Classification: Official

Publication reference: PR00021

NHS England

Revenue finance and contracting guidance for 2023/24

27 January 2023

Contents

Introduction

1. This document sets out the revenue and contracting frameworks for 2023/24 (1 April 2023 to 31 March 2024), and should be read in conjunction with the 2023/24 priorities and operational planning guidance and the capital guidance for 2023/24.

Financial planning process

Planning

2. Integrated care systems (ICSs) will continue to be the key unit for financial planning purposes. NHS trust and foundation trust (referred to collectively in this guidance as trusts) resource use is individually fully mapped to a single system. Each trust's planned financial positions should only be included in that system's plan and reflect the contract arrangements agreed with commissioners outside the system its resource use has been mapped to. As set out in the finance business rules, all integrated care boards (ICBs) and systems have a breakeven requirement.

3. Each plan template cover provides a link to anticipated updates to the template and links to the technical template and submission guidance.

4. The system plan submission will be the source of information for ICB budget uploads, and for trust income and expenditure, bottom line performance and capital.

5. Trusts will continue to be required to submit organisational plans and these plans must be in line with their system's submission, including for the key categories listed above. Where trust plans are not consistent with their system's position, the trust and system returns will both be rejected, and their alignment and immediate resubmission requested.

Reporting

6. Final plan submissions will form the basis of in-year financial monitoring. Plan templates will collect a monthly profile of key data to facilitate in-year monitoring.

Revenue allocations

Overview

7. This section provides the key messages on the following funding components:

   - baseline reset
   - ICB programme allocation
   - ICB elective services recovery funding
   - ICB primary medical care allocation
   - ICB running cost allocation
   - other primary care services
   - specialised services
   - other NHS England directly commissioned services
   - Service Development Fund.

8. ICB allocations are published alongside this guidance, with supporting technical guidance that includes detail on the construction of allocations.

9. The allocation tool that supported systems to understand relative need in different places for 2022/23 has been updated for 2023/24 and 2024/25. This tool can help ICBs allocate budgets at place or service level, and target NHS resources towards reducing inequalities.

Baseline reset

10. In response to the COVID-19 pandemic, the NHS adopted emergency payment arrangements from the start of 2020/21. Those arrangements included the establishment of nationally calculated block payments, with the balance of funding to support system breakeven issued as a 'system top-up' through a host clinical commissioning group (now ICB) for each system. As a consequence, although individual trusts received the totality of funding available either through their individual contract arrangements or system top-up flowing from their host ICB, funding did not necessarily flow to the trust from the appropriate responsible commissioner (ICB or NHS England). To address this issue, a short exercise was run during 2022/23 to correct material issues with contract values and allocations.

11. The outcome of this exercise has been used to adjust 2023/24 allocation baselines and underpinning convergence trajectories. All final changes must be taken into account when setting 2023/24 contract values, such that the funding does flow back to the trust as intended. To assist with this, 2023/24 contract schedules in the planning templates will be pre-populated with the final adjustments.

12. Subject to local agreement, any material changes can be requested through the in-year allocations transfer process and will be processed on a net neutral basis; however, these will not flow into the current calculation of distances from target and convergence adjustments.

ICB programme allocation

13. The allocations methodology continues to move systems towards a fair share distribution of resource at the levels affordable within the settlement.

14. ICB programme allocations are based on:

    - **Baseline adjustments** to reflect recurrently the:
        - Outcome of the baseline reset.
        - Full-year impact from the change in the employer national insurance contribution rate.
        - Transfer of GP improving access funding to the ICB primary medical care allocation (this only affects some ICBs).
        - Transfer of COVID-19 system funding, Ockenden, health inequalities and other 2022/23 inflation funding.
    - **Net base growth** to reflect:
        - Underlying local demographic and non-demographic activity requirements.
        - Inflationary pressures – including a cost uplift factor (CUF) of 2.9% in 2023/24 (as set out in the NHS Payment Scheme (NHSPS)). For the purposes of setting 2024/25 allocations, a planning assumption of 1.8% has been set for the 2024/25 CUF. The lower CUF assumption in 2024/25 reflects the lower GDP deflator forecast. The final 2024/25 CUF will be set using the methodology outlined in the NHSPS guidance.
        - Inclusion of the 1.1% efficiency, as set out in the NHSPS.

  - Support for underlying capacity recovery[1] and additional funding for community and mental health services.

- **Convergence adjustment towards fair share allocations** – in addition to the general efficiency requirement, a differential convergence adjustment is applied to both reduce overall resource consumption to funded levels and move ICBs towards a fair share funding distribution. The convergence adjustment for an ICB depends on their distance from target allocation. Systems consuming more than their fair share will have a greater convergence ask and therefore a lower level of growth than the national average.

15. Distance from target (DfT) allocation is the single measure of under or overconsumption of resource relative to fair share distribution. The convergence adjustment includes consideration of the full range of ICB spend on core services to better reflect the opportunity for efficiency delivery.

Fair share ('target') allocations

16. The formula that determines fair share ('target') allocations has been updated in line with the recommendations of the independent Advisory Committee for Resource Allocation (ACRA) and policy updates. The ACRA recommendations include the introduction of a travel time adjustment for community services and the return to a 12-month average registered population as the basis of allocations. As well as these recommendations, routine data updates have ensured that allocations are based on the most up-to-date data. Further information is available in the supporting allocations technical guidance.

COVID-19 funding

17. The separate COVID-19 system allocation has been moved into core allocations from 2023/24 to reflect enduring Covid-related service requirements. The quantum is in line with the SR21 settlement and therefore reflects a decrease from 2022/23 levels.

18. From 2023/24 the additional COVID-19 funding has been included in allocations to all NHS commissioners on a recurrent population basis, including NHS England. For ICB programme allocations, in line with the allocation principles, funding has been added on a population basis (post-convergence), in proportion to actual allocations.

[1] Further guidance on 'setting the API fixed element' is available in Appendix 1 of the NHS Payment Scheme supporting document, NHS provider payment mechanisms: www.england.nhs.uk/pay-syst/nhs-payment-scheme

As funding will now be allocated on a population basis, not a hosted-provider basis, all commissioners will need to reflect this in their aligned payment and incentive (API) arrangements with all trusts, not just those within their system.

19. To minimise negotiations and expedite the flow of funding[2] to trusts:

    - ICB inter-system and NHS England contract arrangements (excluding ambulance trusts) should be uplifted by an additional 0.6% to reflect that COVID-19 funding is now included in all ICB programme allocations on a population basis.
    - ambulance trust contract arrangements should be uplifted by an additional 1.2% to reflect historic COVID-19 funding distribution and that COVID-19 funding is now included in all ICB programme allocations on a population basis.

20. For intra-system contract arrangements, systems should work collaboratively to understand local service and cost requirements and flow funding appropriately.

Elective Recovery Fund (ERF)

21. Funding for elective recovery will operate on a different basis to that in 2022/23.

22. The ERF has been separately identified in ICB allocations and has been distributed on a fair share basis. NHS England will receive a proportionate share for directly commissioned activity.

23. Each commissioner will be set an individual elective activity target that recognises the level of elective activity delivered in 2022/23 in the trusts it has contracts with. This will mean that the ICBs that delivered the least elective activity in 2022/23, relative to their 2019/20 baseline, will be expected to deliver most year-on-year improvement in 2023/24.

24. Commissioners must agree contracts with their providers in the usual way. For trusts almost all will be on the basis of API, as set out in the NHSPS, with a fixed and variable element:

    - The fixed element will cover funding for the expected level of activity for all services apart from those identified in the variable element below.

[2] Further guidance on setting the API fixed element is available in Appendix 1 of the NHS Payment Scheme supporting document, NHS provider payment mechanisms: www.england.nhs.uk/pay-syst/nhs-payment-scheme

- The variable element will fund elective activity paid at 100% of the NHSPS unit price.

25. NHS England must approve any variations that trusts and commissioners may want to make to the fixed and variable payment approach. In general, NHS England would not approve a payment approach that removes the link between elective activity levels and reimbursement, but would consider approaches such as:

    - linking some payment to reductions in the waiting list, as well as activity levels
    - operating a 100% unit price variable element, but incorporating a floor level of funding where this links to transformation and/or sustainability of services
    - agreeing local trust risk shares to help manage patients on the waiting list across multiple trusts, where such agreements take better account of local costs than the published unit prices.

26. Further details on the commissioner targets will be released as part of elective recovery fund technical guidance.

27. These arrangements will apply to almost all trust relationships with NHS England for any directly commissioned services and with any ICB where the relationship is not covered by low volume activity (LVA) arrangements.

28. Non-NHS providers will continue to be paid on an activity basis for services with NHSPS unit prices, with NHSPS local payment rules applying for other services.

ICB primary medical care allocation

29. ICB allocations for delegated primary medical care services are published alongside this guidance. The allocations have been updated to take account of changes above the previously assumed levels. There have been no changes in policy to the calculation of the target formula for delegated primary medical care allocations. Updates to the target formula have been made to refresh inputs for the latest data, such as population and registration rates.

30. As set out in the update to the GP contract agreement 2022/23, from 2023/24 all GP improving access funding will flow through the ICB primary medical care allocation. This consolidates funding previously provided through the ICB programme allocation, Service Development Fund (SDF) and ICB primary medical care allocation.

ICB running cost allowance

31. ICB running cost allowances (RCAs) covering 2023/24 are published alongside this guidance. 2024/25 RCAs will be made available shortly; ICBs should expect a reduction compared to the 2023/24 level. NHS England will require that ICBs do not exceed their RCA. These values should be considered a maximum, and any underspends in RCA can be used as non-RCA revenue expenditure. The published figures do not include any allocation for the impact of future delegation on RCAs.

Other primary care services

32. The NHS Act 2006 (as amended by the Health and Care Act 2022) allows for the delegation of NHS England's direct commissioning functions to ICBs. ICBs will take on delegated responsibility for pharmaceutical services, general ophthalmic services, dental services (primary, secondary and community) and other primary care services as set out in the delegation agreements. The other primary care allocations (OPC) schedule sets out ICB allocations for services in scope for delegation and retained NHS England allocations for 2023/24 and indicatively for 2024/25. Where delegation is confirmed, ICBs will receive their ICB allocation from 1 April 2023. Finance guidance is available to support delegations – namely:

    - ICB other primary care allocations for 2023/24 and 2024/25 technical guidance – available on ICB portals. This guidance sets out the detail of how allocations have been calculated and the underpinning planning assumptions for 2023/24 and 2024/25.
    - Finance and payments guidance for non-GP primary care services delegated to ICBs – available to finance leads locally via the Finance Guidance Library. This guidance sets out payment terms and transaction guidance.

33. The use of other primary care allocations is subject to the rules set out in the ICB and system finance business rules – namely, the duty to breakeven within the resource use limit. The utilisation of other primary care allocations is also subject to the additional rule that dental budgets are ringfenced. NHS England will use its available levers in respect to any unused resources to ensure these are used on improving dental access or other NHS England priorities or, exceptionally, the unspent allocation is returned to NHS England. A schedule setting out the dental ringfence has been issued to ICB portals and is pre-populated in finance planning templates.

Contracting for delegation

34. For those functions to be delegated to ICBs on or after 1 April 2023, the 2023/24 contracts for the 'to be delegated' services must be awarded by NHS England and not the ICB. Those ICBs that have already taken on commissioning of OPC services in 2022/23 will award contracts for all delegated primary care services for 2023/24.

35. For primary care contract arrangements in accordance with the NHS Act 2006 (general dental, ophthalmic and pharmacy arrangements), NHS England, as the legal commissioner prior to delegation, must agree contractual arrangements for 2023/24. ICBs taking on OPC delegation for the first time from 1 April 2023 will in the first instance take over commissioner responsibility from NHS England in relation to the existing contracts (or community pharmacy terms of service) already in place. NHS England will issue a contractual notice under the delegation agreement specifying the contracts and/or arrangements within the scope of the delegated functions and which will be manged by the ICB from the date of delegation.

36. For services contracted through the NHS Standard Contract, NHS England will award the contract. Once delegation is confirmed, through signature of a delegation agreement on or after 1 April 2023, NHS England will then pass specific functions in respect of the agreed contract to each affected ICB; this is permitted under General Condition 12 of the NHS Standard Contract and will take effect through NHS England issuing a contractual notice as provided for in the delegation agreement. At the same time, NHS England will inform each affected provider of the functions it is delegating to which ICBs and in respect of which services/populations. Affected contracts will neither need to be novated to ICBs or varied to reflect the delegation.

Specialised commissioning

Supporting the integration of specialised services through joint committee arrangements

37. Joint committees will be introduced from 1 April 2023, managed jointly by NHS England regional and ICB commissioners for all services in scope for delegation as defined by the service portfolio analysis.

38. For 2023/24, NHS England regional commissioners will retain all specialised commissioning allocations, including for services in scope for delegation. All prospective partners in the joint committee will be required to agree and approve the

financial plan for specialised commissioning services, before submission, for the population-based services for their ICB. As part of completing the planning template, NHS England regional commissioners will be required to submit their plan at individual ICB level, and also work with ICBs through their joint commissioning arrangements to develop delivery plans identifying priority pathways for transformation.

39. Joint committees will be expected to manage and co-ordinate the use of specialised commissioning financial resources throughout the year in line with broader NHS financial frameworks and specific national guidance on the delegation of specialised services to ICBs. They also need to take steps to integrate the financial planning and delivery of these services with wider system planning and financial management.

40. NHS England expects that full delegation of specialised services to ICBs will start from 1 April 2024. Guidance and tools will be made available to support ICBs and trusts in moving to joint commissioning arrangements and future delegation.

Setting allocations for specialised services

41. The specialised services allocation baselines from 2023/24 onwards have been set with reference to the baseline reset exercise.

42. To support the joint committees, specialised commissioning allocations for most services (namely those services in scope for future delegation to ICBs) have been produced at ICB level for 2023/24 and 2024/25. This means that allocations for specialised services in scope for delegation represent resources for the patients mapped to ICBs on the basis of their GP registration, rather than resources consumed by the individual trusts mapped to that ICB on a hosted provider basis.

43. Specialised services that are not in scope for delegation have been retained by the relevant regional commissioner on a hosted provider basis.

44. For 2023/24, with the exception of any individual alternative arrangements to be agreed with ICBs and regions, NHS England regional commissioners will continue to hold allocations for services in scope for delegation, but with the expectation that these will transfer to ICBs, subject to agreement of full delegation, from 2024/25 onwards.

45. NHS England will retain some central funding for investment in agreed national service and clinical priorities. This funding will be allocated to NHS England regional commissioners 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.

High cost drugs

46. Arrangements for excluded high cost drugs and devices (HCDDs) will be broadly the same as in 2022/23. 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 HCDDs identified as being subject to cost and volume reimbursement arrangements.

47. As set out in the NHSPS, most 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.

48. As in 2022/23, 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.

49. It is imperative that data around drugs, particularly those drugs 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 its annual budget and ensures NHS resource is protected.

Treatment costs and the CAR-T price

50. When CAR-T was first commissioned in 2018/19, an interim price was established, based on the information available at that time about the costs of implementing this novel therapy. It was acknowledged then that the price would need to be revisited to reflect on the actual experience of using these products.

51. Advanced therapy medicinal products (ATMPs), such as CAR-T, are complex treatments, and the delivery of services that use them requires a greater level of

infrastructure and expertise than those using more traditional therapies. There are also now more opportunities for economies of scale as the overall number of patients increases. NHS England therefore proposes to explore options for replacing the existing 'per patient' approach with an underlying infrastructure payment, supplemented by a smaller price to more accurately reflect the marginal costs associated with a more established service.

Genomic testing services

52. In 2023/24, genomic testing services will move to an activity-based payment model that will include all the contracted income currently split between different commissioners and programmes of care. This will be based on a set of currencies for preparation, testing and reporting of genomic testing services. As part of the move to a standardised set of prices across trusts, NHS England will consider the non-recurrent impact of changing contract values from the current values by trust, and may implement a pace of change as part of the full introduction of activity-based prices.

53. Moving to a price-based model will incentivise the full use of testing capacity, which through recent investment has been significantly expanded, and moving to a standardised price will support greater efficiency, and eliminate unexplained cost variation.

High cost devices

54. 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, eg remote monitoring of implantable cardioverter defibrillators and pacemakers.

55. For 2023/24, existing reimbursement arrangements will continue whereby 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 current processes in place.

56. 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 expenditure reported on the DePLCM for devices that should have been ordered via NHS Supply Chain.

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

Mental health provider collaboratives

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

59. MHPC funding is already constructed on a population basis, meaning that NHS England regional commissioner allocations have been adjusted to reflect the funding due to MHPCs within their geographies.

60. 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 2022/23, where such service changes result in material changes to funding flows between the lead provider (LP) and a sub-contracted provider, the LP 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.

61. There are plans to extend the scope of services covered by MHPCs in 2023/24 to other specialised mental health services, in particular forensic child and adolescent mental health services (FCAMHS) and perinatal services. The baseline envelopes for these services have been constructed on the basis of the baseline reset exercise. For phase 2, NHS England regional teams will provide guidance confirming the assumptions that commissioners and providers should use in planning relating to the potential go-live of these services from 2023/24 onwards.

62. All finance and contracting guidance relating to the operation of MHPCs is available through NHS England regional commissioning teams.

Clinical networks

63. Specialised commissioners invest significant funding in provider hosted specialised services clinical networks. These are funded as a separately identifiable component within NHS England regional allocations. A requirement will be the separate identification in contracts of the value of funding for networks.

64. Funding for specialised services clinical networks will be reconfirmed annually and is based on the network ensuring that:

- Robust governance systems are in place.
- An annual workplan is agreed within the network and with commissioners. This will normally include both nationally and locally agreed objectives and deliverables.
- Data to track progress is routinely collected.
- Progress reports (against the annual workplan) are provided to the network board and the relevant commissioning lead at regular agreed intervals. Where necessary, these reports will also include agreed remedial actions to ensure progress continues towards delivery of the annual plan.
- An annual report is published demonstrating delivery of the annual workplan and the impact and value of the network's work.

Excess treatment costs

65. Specialised commissioning clinical trials incur costs relating to routine charges, pass-through costs and excess payable costs. Trials are continually starting and ending, so routine costs should be embedded in 'business as usual' processes. Pass-through costs for excluded HCDDs that are not provided free of charge will be reimbursed in line with existing processes. This leaves the excess payable costs and they are subject to a separate process.

66. For 2023/24, a national specialised commissioning budget will continue to fund these excess payable costs via a top slice from commissioner allocations, with the reimbursement to trusts managed nationally. The national team will provide NHS England regional commissioners with a schedule of assured trials and make payments on a quarterly basis. The top slice will be set each year but is expected to be relatively stable year on year.

67. The top slice will also include funding for the net increase in any exceptional high cost routine charges where a provider or system would be disproportionally impacted by participating in a clinical trial. Payment will be subject to a reconciliation of total activity for the specific procedure against 2023/24 contract activity baseline.

Other NHS England directly commissioned services

68. NHS England will continue to commission healthcare, which form part of Section 7A, in relation to public health and health and justice services in 2023/24, and issue regional commissioners with allocations to commission these services. This will further strengthen joint working with ICBs in preparation for possible future delegations.

69. 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.

70. The policy and operational requirements of the 2023/24 flu campaign will be communicated in the annual flu letter, following agreement with government. Further information in relation to COVID-19 vaccinations services is set out below.

Service Development Fund (SDF)

71. ICBs will continue to receive SDF allocations to support the delivery of the NHS Long Term Plan commitments in 2023/24. The 2023/24 priorities and operational planning guidance sets out national objectives for 2023/24 and also the principle that ICSs are best placed to understand population needs and agree specific local objectives to complement those objectives, while paying due regard to wider NHS ambitions.

72. In line with this approach, NHS England has reviewed and streamlined the number of individual SDF allocations. Most of the SDF for 2023/24 will be bundled into higher level groupings. Separate schedules 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 for which it has been allocated, but can choose how to distribute the funding between those initiatives, other than where specific priorities are set out in the 2023/24 priorities and operational planning guidance.

Other revenue

Capacity funding

73. Initial allocations of recurrent capacity funding for 2023/24 are set out separately as part of published ICB programme allocations. Additional funding will be available for further capacity expansion, and this will be confirmed as part of the planning process.

    - **Physical and virtual bed capacity, including services that specifically support admissions avoidance and timely discharge.** Initial allocations of £590m of recurrent capacity funding for 2023/24 are set out separately as part of published ICB allocations.

      As set out in the operational planning guidance, systems should plan for an appropriate mix of general and acute beds; other physical capacity (such as intermediate care); virtual capacity, home care, and other services that support admissions avoidance and timely discharge, as per the needs of your local population. The split between these should take account of the actual use of capacity funding in 2022/23 and the relative benefits these approaches have delivered locally for urgent and emergency care (UEC) performance.

      Further funding of £380m is available for additional capacity expansion and allocations of this funding will be agreed as part of the planning process. This will be contingent on demonstrating impact on UEC performance. Details of the process will be communicated shortly.

      In 2022/23 there were separate allocations for virtual bed capacity. In 2023/24 funding for virtual capacity forms part of the wider capacity allocations described above.

    - **NHS 111.** Systems should ensure that they maintain appropriate capacity for 111 services. There will not be a separate additional national allocation for NHS 111 capacity in 2023/24.

74. Additional funding arrangements for supporting ambulance service capacity and performance will be communicated shortly and should only be included in plans once confirmed.

Revenue support for capital investments

75. Pressures created by depreciation, public dividend capital (PDC) dividend charges or other short-term revenue costs can inhibit necessary capital investment. This funding is to help mitigate any 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 until efficiencies or productivity benefits associated with the capital investment are fully realised.

76. Systems will also be able to access dedicated revenue funding to contribute to the set up and running of community diagnostic centres.

Education and training funding

77. 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 2023/24 during Quarter 4 of 2022/23.

78. To better support the planning process, education and training income (from NHS England from 1 April 2023) and expenditure will be collected in more detail than in previous years, using the following categories:

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

79. For the purposes of planning, and to ensure there is a consistent approach, a set of assumptions will be provided for each category in the collection template supporting guidance.

ICB and system finance business rules

80. The ICB and system[3] 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	

[3] For the purposes of the business rules, 'systems' are defined to be the ICB and those NHS foundation trusts and NHS trusts mapped for the purposes of financial apportionment.

81. Generally, NHS England does not anticipate widespread access to drawdown. However, subject to national affordability, if systems can make a case for additional non-recurrent funding and this supports the aims set out in the planning guidance, we will consider these on a case-by-case basis.

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

Contracts and payment approach

NHS Payment Scheme (NHSPS)

83. The consultation on the 2023–25 NHSPS has been launched and, subject to its outcome, the proposed NHSPS would come into effect from 1 April 2023, replacing the National Tariff Payment System.

84. The 2023–25 NHSPS would be set for two years and apply to all secondary healthcare – acute, ambulance, community, mental health. It includes rules for four 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; and • with any ICB where the relationship is not covered by LVA arrangements
Low volume activity (LVA)	Nationally set values for low volume activity	Almost all trust and ICB relationships for which NHS England has mandated an LVA block payment (normally those with an expected value of annual activity of £0.5m or less, prior to inclusion of any services delegated by NHS England)
Activity-based payments	Each unit of activity is paid for using NHSPS unit prices, with relevant adjustments (eg 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

Aligned payment and incentive (API)

85. Almost all secondary healthcare commissioned between trusts and NHS commissioning bodies would be subject to API, with no threshold below which contractual relationships between trusts and ICBs in different ICSs are subject to local payment arrangements. Activity is excluded from an API where a low volume activity (LVA) arrangement is in place or where a single specialised service is individually procured.

86. Under the API rules, trusts and commissioners would be asked to agree a fixed element,[4] based on funding an agreed level of activity but excluding elective activity (covering elective ordinary and day case, outpatient procedures with an NHSPS unit price, outpatient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery). NHS England is not expecting or encouraging trusts and commissioners to re-price activity using NHSPS prices for the purposes of agreeing fixed payments. The fixed element should include funding for all expected activity other than elective activity, expected annual best practice tariff (BPT) achievement and assumed full CQUIN achievement (so funding of 1.25% of contract value).

87. The API variable element would mean trusts are paid 100% of NHSPS prices for elective activity. The price paid would be adjusted by the trust's market forces factor (MFF) value. Where the relevant criteria are achieved, elective activity BPTs would be paid. If CQUIN criteria have not been fully achieved, the fixed element would be reduced for any relationships with an annual value above £10m.

Low volume activity (LVA)

88. The NHSPS consultation is proposing that payments for LVA move within the scope of the NHSPS from 2023/24. All NHS trust–ICB relationships with an expected annual value below £0.5m would be subject to LVA arrangements, with the only exceptions being:

[4] Further guidance on 'setting the API fixed element' is available in Appendix 1 of the NHS Payment Scheme supporting document, NHS provider payment mechanisms: www.england.nhs.uk/pay-syst/nhs-payment-scheme

- 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 where there is no contractual relationship to enable the transfer of existing patients under patient choice arrangements.

89. The LVA payments schedule will be published are part of the NHSPS and ICBs must pay each trust identified on the schedule the calculated amount in Quarter 1 of 2023/24.

90. The normal arrangement for payment is that the provider bills the patient's responsible commissioner for their treatment. 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 agreed to by all parties to a specific contract. It should not be used for non-contract activity (NCA) payments or as a way of circumventing LVA arrangements.

91. Where transactions are needed, they should be done in the most cost-effective way to minimise the volume of invoices.

Activity-based payments

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

93. The 2023/24 unit prices being consulted on are the 2022/23 National Tariff prices updated for inflation and efficiency. Prices for 2024/25 will be set using a formula, which will involve rolling forward the 2023/24 unit prices and applying relevant cost uplift and efficiency factors. The data used to calculate MFF values has also been updated.

Local payment arrangements

94. Activity not covered by one of the payment mechanisms would be subject to local payment arrangements. This would include services delivered by non-NHS providers for which there are no NHSPS unit prices. Local payment arrangements would mean that providers and commissioners locally agree an appropriate payment approach.

The NHSPS rules would require them to consider the NHSPS payment principles and cost uplift and efficiency factors.

Commissioning for Quality and Innovation (CQUIN)

95. The CQUIN scheme would continue to operate in 2023/24 as part of the API arrangements only. The API fixed element should be set on the assumption that trusts will fully attain CQUIN indicators, with actual CQUIN performance assessed at the end of the financial year. For trust contractual relationships with an annual value above £10m, if the actual CQUIN indicator attainment is not fully attained, payments should be deducted from the trust as part of API. CQUIN funding continues to be included in the NHSPS prices, including the 1.25% transfer made in 2021/22. CQUIN guidance will be published on the CQUIN webpage.

Overseas visitors and UK cross-border emergency activity

96. The in-year ICB allocations adjustment for charge exempt overseas visitors and UK cross-border emergency activity will be reintroduced. For 2023/24, the adjustment will be captured in a manual collection requested from ICBs in spring 2023.

97. In advance of setting 2025/26 allocations, NHS England will work with ICBs and trusts to assess the requirements for introducing a prospective adjustment to target allocations based on Secondary Uses Service (SUS) reported activity rather than a manual data collection. To prepare for this transition, trusts should seek to review and strengthen their processes for identifying overseas visitor activity within SUS.

98. Providers and commissioners should continue to review latest guidance in relation to overseas visitors – and in particular note the changes to reciprocal healthcare arrangements (eg Malta and Gibraltar) that shift the scope of chargeable (COV) and charge exempt (CEOV) overseas visitor activity. Commissioners should continue to note their legal responsibility to commission services for CEOV cohorts and 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 and UK cross-border emergency activity can be found in Who Pays? (2022).

99. From 2023/24 the nationally mandated episodic charging risk-share terms for COV will end. In its place, trusts and commissioners must agree annual funding for their shared risk of non-payment as part of setting their API values in contracts. As part of

agreeing the annual value, trusts and commissioners should consider the element of funding embedded within the contract values when these were calculated by the NHS England national team (based on 2019/20 payment values and the contract uplifts that have subsequently been applied). As an example, the future value could consider the historical rate of non-recovery of patient charges and an agreed rate of income recovery improvement. The change to provider and commissioner charging does not alter the mandatory requirement to collect payment upfront for any chargeable patient not in need of urgent or emergency care, and activity should continue to be billed to the COV using the NHSPS unit prices. The rates differ for patients who are subject to the EU Exit Withdrawal Agreement and those who are not, as set out in the Improving systems for cost recovery for overseas visitors.

Contracts

100. It is essential from a governance perspective that fully populated contracts in the form of the NHS Standard Contract 2023/24 are put in place between commissioners (ICBs and NHS England) and each provider (NHS trusts, foundation trusts and non-NHS organisations), covering at least the full financial year of 2023/24. Every effort must be made to agree and sign contracts in advance of 1 April 2023.

101. 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 is consulting on the draft NHS Standard Contract for 2023/24 and expects to publish the final version in early 2023 following review of feedback. Further detail about NHS contracting generally is set out in the contract technical guidance.

102. Further information on contractual arrangements for services where NHS England is delegating commissioning functions to ICBs is given in the other primary care services section.

Procurement

103. DHSC has confirmed that the new NHS Provider Selection Regime, the new set of rules governing the commissioning and sub-contracting of healthcare services, will not be in effect in time for the 2023/2024 NHS contracting round. For contracts and sub-contracts for service delivery to start from 1 April 2023 onwards, NHS

organisations should for the time being continue to operate on the basis of existing procurement regulations and guidance.

Collaborative commissioning

104. 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 schedules

105. The NHS Standard Contract has three sections – the General Conditions and Service Conditions, which set out nationally-mandated terms that cannot be varied, and the Particulars, which include the schedules for local completion and agreement. It is important to agree which schedules are relevant to each contract and the schedules to be prioritised; not all schedules will need to be populated in every case. Further details on this are set out in the contract technical guidance.

Failure to agree contracts

106. As system working is now well established NHS England does not propose to put in place a formal process for arbitration between commissioners and trusts where they cannot agree a contract by 31 March 2023. Rather, we will rely on local NHS leaders to work together to ensure issues relating to contract agreement are resolved locally, collegiately and in a timely manner. NHS England regional teams will track local progress and help systems resolve issues where necessary.

System Collaboration and Financial Management Agreement (SCFMA)

107. 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 sub-committees or joint committees) to deliver the aspirations set out in the model SCFMA.

Key financial commitments

Mental health services

108. The Mental Health Investment Standard (MHIS) will apply to ICBs and continue to be subject to an independent review. For 2023/24, the MHIS requires ICBs to increase spend on mental health services by ICB programme allocation base growth (prior to the application of the convergence adjustment) plus an additional amount to reflect further recurrent funding that has been added to ICB allocations for mental health in 2023/24. MHIS requirements by ICB, including the calculation methodology, are set out in supporting MHIS schedules and supporting technical guidance. The growth is a core part of funding the NHS Long Term Plan commitments for mental health.

109. 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 the development of 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.

110. The NHS Long Term Plan makes recurrent commitments on mental health services. While SDF allocations are currently issued as non-recurrent, these commitments are recurrent within the NHS mandate and therefore systems will continue to be funded to deliver them.

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

112. Further information in respect to mental health capital is set out in the Capital guidance for 2023/24.

Primary medical and community services (PMCS)

113. The NHS Long Term Plan commits to £4.5bn real-terms investment growth (£7.1bn investment growth in cash terms) in PMCS by 2023/24.

114. For 2023/24, ICBs will continue to support progress towards meeting this commitment through their allocations for:

- primary medical care – both delegated and non-delegated expenditure; non-delegated spend includes locally enhanced services, out-of-hours, extended access schemes (but excluding general practice prescribing costs) and Investment and Impact Funding (IIF)
- community services
- continuing healthcare (CHC) including funded nursing care (FNC)
- regional and national expenditure delivering or supporting the above.

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

- funding to support workforce initiatives in primary care (including GP fellowship, new to partnership payments, GP retention, flexible staffing pools and the Supporting Mentors Scheme)
- improving access
- digital first initiatives
- Additional Roles Reimbursement Scheme (ARRS)
- funding to support ageing well and virtual wards.

116. As part of the plan assurance process, the planned investment in PMCS at system level will be reviewed.

Better Care Fund (BCF)

117. The BCF will continue in 2023/24 and 2024/25. Government will publish a policy framework in due course. For the purposes of final plans, ICBs should assume a minimum contribution to the BCF and the minimum BCF contribution to social care will rise by a flat 5.66% at health and wellbeing board level; minimum contributions for each ICB are published alongside this guidance.

118. The Autumn Statement 2022 confirmed that an additional £600m (provided equally through NHS England and local authorities) will be made available in 2023/34 and £1bn in 2024/25 through the BCF to support timely discharge. The NHS component of this funding (£300m in 2023/24 and £500m in 2024/25) has been allocated to ICBs, and is separately identified as part of published ICB programme allocations. Further details will be made available in due course.

Other planning assumptions

Inflation

119. The NHSPS sets out the basis for the inflation assumptions in the cost uplift factor applied to NHSPS payments and allocations, including relevant pay and non-pay assumptions.

Reducing expenditure on NHS agency staff

120. ICBs and trusts should focus on improving workforce productivity and reducing their reliance on agency workers.

121. NHS England has re-established measures to control agency expenditure, including system agency expenditure limits. Metrics to monitor performance on agency use are included in the NHS Oversight Framework, reinforcing the rules that ICBs and trusts should comply with.

122. Planned system agency expenditure will not be used to set limits in 2023/24, unlike in 2022/23. Instead, the goal in 2023/24 is to reduce total agency spending by trusts (in aggregate) to 3.7% of the total estimated NHS pay bill. We will therefore set system agency expenditure limits for 2023/24 with a requirement for systems currently spending above 3.7% as a percentage of pay to reduce this (with those spending the most as a percentage of pay required to deliver the biggest reductions) and the expectation that systems currently spending below 3.7% will maintain (or reduce) their spending levels. System agency expenditure limits will be built into planning templates.

123. Trusts should therefore take action to reduce their agency staff bills, encourage workers back into substantive and bank roles, and move back towards compliance with agency controls. We have produced additional toolkits to support better use of substantive and bank staff, including a bank development toolkit.

NHS pension employer contribution rate

124. For the purposes of planning, it should be assumed that NHS England will continue to pay the central payments in 2023/24, and therefore no impact should be reflected in plans.

125. The transitional approach that has operated since 2019/20 for employer contributions will continue in 2023/24. For 2023/24 an employer rate of 20.6% (20.68% inclusive of the administration charge) will apply; the NHS Business Service Authority will continue to only collect 14.38% from employers and organisations should plan on this basis. Employers should ensure that their payroll provider continues to apply an employer contribution rate of 14.38% from 1 April 2023. Central payments will again be made for the remaining 6.3%.

126. Further guidance will be issued during 2023/24 in respect to the arrangements for 2024/25.

All-age continuing care

127. A sustainable social care provider market is essential to support hospital discharge and maintain services for individuals receiving care. ICBs should locally, and in conjunction with their integrated care partnership (ICP), consider the sustainability of the local social care provider market and the challenges faced by these providers. To support the sustainability of this market, ICBs should negotiate and agree reasonable contract uplifts that consider general price inflation.

128. The ICB and social care providers must together engage constructively with the 'local prices' approach for all-age continuing care and, as set out in 2022/23, CQUIN no longer applies to contractual relationships outside the scope of API. This means that it no longer applies to smaller providers of NHS-funded services, such as those delivering care home and/or domiciliary care services (social care providers) to all-age continuing care.

129. ICBs should have CHC management systems in place that comply with the Information Standard and Data Set Specification.

130. We expect government will announce the FNC rate for 2023/24 shortly.

MedTech funding mandate

131. The MedTech funding mandate (MTFM) policy requires trusts to make selected NICE-approved medical technologies available to patients where clinically appropriate. The full list of supported technologies can be found in the MTFM 2022/23 policy guidance. As no new technologies were selected for support in 2023/24, systems should prioritise adopting the currently supported technologies.

132. Technologies should deliver cost savings within three years, and reduce hospital visits and clinical interventions, which is vital for recovery from the pandemic. It is important that eligible patients can access the technologies to ensure equity in healthcare provision and tackle health inequalities.

133. For 2023/24, the MFTM will remain a 'pass-through' payment approach, where commissioners are required to pay for the cost of MTFM technologies from existing allocations on a 'cost and volume' basis. The MTFM technologies will be excluded from NHSPS prices and so implementation costs related to MTFM technology adoption should be incorporated in the fixed payment.

134. All but one of the supported technologies (Spectra Optia) are available via NHS Supply Chain, removing the need for individual contracts. The Academic Health Science Networks (AHSNs) and the technology suppliers will assist systems to adopt these technologies.

Medical examiners

135. Government is expected to lay regulations to enable the introduction of the statutory medical examiner system from April 2023. Trusts hosting medical examiner offices should continue to support their work with all healthcare providers in their locality, including general practice, to ensure that sufficient capacity is available and arrangements are in place to provide medical examiner scrutiny to all non-coronial deaths in all settings from 2023/24. Trusts that do not host medical examiner offices should have developed processes for their local medical examiner office to provide independent scrutiny of non-coronial deaths in their care.

136. The funding for medical examiner offices will continue to be issued to trusts on a cost reimbursable basis. NHS England will write to trusts to confirm the funding available for their medical examiner offices and the expenditure reporting process to be followed.

ICB Clinical Negligence Scheme for Trusts (CNST) contributions

137. As in 2022/23, the growth in trust contributions to the CNST is funded in ICB allocations on a uniform basis. The overall increase in CNST contributions to NHS Resolution for trusts in 2023/24 is 9.6%; however, each trust's individual change will reflect its relative risk factors.

138. 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 ICBs and providers on the change in API and local payment arrangements, eg to reflect average growth in different specialties.

139. ICBs also make a nominal contribution to NHS Resolution as part of their membership of the CNST. NHS Resolution will contact ICBs to confirm the contribution required for 2023/24.

140. The cost of claims raised against ICBs, or falling back on ICBs 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 providers have appropriate indemnity cover in place, in line with the requirements of the NHS Standard Contract.

External income

Other government income

141. Trusts should agree contracts with non-NHS commissioners, eg local authorities (LAs), based on the appropriate funding for services, including inflationary uplifts. Once government's response to the recommendations of the pay review bodies is announced during 2023/24, contracts should be updated accordingly. The non-recurrent funding for 2022/23 pay pressures on LA contracts has not been recurrently included in ICB allocations. From 2023/24, these costs should be reflected within locally agreed contract values with LAs. DHSC will publish LA public health allocations in due course.

142. Contracts between NHS Wales and English trusts should have regard to the NHSPS cost uplift factor, additional COVID-19 costs, which are now recovered on a population basis, and appropriate activity growth assumptions. Similarly, English commissioners using Welsh providers will be expected to fund equivalent uplifts. Payment arrangements should comprise of 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 for 2023/24 and any

additional elective recovery activity will be locally determined on an individual commissioner and trust basis.

Commercial income

143. Trusts should continue to explore and develop opportunities to recover and, where appropriate, grow their external (non-NHS) income. While continuing to prioritise core NHS service delivery and recovery, NHS England expects the NHS will return to working towards securing the benchmarked potential for commercial income growth, while maximising cost recovery and making sure it is always paid for the work it does, including in private patient services. Following the launch of the NHS Export Collaborative in 2021, we (along with HealthcareUK) will continue to work with trusts to identify and scale-up NHS export opportunities and develop other appropriate opportunities to generate revenue and benefits to reinvest in NHS staff and local patients and services. Commercial income opportunities should only complement and never interfere with core NHS work and post-pandemic recovery efforts.

COVID-19 services

COVID-19 testing

- **High-throughput PCR and rapid testing.** Funding for COVID-19 testing services will move to a fixed allocations based funding model during 2023/24. Until such point, the current cost reimbursement model will remain in place. For 2023/24 planning purposes, trusts should plan on the basis that expenditure and income are neutral within plan positions.

  Allocations will be set based on a fixed cost per test. This fixed cost per test will be no greater than £18.50 for high-throughput PCR testing and £14.00 for rapid testing, excluding MFF and centrally procured supplies. These price points are provided for guidance purposes only at this stage so that trusts can review their cost bases and begin delivering necessary efficiency requirements. These price points are subject to change through the finalisation of allocations.

  The stated cost per test excludes the cost of supplies currently centrally procured by the UK Health Security Agency (UKHSA). During 2023/24, it is anticipated that the procurement of these supplies will transition to the NHS. Trusts should not commence procurement prior to confirmation of the transition date. Any procurement before this point will not be reimbursed.

The details of the transition timeline, procurement process and associated funding will be announced in due course. Allocations would be adjusted for changes in clinical guidelines that impact on volumes or testing technologies, with an appropriate period of tapering to enable trusts to action changes.

- **Lateral flow devices (LFDs).** It is anticipated that from 1 October 2023, trusts will become responsible for the procurement of COVID-19 LFDs through a centralised supplier arrangement. Trusts should not commence procurement prior to this date or prior to the formal notification of the procurement process. Any procurement before this point will not be reimbursed.

  The details of the process and associated funding will be announced in due course. Trusts should not include planning for LFD procurement in their 2023/24 plans. Separate guidance will be issued on LFD testing for the purposes of accessing COVID-19 antiviral therapeutics.

- **SIREN.** Costs associated with the SIREN research programme will no longer be funded through NHS England. From 1 April 2023, the SIREN study will be funded directly by UKHSA. UKHSA will issue separate guidelines to participant trusts to outline the revised charging and reporting processes.

COVID-19 Vaccination Programme

144. COVID-19 vaccination services are no longer funded on a central reimbursement basis. From September 2022, allocations were issued to regions for services to be commissioned locally and NHS England expects this approach will continue for 2023/24 and should be the basis of planning. We are developing a wider immunisation strategy, of which COVID-19 vaccination will be a part, and commissioning, procurement and funding arrangements are being developed to support this.

Personal protective equipment

145. Since 2020/21 personal protective equipment (PPE) for COVID-19 has been procured centrally, funded by DHSC and from April 2021 delivered by NHS Supply Chain. This was part of the temporary arrangements put in place to facilitate centralised distribution of PPE to all health and care settings during the COVID-19 pandemic.

146. The government announced its decision to extend the central, free provision of COVID-19 PPE to the health and care sector by up to one year to March 2024 or until

stocks are depleted. This means that in 2023/24 COVID-19 PPE purchased during the pandemic that remains in stock will be distributed to the NHS at no cost. Trusts and primary care organisations will be able to order the free PPE, while it remains in stock, through the same routes they have used so far. DHSC will publish further information about available stock by April 2023.

147. Trusts and primary care organisations will be expected to cover the costs of the additional PPE they require during 2023/24 and plans should reflect this.

148. In line with the Living with COVID-19 strategy, systems should seek to encourage appropriate and efficient use of PPE across all care settings.

Inventory management

149. In 2023/24 NHS Supply Chain will introduce a new inventory management solution in the NHS, with the aims of: supporting more efficient management of local inventory; increasing visibility of products available to improve supply resilience; and enabling automated capture of point of care data on inventory use in clinical practice, which can be used to reduce clinical variation.

150. The inventory management solution will initially be implemented in 20 trusts over the next two years. While it will be partly nationally funded, trusts taking part in the project in 2023/24 will be expected to allocate some local funding for a dedicated project team to work with the national team to drive the project locally and ensure sustainable implementation and benefits realisation.

Cash regime

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

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

153. 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 providers will remain invoice payment file (IPF), with limited use of invoices and payment requests.

154. NHS England anticipates 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 the few 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 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 via a mechanism that allows a trust to repay PDC to DHSC and then 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

155. Frequently asked questions (FAQs) will be issued on a regular basis to ICBs and trusts through FutureNHS and the PFMS portal.

156. For further queries on the financial arrangements, please email england.finplan@nhs.net.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of alternative formats on request

Publication reference: PR00021