7 January 2022

Briefing - Consultation on 2022/23 National Tariff Payment System and Standard Contract

NHS England and Improvement (NHSE/I) have launched the formal consultation on changes to the national tariff payment system (NTPS) and standard contract for 2022/23. Both consultations opened on 24 December and will run until 28 January. NHS Providers will be responding formally to the consultation surveys for the NTPS and standard contract. We encourage members to take part, both by responding individually, and by feeding back to Olivia.O'Brien@nhsproviders.org.

Key points

- The proposed 2022/23 national tariff payment system (NTPS) will be set for one year. The 2022/23 NTPS aims to provide a straightforward transition out of the COVID-19 block payment arrangements towards a long-term financial system that helps promote integrated care. The 2022/23 NTPS proposals build on the move away from activity-based payment approaches via a blended payment model, known as aligned payment and incentive (API), introduced in the 2021/22 NTPS.
- It is proposed that the API model will apply to all contracts with NHS providers for all secondary care services, including acute, ambulance, community, and mental health providers. Block contracts previously used by mental health and community providers will be replaced with the fixed element of the API. This fixed element will be locally agreed between providers and commissioners, and will fund agreed levels of activity
- The fixed element of API will become the largest single source of funding for systems and will apply to any contracted activity with a total value above £30m.
- Most unit prices published as part of the tariff will no longer be nationally mandated.
- Like 2021/22, a variable payment is proposed for elective activity to support the reduction of the elective backlog. However, for 2022/23 the Elective Recovery Fund (ERF) will be replaced by the variable element of the API. This will enable providers to access additional funding for elective recovery above funding provided via the fixed element.
- For 2022/23 NHSE/I will set the efficiency factor at 1.1%.
- NHSE/I is not intending to make an adjustment to the cost uplift factor to reflect COVID-19 costs. The proposed cost uplift reflects pre-COVID activity, as government funding to address COVID-19 costs will continue to be distributed outside of the tariff.

- To reflect the new requirements set out in the 2022/23 operational planning guidance, NHSE/I proposes to change the content of the national quality standards referenced in the standard contract. These include: a requirement for least 98% of patients in A&E to wait less than 12 hours; amending zero tolerance standard for 52-week RTT waits to 104 weeks; and establishing a minimum 70% performance threshold for the national two-hour urgent response time standard for community health services.

Summary

The aligned payment and incentive approach

The API approach covers almost all activity within the scope of the tariff. The API for the 2022/23 NTPS largely mirrors the approach introduced in the 2021/22 NTPS, being composed of "fixed" and "variable" elements. Updates to the 2022/23 design are detailed below.

Thresholds: NHSE/I will apply the API approach to any contracted activity with a total value above £30m. This is higher than the £10m contract value threshold set for 2021/22, and is intended to reflect the shift towards larger geographies covered by ICBs compared with clinical commissioning groups (CCGs). The total value of activity captured by API agreements is intended to remain broadly the same as 2021/22 For activity below the threshold, NHSE/I encourages local areas to adopt API arrangements. Where local agreement is not possible, payment will be based on tariff unit prices (see section below). Providers and commissioners should also refer to the forthcoming low volume payment arrangements guidance for activity with an annual value below £0.5m (this is higher than the £0.2m threshold in 2021/22).

Fixed element: As with the 2021/22 NTPS, the fixed element of the 2022/23 API approach will involve funding locally agreed activity levels – these will be set at a level that aligns with the system plan. NHSE/I does not set out a mandated method for setting the value of fixed payments for 2022/23, but suggests using block payment values for the second half of 2021/22 as the starting point. Providers and commissioners should consider factors such as: inflation, efficiency, demand for services, other funding for specific services, the expected costs of delivering the elective activity plan, and services changes resulting from the system plan.

Mental health and community providers: API arrangements will apply to all NHS providers, including mental health and community providers. Block contracts previously used by mental health and community providers will be replaced with the fixed element of the API.

Guidance for constructing fixed element: The supporting document, Guidance on the aligned payment and incentive approach, sets out a high-level guide for constructing and agreeing the fixed element. NHSE/I is working on a range of tools and products to help support providers and commissioners develop their fixed elements, such as costed pathways supported by GIRFT, patient-level cost (PLICS) analysis, programme budgeting and population group analysis. Tools and guidance will be published on FutureNHS, however, there is no requirement to use these tools when setting the 2022/23 fixed element. Providers and commissioners who want to agree alternative arrangements to the fixed element need to apply to NHSE/I for approval.

CQUIN: Existing Commissioning for Quality and Innovation (CQUIN) indicators will apply for the 2022/23 NTPS, therefore the fixed element should include the CQUIN funding of 1.25% of the contract value.

Variable element: For 2022/23, a variable payment is proposed - largely for acute trusts - for elective activity to support the reduction of the backlog, for advice and guidance activity and for best practice tariff (BPT) and CQUIN performance. The Elective Recovery Fund (ERF) will be replaced by the variable element of the API. This will enable providers to access additional funding for elective recovery above funding provided via the fixed element. Systems will be required to set out elective activity plans with their providers based on the total funding allocated (both core and elective recovery funding).

NHSE/I proposes the following design for the variable element:

- Elective activity delivered above the level agreed is paid for at a rate of 75% of the national or unit price.
- Activity below the agreed baseline is deducted at 50% of national or unit prices.
- Advice and guidance activity which differs from the amount agreed is paid or deducted via local agreement.
- BPT attainment which differs from that assumed as part of the fixed element means funding is paid or deducted from providers.
- CQUIN indicator attainment less than 100% means payment is deducted from providers, in accordance with CQUIN guidance issued by NHS England.

As with the fixed element, providers and commissioners wishing to opt out of the default variable element design would need to apply to NHSE/I for approval.

National and unit prices for 2022/23

NHSE/I proposes that, as in 2021/22, only unbundled diagnostic imaging services will have mandatory national prices. While for all other services national prices will no longer be mandatory, NHSE/I will continue publishing them. . The 2022/23 NTPS will use the same calculation method as used for the 2021/22 NTPS.

Healthcare resource groups (HRGs) and treatment function codes (TFCs) will continue to underpin unit prices, and will be used for the variable element under API and for activity under the NHS Increasing Capacity Framework). Non-mandatory guide and benchmark prices will be used where the source data is insufficiently robust for national or unit prices, or where the prices are being tested.

Price relativities will be calculated using 2018/19 patient-level cost (PLICS) and hospital episode statistics (HES) data. A step-by-step description of these calculations can be found in Annex DtD: Method used to calculate national and unit prices. NHSE/I also plans to use the same approach to calculating prices for best practice tariffs as used in the 2021/22 NTPS. Detailed guidance on the proposed BPTs for 2022/23 can be found in Annex DtC: Guidance on best practice tariffs.

Cost base and uplifts

Efficiency factor: For 2022/23 NHSE/I will set the efficiency factor at 1.1%.
Cost base: 2021/22 prices and revenue will be used as the starting point for the 2022/23 cost base for both national prices and unit prices.
No adjustment for COVID-19 costs: NHSE/I is not intending to make an adjustment to the cost uplift factor to reflect COVID-19 costs. The proposed cost uplift reflects pre-COVID activity as government funding to address COVID-19 costs will be distributed outside of the tariff.
Inflation cost uplift factor: NHSE/I proposes to set the inflation cost uplift factor at 2.8% for the purpose of calculating prices for 2022/23.

Impact assessment of tariff

The fixed element of the API model is now the largest source of funding that systems can access, and most prices published as part of the tariff are no longer national, mandated prices but are instead non-mandated unit prices.

Unit prices will be used to help inform local pricing of services, and in the determining the variable element under API, though they are only expected to be used to directly pay for around 5-6% of activity covered by the national tariff. However, NHSE/I's quantitative impact assessment

of the tariff revenue distribution assumes that the fixed element of the API will be based on national or unit prices.

Based on this analysis, NHS providers are expected to receive £39.9bn in tariff revenue in 2022/23 - an uplift against 2020/21 of +1.66% for inflation and efficiency. Only £300m in tariff revenue will flow to non-acute trusts. Including expected payment of £1.6bn to independent providers, the total tariff for 2022/23 should be £41.5bn. However, given the uncertainty about how precisely system partners will determine prices, these calculations should be seen as contextual and indicative.

The impact assessment of tariff prices also does not take COVID-19 costs into account. NHSE/I acknowledges the 'simplifying assumption' that there will be no COVID-19 impacts on prices, costs, and activity.

High-cost drugs and devices within API approach

High-cost drugs and devices: Reimbursement for high-cost drugs and devices will reflect the 2021/22 NTPS rules, whereby funding is included in the API element (while some items commissioned by NHS England specialised commissioning are funded on a cost and volume basis). NHSE/I proposes a parity of funding approach (any drug commissioned by NHS England on a cost and volume basis would be funded in this way), and that any commissioner-funded item introduced during the financial year should be paid for on a cost-and-volume basis and therefore excluded from the fixed element.
MedTech Funding Mandate and innovative products: Within API arrangements, items on the innovative products list will be funded by commissioners on a cost and volume basis through the High Cost Tariff Excluded Devices (HCTED) programme. Any additional cost of implementation will be factored into the fixed element.
High-cost exclusion lists: Further to NHSE/I's proposals for the funding of high-cost drugs, devices and innovative products, there are additional proposals for the high cost exclusion lists. Further detail can be found in Annex DtA: National tariff workbook.

Currency design

NHSE/I propose the API approach uses a 'global currency' for the bundle of services within the scope of payment. The tariff rules will determine when this is applied and when individual unit currencies apply. There will be minimal changes made to the currency design for 2022/23. PLICS data will be used to calculate prices for the first time, using 2018/19 data as it is the most recent full year that is not affected by COVID-19. The HRG4+ phase 3 currency design will be used for 2018/19 reference costs to accurately compare changes in prices.

Five new currency areas are in the process of being developed for community services. These include children and young people with disabilities, long term conditions, single episodes of care, frailty, and last year of life. Work is also being undertaken to create a new model for mental health currencies.

National variations

Locally determined prices: For 2022/23, the NTPS will contain two types of local pricing rules: API rules and general local pricing rules. As with previous tariffs, NHSE/I will continue to publish non-mandatory guide prices and currencies alongside the tariff. Two updates will be made for 2022/23, including a requirement for providers and commissioners to consider how any payment approach could contribute to reducing health inequalities.

Market forces factor: NHSE/I will implement the fourth year of the five-year alterations to market forces factor (MFF) values published as part of the 2019/20 NTPS. Any future step will be subject to consultation on subsequent national tariffs.

Top-up payments for specialised services: NHSE/I's proposals include retaining the use of the University of York model and the baseline of the prescribed specialised services (PSS) flags, and continuing with the payment approach for specialist knee revision services introduced in 2020/21. No changes will be made to the PSS identification rules, hierarchy and provider eligibility lists, and the PSS top-up payment rates from the 2021/22 NTPS.

Standard contract

NHSE/I have also launched the consultation on proposed changes to the 2022/23 standard contract. As for the statutory tariff consultation, the deadline for responding to the online survey is Friday 28 January 2022.

Commissioners must use the standard contract for all local contracts for secondary care services. Given the new legal duties on ICBs and partner trusts to deliver financial balance (once ICBs are formally established), it will no longer be a requirement for trusts to sign up to a model system collaboration and financial management agreement (SCFMA).

The provisions of the contract will come into effect regardless of whether Parliament enacts the Health and Care Bill, as expected, before 31 March. As part of NHSE/I's aim of simplifying the standard contract, the contract will now exist solely as an updated online form published by NHSE/I: providers and commissioner are not expected to exchange physical copies of the contract, and should incorporate it into local contracts by reference only. NHSE/I also states it does not expect to

make rolling in-year updates to the general conditions and service conditions in the contract, and that the process for updating the conditions will remain annual (unless there is an urgent need for change).

Changes to national quality standards

To reflect the new requirements set out in the 2022/23 operational planning guidance, NHSE/I proposes to change the content of the national quality standards referenced in the standard contract, including:

- Amending the zero tolerance 30-minute standard for delays in handover from ambulance to A&E – the standard will be raised to 60 minutes, though 95% of handovers must take place within 30 minutes.
- Requirement for least 98% of patients in A&E to wait less than 12 hours.
- Amending zero tolerance standard for 52-week RTT waits to 104 weeks.
- Establishing minimum 70% performance threshold for national two-hour urgent response time standard for community health services

Other changes

Primary care networks: the contract also strengthens the requirements for providers to work with primary care networks (PCNs) and other partners to set up new national care models for out-of-hospital services. Whether providers are expected to deploy additional mental health practitioners wil depend on discussions between NHS England and the General Practitioners Committee (GPC) England.

Green NHS: there are also additional proposed changes relating to trusts' compliance with Green NHS commitments and the use of the NHS e-Referral Service.

Low volume activity flows: new arrangements will be introduced from 1 April 2022 to reduce the transactional costs between commissioners and distant trusts, but these arrangements will not require changes to the standard contract.

NHS Providers view

After two years in which most provider funding has been allocated via block payments, the financial framework for 2022/23 represents a significant move towards the aligned payment and incentive (API) approach, which is set to become the largest source of funding for providers across all sectors. We welcome that NHSE/I has committed to provide additional guidance on agreeing the fixed element of the API, and the detail about how provider sector input fed into the financial framework

design process. NHS Providers will be engaging with acute, ambulance, community and mental health trusts to assess how locally determined price arrangements are working within the context of ICSs.

It is unclear how unit prices will be used in practice by commissioners, or to what extent the contract values will be based on a roll-over of block contracts for 2021/22. Also, given the use of patient-led costing across the provider sector, it is important that community providers and others can access the relevant data to effectively capture costs. More broadly, NHS Providers will monitor local pricing arrangements within systems as they develop over 2022/23.

The operational planning guidance emphasises the need to reduce the waiting list backlog. NHSE/I's proposals for a variable element tied to elective activity may go some way to assure providers that funding is available if additional activity is delivered, though it is too early to determine what role the variable element will play as a potential incentive to increase elective activity.

We welcome NHSE/I's commitment to reducing health inequalities through its proposal for providers and commissioners to consider health inequalities as part of all local pricing arrangements. As mentioned in the document, addressing health inequalities is a key priority for the NHS and a core aim of ICSs. Given the variation in ICS maturity by geographical region, it is important that updates to the pricing principles help enable material improvements in reducing health inequalities.

The feedback we have received to date suggests that providers welcome NHSE/I's proposals to simplify the standard contract, to ensure it is fit-for-purpose, and to minimise the burden and bureaucracy that can be associated with the contracting process.

The changes to the national quality standards reflect the extraordinary pressures across health and social care. The one-year standard contract is not permanent, and therefore it makes sense for it to address the reality that trusts and systems are facing, rather than an aspiration which at least for the time being, is out of reach.

Whilst these changes are a reflection of a welcome sense of realism by NHSE/I, we recognise this represents a dilution of standards that could affect the quality of care for some patients. That goes against the grain for trust leaders, who want to see a longstanding commitment to high quality care, matched by the resources and workforce to deliver it.