2022/23 finance and payment engagement – mental health, community and non-acute

Please access www.menti.com and use code: XXX

NHS England and NHS Improvement

About this workshop

- The session involves a series of short presentations and questions.
- The content of the workshop focuses on policies being considered for 2022/23. We will not be discussing the financial arrangements for the rest of 2021/22.

Please note: What we are sharing here are policies in development. They are not final and will be subject to change as we continue to receive feedback, both internally and externally, and undertake further work.

Giving feedback

NHS

- The purpose of these events is to help you understand the work we are doing on developing the 2022/23 payment system and also discuss other aspects of the potential financial environment in place from April 2022.
- To give your feedback **during the event**:
- Please access Menti on another browser or device to respond to the questions.
    - Use the Teams chat for comments or questions, or raise a (virtual) hand.
    - A number of Menti questions include an ‘Other’ option. If you select ‘other’, please add your option to the chat.
    - Please do ‘Like’ other people’s chat messages if you agree with the point or option. Responses to messages in the chat will form part of our feedback analysis.
    - We particularly welcome any comments in the chat to explain the reasons behind the answers to questions in Menti.
- **After the event**, we welcome responses to our online survey, which closes on 1 October.
- You can also email any thoughts, comments or questions to: pricing@england.nhs.uk.

Tariff development timetable

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

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

Introduction and context

NHS

- Policies being considered for 2022/23 are shaped by three important contexts:
  - **COVID-19** – in particular, the NHS response to the pandemic, the financial arrangements implemented as part of that response, and now the need for NHS financial architecture to support recovery and address the backlog
  - **The Health and Care Bill** – central to the legislation is Integrated Care Boards (ICBs) being established as statutory bodies, crystalising the shift from competition to collaboration as the key driver of improvement for the NHS
  - **The NHS Long-Term Plan** – continues to be the plan that we are working to. This includes the LTP commitment to payment system reform and moving away from activity-based payments to ensure a majority of funding is population based.
- We are also working to ensure that health inequalities are carefully considered in all our work, and the policies we will choose to propose.
- The material presented here has been developed by the Pricing and Costing team in collaboration with colleagues from across NHS England and NHS Improvement Contracting and Strategic Finance teams.

Financial considerations for 2022/23

Health and Care Bill

NHS

► Integrated Care Partnerships

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

► Integrated Care Boards

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

► NHS England

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

Health and Care Bill

NHS

► Other relevant clauses & financial duties

- NHS England, Integrated Care Boards, NHS trusts and foundation trusts would be required to have regard to all likely effects of decisions in relation to the **Triple Aim**
- NHS England could impose **capital expenditure limits on foundation trusts** for a defined period, which would be published after consultation
- NHS England, Integrated Care Boards, NHS trusts and foundation trusts have a new power to allow any **functions to be exercised by or jointly with any other statutory bodies or local authorities.**
- NHS England could publish **guidance on joint appointments** between Integrated Care Boards, NHS trusts, foundation trusts and local authorities, which the relevant NHS body must have regard to
- NHS England would have new powers to set **rules for the NHS payment scheme**
- New **joint financial duty** on the Integrated Care Board and its partner NHS trusts and foundation trusts to ensure they collectively exercise their functions in a way that **does not consume more than their agreed share of NHS resource**
- NHS England has increased power over capital and revenue **resources including how they should be allocated locally and between integrated care boards**
- The Bill would also **strengthen the duty on NHS bodies to cooperate**,
- On many if not all of the issues above NHS England will be required to produce guidance

ICB Financial Framework

NHS

► Transition to ICB allocations

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

ICB Financial Framework

NHS

► Transition to ICB allocations

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

	2021/22	2022/23	2023/24
Primary medical	Delegation		
Dentistry	National	Agreed delegation or joint committee	Delegation
Ophthalmology	National	Agreed delegation or joint committee	Delegation
Pharmacy	National	Agreed delegation or joint committee	Delegation
Public health	National	To be confirmed	
Health and justice	National	To be confirmed	
Armed forces	National		

Functions retained by NHS England nationally:

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

ICB Financial Framework

► Managing ICB NHS resources at place

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

► Managing ICB NHS resources at scale

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

- **2022/23 is about developing partnerships and 2023/24 should see deeper collaboration and more formal arrangements**

ICB Financial Framework

- FutureNHS will host the latest materials produced by NHS England to support ICBs. Register on http://future.nhs.uk and join the ICB Guidance workspace: http://future.nhs.uk/ICSGuidance/grouphome

► Recent

June 2021	ICS Design Framework	Future ambitions for ICBs
June 2021	Guidance on the employment commitment	What commitment means in practice
July 2021	NHSE direct commissioning functions	Confirming plans for 2022/23 and beyond
August 2021	Guidance on provider collaboratives	Minimum expectations for providers working together
August 2021	ICB functions and governance	Expected governance requirements for ICBs
August 2021	HR framework to support people change	National policy ambition and practical support
August 2021	People function and operating model	Builds on the priorities set out in the People Plan
August 2021	ICB Readiness to Operate Statement	Template for ROS and accompanying checklist
August 2021	Due Diligence guidance	Due diligence process underpinning legal transfers
September 2021	Guidance on place-based partnerships	Place-based partnerships as part of ICSs
September 2021	Guidance on involving people and communities	Listening to, and acting on, local people's experiences and views
September 2021	Guidance on professional and clinical leadership	Supporting clinical and care professional leadership across ICSs
September 2021	Guidance on ICB and VCSE sector	How to embed VCSE partnerships in ICSs

► Key documents soon

Supporting information on managing ICB resources
ICB financial governance guides

Contracting

NHS Standard Contract

NHS

- Under the Health and Care Bill, ICBs will continue to act as commissioners, paying different (NHS and non-NHS) providers to deliver healthcare services. So there will still be contractual relationships between commissioners and providers.
- As such, we expect that NHS England will continue, by publishing the NHS Standard Contract, to mandate core terms for such contracts at national level, with local content being agreed between ICBs and providers locally.
- But we are keen to think through how the NHS Standard Contract may need to evolve, in order to remain fit-for-purpose in an ICB world.
- The precise timescale for introduction of statutory ICBs will be driven by the progress of the Bill through Parliament – but the current expectation is for establishment from 1 April 2022.
- We want to try and minimise the burden and bureaucracy which can be associated with the contracting process – and we are interested in your views on appropriate ways of doing this.
- We are also keen to gather views on the timing of any significant changes to the Contract.

Menti question

Costing

Progress on patient-level costing

NHS

- A patient-level cost collection allows for detailed information that can then be used to:
  - evaluate new models of care for better decision making internally and externally
  - allow for better benchmarking with other providers
  - improve reporting aspects for identifying efficiencies and improved links to other activity identifiers such as health inequality.

The Costing Transformation Programme has been progressing well:

- The **patient-level costs (PLICS)** acute collection has been mandatory since the 2018/19 financial year. Ambulance and mental health patient-level data was made mandatory in 2019/20 (ambulance is collected at incident, rather than patient level). Community will be mandated for the 2021/22 financial year.
- For 2019/20, approximately **5 billion rows of costing data** was collected.
- Data is collected through NHS Digital, who consistently pseudonymise the patient record so we are able to link between years and care settings. Cost data is linked to Hospital Episode Statistics (HES) for acute. For mental health and IAPT we link the data to their minimum data set (MHSDS). This adds many patient fields that we are able to transform the data by, including: postcode, GP code and overseas visitor charging category.

Using cost data – available tools

Products	Acute	Mental Health	Ambulance	Community
Data validation tool*	Published	Published	Published	Published
In-collection data quality tool	Published	Published	Published	Published
Post-collection data quality tool	Published	Published	Published	Expected early 2022
PLICS portal	Published	Published	Published	Expected early 2022
ICS dashboard	Expected early 2022	Expected early 2022	Expected early 2022	Expected early 2022
Self-service platform	Expected late 2021	Expected late 2021	Expected late 2021	Expected late 2021

*Pre collection validation tool used by the submitting trusts to validate that data is in the correct format.

You can sign up to access these tools via: https://apps.model.nhs.uk/

Note: Different organisations have different product availability

What does the future hold?

- It is expected that PLICS data will support system comparison (Place/ICS/Region, etc.)
- Data on fixed/semi-fixed/variable is about to be collected on a voluntary basis, with mandatory collection likely to be a year later after a period of review and feedback
- There is currently information at patient level for place. As ICSs become more established this could pull through from HES.
- More of the costs still collected at an aggregate level will be moved into the patient-level collection
- A 'self-service' portal is currently being investigated so that users can generate their own reports.
- We are also undertaking a project to consider more frequent cost collections in the future and what the implications and practicalities of it might be.

- The costing team are also working on with colleagues on **programme budgeting** and **PLICS analysis** products, which are discussed later.

2022/23 tariff: context

Context

NHS

- The block payment funding arrangements brought in at the start of the pandemic are **expected to be in place for the remainder of the 2021/22 financial year**.
- Proposals for the 2022/23 payment system are intended to **smoothly transition out of these arrangements,** while also making progress on developing **the payment system to suit the evolving NHS landscape**.
- Our starting point for 2022/23 is the 2021/22 tariff and, in particular, the **aligned payment and incentive blended payment rules**. However, as they are unlikely to have been used in practice, we want to explore them in detail again as we develop our proposals for 2022/23.
- We're anticipating **setting the national tariff for one year – 2022/23.** We feel that there is too much uncertainty for to set it for longer. However, we do intend to set out the future direction for the coming years.
- In addition, if the Health and Care Bill passes through parliament, there would be some **changes to the legislation** underpinning the NHS payment system. We would expect this to be reflected in the payment system put in place for 2023 onwards.

2022/23 tariff: blended payment

Blended payment in 2022/23

NHS

- Aligned payment and incentive (API) is a type of blended payment, introduced for 2021/22. For 2022/23, we are considering continuing with the API blended payment model, involving:
  - providers and commissioners locally agreeing a **fixed element** to deliver an agreed level of activity
  - a **variable element** to reflect quality of care (best practice tariffs and CQUIN) and address deviations from planned elective activity levels used to set the fixed element.
- API arrangements would **cover almost all secondary healthcare services**, including acute, community, ambulance and mental health.
- **All NHS England Specialised Commissioning would be covered by API blended payment (regardless of value).** The detail of this is being drawn up by NHSE/I and we will ensure this aligns with the final payment rules and guidance.
- Should it continue, contracts under the **Increasing Capacity Framework agreement for elective activity** would again be excluded from the API blended payment.

Blended payment in 2022/23

- The API approach would apply to all contracts for secondary healthcare services between a commissioner and providers **who are members of the same ICS**.
- For providers and commissioners in different ICSs:
  - API would apply to all commissioned activity **above a contract value threshold**.
  - Payment arrangements for contracts below this threshold would be **determined by agreement** between the commissioner and the provider. Where agreement cannot be reached, we are considering whether unit prices published as part of the tariff should continue to be the default approach, on a payment by activity basis.
- As with 2021/22, national prices would be set for unbundled diagnostic imaging services.

Menti question

Blended payment threshold

- In the 2021/22 tariff, the contract value above which API would apply (for organisations in different ICSs) is set at **£10 million**. This aims to ensure that the majority of services, by value, are subject to API, while limiting the number of such agreements required.
- With the move to ICS-level commissioning, **this threshold value needs to be reassessed**.
- For 2022/23, we are considering two options:
  - **A £10 million threshold**. This maximises the scope of API and means there is no policy change from 2021/22.
  - **A £30 million threshold**. This, broadly, retains the same level of contract value as 2021/22. It also keeps a significant level of funding locally determined and simplifies things for specialist trusts and independent sector providers.
- Our analysis shows that **there is relatively small difference between a threshold of £10 million or £30 million**, with around £2bn and 100 contracts moving from the scope of API were the higher threshold used.

Menti question

Low-volume activity

NHS

- To reduce the level of invoicing and associated transactional burden in the NHS, we are working with colleagues on potential arrangements for payment of contracts for low volume activity. We are considering introducing the arrangements for contracts **below an annual threshold of £0.5 million**.
- We previously consulted on an approach involving payments being made by host commissioners, with adjustments made to respective allocations. We have considered the feedback from this consultation and revised the proposals in response.
- For 2022/23, the low volume activity arrangements would involve providers being paid a set amount for activity below the threshold, reducing the costs and burden of processing low-value invoices. The amounts paid would be based on the best available information, although the exact process for deciding them is still being established. In setting the method, we are prioritising simplicity and minimising any associated burden.
- Initially, the focus would be NHS acute services, but the same approach could also be applied to other providers where agreed.

Menti question

Fixed element

NHS

- The fixed element is the **key component of API** and comprises the majority of funding.
- The value of the API blended payment **fixed element would be agreed between an individual commissioner and an individual provider.** For NHS providers, we would expect the starting point for discussion to be based on the agreed costs of delivering a level of activity which conforms to the ICS system plan.
- We are planning to highlight a range of tools and products which can **help the construction of fixed elements,** based on different local priorities and methodologies.
- We are considering how some items **previously excluded from national prices** should be best included in the fixed payment (if at all).
- For high cost drugs and devices (HCDD), we are considering continuing with the arrangements used in 2021/22 block payments. This would involve:
  - Including funding for HCDD commissioned by ICSs, and certain other specialised drugs funded by Specialised Commissioning, in the API fixed element.
  - Funding the majority (by value) of other specialised HCDD on a cost and volume basis.
- We are considering how to ensure payment policy, and associated guidance, encourages the use of NICE-approved innovative products covered by the MedTech Funding Mandate. For more details, please join our 'Innovation and the MedTech Funding mandate' session on 29 September.

Variable element

NHS

- The API blended payment model contains a **variable element.** Variable elements can be used to deliver specific policy priorities.
- For 2022/23 we are considering whether to use the same design as 2021/22, in which the variable element:
  - **adjusts the fixed element by +/-50% of unit prices for elective activity** above or below what was agreed
  - reflects achievement of best practice tariff (**BPT**) criteria which is different to what was agreed in setting the fixed element
  - deducts payment for any **CQUIN** criteria not met.
- Local areas can agree to change the design of the variable element, but any proposal to reduce the level of adjustment below 50% **needs to be approved by NHSE/I**.
- The initial variable element design focused on supporting elective activity. We are considering whether it might also be helpful for a locally agreed variable element to be used for non-acute services in future years.

Menti question

Risk sharing

NHS

- Given the **expected uncertainty next year**, we are considering how the variable element could be used to help share risks over the year.
- For example, a similar approach to elective activity could be **employed in different areas and circumstances**. This could mean providers and commissioners agreeing in advance how a variable mechanism would distribute a contingency fund triggered by a localised COVID-19 outbreak.
- The powers granted to ICSs could also be leveraged, with systems drawing on the requirements around financial envelopes **to manage and jointly own risks and uncertainty**.
- To date, system financial management has relied on **voluntary** collaboration between CCGs and Trusts. For example, using the **System Collaboration and Financial Management Agreement** (SCFMA) – locally completed, based on a national template, committing the local NHS bodies to a partnership approach, with open-book working and "best for system" decision-making.

Menti question

2022/23 tariff: prices and other policies

Setting tariff prices using PLICS

- The last time tariff prices were fully recalculated, using new cost and activity data, was in 2019/20 (using 2016/17 reference costs). For the 2020/21 and 2021/22 tariffs, these prices were rolled over, with efficiency and inflation factors applied.
- For 2022/23, we are considering recalculating prices using more recent activity data. As reference costs are no longer collected, this would mean using the **national cost collection patient-level cost (PLICS) data**.
- We are considering using **2018/19 PLICS data**, as this would allow a full year's worth of data, unaffected by Covid.
- Analysis suggests that the level of change in the prices is similar to the variation seen when updating cost and activity data in previous years. This suggests that the change in data itself is the biggest factor in changing price relativities, rather than the move from reference cost to PLICS.
- For more detail about the changes to the method, and the impact, see the 7 September webinar, Setting tariff prices for 2022/23.

Market forces factor

NHS

- The market forces factor (MFF) estimates the unavoidable cost differences between healthcare providers.
- In 2019/20, the data and calculation method for the MFF were updated. The data had not previously been updated for almost ten years. The resulting changes are being introduced over a five-step glidepath.
- The 2021/22 tariff moved to the third step of the glidepath. For 2022/23, we are considering three options:
  a. **Making no changes to MFF values** – maintaining the MFF values used in the 2021/22 tariff (step three of the 2019/20 MFF glidepath).
  b. **Moving to the fourth step of the 2019/20 MFF glidepath** – a similar change as the 2020/21 to 2021/22 tariffs as the glidepath operates in equal steps.
  c. **Updating the data used to calculate MFF values** – implementing a new glidepath if needed
- Analysis of the MFF values produced by the updated data indicates that some providers' values, including some in London, would change in the opposite way to the glidepath. However, as the time since the last update is relatively short, the changes are smaller than those in the 2019/20 update,

MFF options

Option	Pros	Cons
A – hold at step 3 of current glidepath	Avoids uncertainty and potential volatility. Ensures organisations do not move in opposite direction to that indicated by data update.	MFF values do not progress towards target, extending the length of the glidepath.
B – move to year 4 of current glidepath	MFF moves closer to target values. The change may be expected by stakeholders.	Increased risk MFF values deviate from underlying data, requiring bigger changes in the future. Analysis suggests that the glidepath may move some providers' MFF values in a different direction to updating the underlying data.
C – update the underlying data for the MFF and create a new glidepath if needed	MFF reflects more recent available underlying data. Uses 2019/20 datasets. 2020/21, and likely 2021/22, datasets will be impacted by COVID-19 and may not be suitable to use in an MFF update. May not be possible to update data for some time. Update results in smaller impacts than the 2019/20 data update.	The underlying data is from 2019/20, so would not capture the impact of COVID-19 or Brexit. Creating new MFF values could create uncertainty in the challenging times of COVID-19 recovery. Changing an active glidepath could reduce trust in the stability of future glidepaths.

Menti question

Policies with minimal changes

NHS

There are a number of policy areas where we are either expecting to make no change for 2022/23, or are planning to update in the same way that we have done in previous years.

- **Cost adjustments (inflation, efficiency, cost base)**. We would work with colleagues from across finance to review these factors to be included in the final tariff. These will not form part of the engagement.
- **High cost drugs and devices excluded from tariff prices.** We will be reviewing nominations for changes to the high cost drugs and devices lists and discussing changes with expert steering groups. This is separate to questions about the items to be included in blended payment fixed elements.
- **Specialist top-ups**. We would keep the specialised services transition path on hold at 50%. The path was introduced following the 2017/19 tariff move to prescribed specialised services (PSS) designation of specialised services. We would also use the same top-up payment rates and PSS identification rules.
- **CNST**. We would continue to make adjustments to prices to reflect CNST contributions in the same way as previous years.
- **Centralised procurement**. We would again remove £204m from commissioner allocations, with tariff prices lowered accordingly, to fund overhead costs of SCCL.

Longer-term projects

NHS

- Relevant updates to the **payment system in the Health and Care Bill** include:
  - Changing the name from 'National tariff payment system' to 'NHS payment scheme'.
  - Increased flexibility for setting prices, both as a formula and to apply differently in different circumstances. This would support a longer-term tariff.
  - Removing emphasis on competition, including local modifications and references to CMA.
  - Allowing pricing rules to be set by reference to status of provider (eg NHS/public/private/charity).
- We are exploring options for reforming **clinical negligence scheme for trusts (CNST)** contributions and NHS payments to create **stronger financial incentives** for NHS providers to **reduce clinical negligence costs**, while recognising the costs that are reasonably unavoidable due to historic claims.
- We are working with Department of Health and Social Care and Health Education England on **tariffs for education and training**. There is likely to be further engagement on this later in the year.
- We are also running a project looking at how the move away from activity-based payment may adversely affect the **quality of coding of clinical activity**. This will identify metrics for monitoring coding quality and observing trends across recent years. The metrics could then be monitored regularly, with feedback provided to concerned stakeholders.

Supporting the fixed element

Supporting the fixed element

NHS

- As the fixed element makes up the largest proportion of funding, it should be set using the best possible national and local intelligence. We intend to provide a **range of products and tools** to support systems to **develop and adjust the fixed element**.
- To support continuity for 2022/23, we expect the starting point for setting fixed elements would be **similar approach to that used for 2020-22**. Local adjustment could then be made using the guidance, tools and intelligence described below.
- We are looking to **iteratively refine, evaluate and develop** these products as required over future years. This will increasingly support systems to adapt and, where necessary, fully rebuild fixed payments to meet their population's needs.
- In 2022/23, some products may initially be made up of qualitative materials, links and guidance. However, we intend to offer more developed interactive products in future.
- We are seeking feedback on our initial product proposals, both as part of this session and on the **1st October session: Products to support fixed payments.**

The products

NHS

Costed pathways supported by GIRFT	Programme budgeting	PLICS analysis	Population group
• From a range of medical specialities • Used for benchmarking	• One of the best opportunities to understand how resources are used across a system	• Rich benchmarking information • Detailed information on cost structures	• Move towards commissioning based on population need

With a range of options available to build the fixed payment locally, each of the products are intended to support providers, systems and commissioners explore different ways to build their fixed payment

Programme budgeting

NHS

- The Costing Team are working to re-establish the publication of programme budgeting as it is the NHS's best opportunity to understand how resources are utilised across a system.
- Programme Budgeting is a central tool that can support setting fixed payment.
- Programme budgeting gives systems and providers the chance to identify and analyse their **whole costs across the system** which may support the establishment of baselines for budgets.
- Programme budgeting allows for benchmarking against relevant peers with more specific additional benchmarking functionality planned.
- For 22/23 we would be looking to produce some **commissioning guidance** to present options for how the product could be used to develop fixed payments within systems.

PLICS analysis

NHS

- Patient-level costs (PLICS) can provide rich benchmarking information and give systems more detailed analysis of their cost structures.
- Payment is increasingly focusing on cost as the foundation to develop the fixed element, from which PLICS provides a rich source of data across NHS services.
- The costing team are working to develop a range of products that will enable users to make better use of the available PLICS information, including an ICS dashboard and a self-service portal.
- We can provide supporting guidance detailing how to use the PLICS information to understand the cost base of each provider and to support the commissioning of service transformation via the fixed element allocation
- To inform the nature of this guidance and the future of the fixed element we are interested to get your views on how to develop PLICS into the future.

Menti question

Costed pathways supported by GIRFT

NHS

- Supported by GIRFT clinicians, the Pricing and Costing team are working to produce some **costed pathways** from a range of medical and surgical specialties
- The purpose of the product is threefold:
  - To support systems to either set or spend their fixed payment efficiently.
  - To support providers to **benchmark** against a cost range for an efficient pathway.
  - To **NOT** provide a pathway price.
- The focus of the pathways have been on **high volume, low acuity** patients and aims to support and cost the **whole system** where possible.
- Engagement is planned with a wide range of clinical, provider and commissioning stakeholders.
- The 1 October session will include a deep-dive into the **cataracts pathway**, including the methodology used and its potential application.

Population group analysis

NHS

- As systems continue to assess the needs of their population, the payment system can support transformation towards a commissioning model focused on patient need.
- There is demonstrable value to systems by analysing data from a subset of their population and commissioning more efficient models of care.
- This would then support the fixed element, by providing analysis on a sub-set of the population, assessing their need, cost, resource use etc.
- Colleagues at NHSE/I are looking at national data and local case studies in order to draw out value adding information including a segmentation model, learnings from case studies, and how to scale to a whole system approach.
- For development in future years, there is an opportunity for us to develop models and dashboards that support financial analysis of population groups, including aligning to Model System and Bridges to Health.
- The 1 October session will include examples of how population group analysis can support the fixed element, as well as seeking feedback on future developments.

Products supporting mental health

MHIS (modelling, reporting, benchmarking	Population Group Analysis	PLICS analysis / Currencies	Programme Budgeting
• LTP Analytical tool model of MHIS spend • NHS Mental Health Dashboard • Spend per head benchmarking / finance planning analysis	• Move towards commissioning based on population need • PHE modelled MH population need at local level • MHSDS activity information	• Initial/experimental information on cost structure and benchmarking • Adult MH currencies are currently in development	• Helps understand how resources are used across the whole health system

In addition to the products already discussed, we are also considering how products can help support mental health services

Products supporting mental health

NHS

Mental Health Investment Standard (MHIS) spend – Modelling, Benchmarking, Reporting

- The LTP Analytical tool provides modelling of spend required by ICS to meet MH objectives set out in the LTP tool. Note that LTP objectives do not fully address the treatment gap.
- Finance planning provides systems with required spend breakdowns to meet LTP objectives
- Finance planning analysis provides spend per head benchmarking in MH programmes.
- The NHS Mental Health Dashboard shows total mental health spend at system level.
- Reports on how much money systems have been allocated to deliver the NHS LTP e.g. increasing access to CYP MH services, or developing CMHTs.

Population Group analysis

- Public Health England are in the process of developing models to predict the levels of mental health need of local populations. Data for certain conditions has already been published on Fingertips.
- Data in the Mental Health Services Data Set (MHSDS) can also be used to inform understanding of levels of need, although it only portrays access to services rather than truly representing need.

Products supporting mental health

PLICS

- Mental Health PLICS are being refined to provide more detailed MH costing information

Mental Health Currencies

- We are in the process of developing five adult mental health currency models, for five distinct mental health populations.
- We have identified a data-driven approach (using the MHSDS) to allocate service user to currency units, which will ultimately result in burden reduction for clinicians

Phase 1
2021/22

Develop a data-driven approach to group patients into the 5 currencies

Improve data collection and start analysis for the 5 currencies

Phase 2
2022/23

Identify and implement a data-driven-approach to group service users into the complexity groupings, and start associating costings

Phase 3
2023/2024

Full model to be implemented and reviewed

Support the system in the transition to the new AMH currencies model

Menti question

Mental health considerations

Mental Health Investment Standard (MHIS)

- Due to the treatment gap, and historic under-investment, MH funding remains ringfenced via the Mental Health Investment Standard (minimum investment required), protecting and growing investment at a rate that aligns with credible workforce growth.
- Even areas that are performing well in the MHIS and in activity metrics are likely not meeting the mental health needs of their local population. Systems should retain a strong focus on where they direct investment, ensuring it deliver NHS LTP commitments and closes the treatment gap.
- Due to persistent under-investment in LTP mental health services, where data has been poor, we will consider potential changes to the MHIS to ensure delivery of key LTP commitments (eg core community MH spend).
- In the longer term, a new currency model will help local areas understand how to pay for activity to reflect costs of providing care to their population.

Menti question

Provider Collaboratives in Mental Health

NHS

- The NHS has committed to manage all appropriate specialised mental health, learning disability and autism services, through NHS-led Provider Collaboratives by 2023/24.
- The shifting system architecture provides a significant opportunity to embed the roles of Provider Collaboratives in ICSs to take on the 'commissioning' function for mental health and learning disability and autism, including the management the MHIS-compliant budget.
- We understand that 16 systems plan to implement Provider Collaboratives across the whole mental health pathway from 1 April 2022. This will enable a new approach of whole mental health pathway commissioning (from community to specialised services).
- This is happening thorough a number of approaches depending on the local landscape. The National Mental Health team is keen to understand and support these plans.
- Provider Collaboratives will enable transformation at scale and local place-based partnerships which see joined-up decision making across primary care, physical health, mental health and social care.
- Assessment of the readiness of each system to adopt this approach is underway through joint work with regional teams. We expect that a series of 'frontrunners' to go live from April 2022 with other systems starting to operate in shadow form.

Menti question

Discussion points

- **How can NHSE/I support ICSs and the wider system to ensure that Mental Health funding is grown in line with population need and is appropriately invested/is not spent on low quality care?**
- **For many mental health conditions, services currently see less than 50% of patients who need care. How can we ensure that local systems understand the steps they should take to address the unmet treatment gap?**

Community currency development

Developing currency models for community providers

- The Pricing and Costing Team are developing population and needs based currencies for a range patients being supported by community care.
- We want to understand the whole patient, rather than specific aspects of their care. This will involve multiple models which, when combined, allow understanding of a patient's overall need and complexity.
- We expect this to add value to systems by providing an enhanced understanding of community-based costs, as well as patient pathways, by linking currency data sets to PLICS.

Challenges to address

- Interoperability with primary care, social care etc.
- Developing currencies which can be used as building blocks for PHM approaches.
- Ensuring clinical relevance is not lost when developing new approaches to currency models.
- Ensuring patient groups are not missed or excluded within population-based models.
- Ensuring accurate costs can be assigned to the currencies.

Developing currency models for community providers

Children and Young People (CYP) Patient Populations

- A model for CYP with disabilities is being tested currently, however this model also has applications for a wider group of patients, including those with Long Term Conditions. In 2022/23 we will test these applications and also consider linkages with mental health.

Adult Patient Populations

- **Frailty and Last Year of Life (End of Life)**
  These two currency models were consulted on last year and testing continues. In 2022/23 we will continue testing, applying these currencies within systems to understand their value within planning and clinical settings.

- **Long Term Conditions and Single Episodes of Care**
  Development of these models is ongoing and we expect to begin testing models in 2022/23. We are considering how supported self management assessments will combine with needs measurement models to form a useful currency model.

- **Other Population Groups**
  We are aware that these currencies will inevitably not capture all care and we continue to consider other groups for future development.

We welcome support with this currency development. Please contact: Gary.Stinson@nhs.net

Menti question

Implications for ambulance services

Background

NHS

- In 2019/20, the national tariff specified four currencies for ambulance services:
    1. Urgent and emergency care calls answered
    2. Hear and treat/refer
    3. See and treat/refer
    4. See, treat and convey

- None of these currencies had a national price and so the prices needed to be locally negotiated, using the local pricing rules, including:
    - Rule 10: Quality and outcome indicators must be agreed locally and included in the commissioning contracts covering the services in question.

- Commissioning footprints remain as they have been for a number of years.

Ambulances – implications of potential blended payment

For the 2021/22 tariff, and potentially 2022/23, it is important to note the following points:

- Local pricing rule 10 has been incorporated within local pricing rules 1-3.
- Currencies remain (as per 2021/22: Calls answered; Hear & Treat; See & Treat; See, Treat and Convey) but are not directly linked to payment unless locally agreed.
- Activity and cost continue to be recorded using existing currencies.
- Most ambulance services would be above the blended payment threshold and so use the API arrangements, with the majority of funding fixed.
- Fixed payments are more closely aligned to the fixed cost structure of ambulance providers.
- Ambulance commissioning may be an area of more limited change initially.
- We are aware of conversations as to the future of ambulance footprints.
- Aligning the payment approach with that of acute should support parity and effective risk sharing.

Future payment system (2023+)

Future payment – work priorities

Future payment implementation	• Evaluation • Direct support and learning from PHM pilots • Scale and pace-setting
Whole system blended payment	• Fixed element design • Variable element design and risk/resource sharing
Direction of travel	• Principles of future payment • Place and collaboratives • Long Term Plan (and post-LTP) objectives • Products to support payment implementation
Data infrastructure	• Data quality • Data coverage and linkage • Co-ordination

Payment system development

Historic	Current	Future
Detailed specifics	High level / macro	High level framework
Based around published prices	Provide a default approach	Potential more specific defaults
Mandated (but not enforced)	Flexibility on implementation	Question on flexibility

Any questions?

Further discussion sessions:

- 29 September, 11am-12pm: **Innovation and the MedTech Funding Mandate**
- 30 September, 3-4pm: **Whole system payment – from place to board and for all sectors**
- 1 October, 11am-1pm: **Products to support fixed payment**

You can also contact us on **pricing@england.nhs.uk**