issued to its commissioning ICBs based on the weighted population of the ICBs. A separate schedule has been issued on FutureNHS setting out the required amendments to contracts to ensure that the allocation change has a neutral impact on ambulance trust income. **Other adjustments** Include other relevant allocation baseline adjustments, as set out in the 2024/25 revenue and finance contracting guidance.
Additional efficiency (convergence adjustment)	In addition to the general efficiency factor, additional efficiency ('convergence') has been applied to allocations to move ICBs towards a fair share distribution of resource at the levels affordable within the settlement. This additional efficiency requirement may be applied as a generic additional efficiency to the opening 2024/25 baseline, or targeted to specific trusts for specific efficiency opportunities. • For significant contracts (for example, with trusts in the system or those outside where the relationship is material to both parties), NHS England would expect convergence to be considered in relation to the relative cost of services and addressing situations where services are costing more than is reasonable or justifiable. • Where the contract is small to both parties and the contract is in excess of reasonable levels for the provision commissioned, both parties could agree a

Item	Guidance
	pragmatic solution to apply convergence at the level of the commissioner convergence percentage.
Adjustment to remove the variable payment element	The payment value should then be adjusted to remove the 2024/25 value of variable payment elements, comprising: • 2024/25 variable baseline being the value weighted 2024/25 ERF target of elective activity (as published by NHS England) • 2024/25 planned value of delivering chemotherapy, unbundled diagnostic imaging and nuclear medicine Further information is set out in the elective recovery technical guidance.
Service development funding (SDF)	Having removed the 2023/24 value of SDF to form the opening baseline value, the API fixed payment should now be adjusted to include the confirmed level of 2024/25 SDF funding. This should be identified as the full value in the contracts planning tab, split between mental health and non-mental health service expenditure.

Illustrative example

Item	Calculation	Illustrative value
Opening baseline	2023/24 fixed payment = £175m 2023/24 SDF to be removed = £25m 2023/24 target ERF (variable) = £45m 2023/24 planned chemotherapy = £2m 2023/24 planned unbundled diagnostic imaging = £3m = £175m – £25m + £45m + £2m + £3m	+£200.0m
Baseline reset for public health services	The public health baseline exercise identifies an additional £5m of costs to include in the fixed payment.	+£5.0m
Service changes from 1 April 2024	An agreed change to a commissioned pathway results in an agreed reduction to the API fixed payment of £2.5m.	-£2.5m
Growth: activity	A general assumption of 2% is used for the purposes of this worked example.	+£4.1m (2% of adjusted opening baseline of £202.5m)
Growth: inflation net of general efficiency	Cost uplift factor (CUF) of +1.7% General efficiency factor of -1.1% Appropriate growth in CNST between 2023/24 and 2024/25. The change for each individual trust will reflect its relative risk factors.	+£1.7m (0.6% net CUF of £206.6m plus £0.5m CNST)
Additional allocation funding	Action adjustment to reflect the additional allocation funding items described in the baseline adjustments section, and the 0.6% uplift for acute and ambulance capacity support.	+£7.5m
Additional efficiency (convergence adjustment)	An example level of additional efficiency requirement of -1.2%.	-£2.6m (1.2% of £215.8m)
Variable payment adjustment	Target level of ERF performance plus agreed other variable elements £52m.	-£52.0m
Service development funding (SDF)	Add confirmed 2024/25 SDF values to the fixed payment.	+26.0m

Total fixed payment for 2024/25 = £187.2m