Introduction to the 2021/22 national tariff

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Contents

1. About this guide

This guide is an introduction to the national tariff. The tariff is a set of rules, prices and guidance that governs the payments made by commissioners to secondary healthcare providers for the provision of NHS services. The guide is for NHS health professionals, managers and administrators, as well as people engaged in academic study and interested members of the public in the UK and abroad.

The national tariff is published by NHS England and NHS Improvement and includes detailed guidance on its operation and a wide range of other information. These resources are available at: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/

This guide describes the tariff for 2021/22. However, the tariff, and the wider payment system, will continue to evolve. The NHS Long Term Plan sets out the intended direction for the payment system. In particular, the Plan commits to moving away from activity-based payments to ensure a majority of funding is population based, and to introduce blended payment for all services. In addition, the recently publish Health and Care Bill includes proposed provisions for a new NHS payment scheme to replace the 'national tariff'.This guide and supporting material will be updated as developments are made.

In addition, as part of the NHS response to Covid-19, providers and commissioners have agreed block payment arrangements, as a departure from national prices and any national blended payment arrangements. For details of the payment arrangements, see: www.england.nhs.uk/coronavirus/finance/

2. What is the national tariff?

Background

The national tariff is the payment system used by commissioners and providers of secondary healthcare. It sets the rules and prices that commissioners use to pay providers (such as acute hospital trusts) for NHS services. Payment is made to the organisation, not to individual departments within a hospital. The tariff accounts for around £76 billion of spending each year and an average of 60% of a hospital trust's income. Other funding streams (such as the Financial Recovery Fund) operate outside of the tariff as does primary care (GP services, for example – see Services outside the tariff's scope below)

The national tariff has its roots in the Payment by Results (PbR) system that was introduced in England by the then Department of Health in 2003. Before PbR, commissioners tended to agree block contracts with hospitals, meaning the amount of money a hospital received was fixed, regardless of the number of patients it treated.

PbR was introduced to:

- support patient choice by allowing the money to follow the patient to any provider
- reward efficiency and quality by allowing providers to retain the difference if they could deliver the required standard of care at a lower cost than the national price
- reduce waiting times by paying providers for volume of work done (rather than via block contracts), incentivising trusts to increase activity levels
- focus discussions between commissioners and providers on quality and innovation rather than price.

The Nuffield Trust online book, *The history of the NHS*, includes details of how provider payment was managed from formation of the NHS in 1948 to implementation of the 2012 Health and Social Care Act (2012 Act).

What is the national tariff?

A set of rules, guidance and prices

The 2012 Act introduced a statutory national tariff and led to a transfer of responsibility for the pricing system from the then Department of Health to Monitor

and the NHS Commissioning Board (now known as NHS Improvement and NHS England respectively).

The 2012 Act sets out that the tariff covers the pricing of healthcare services for the NHS in England. With some exceptions (see Services outside the tariff's scope below), the tariff covers all forms of NHS healthcare, whether relating to physical or mental health and whether commissioned by clinical commissioning groups (CCGs), NHS England or local authorities acting on behalf of NHS commissioners under partnership arrangements.

The tariff contains a set of rules that must be followed as well as currencies (units of healthcare for which payment is made – see Section 4, Currencies), prices and variations that apply to prices when they are used. Up until 2021/22, the majority of these prices were 'national' prices – this meant that providers and commissioners were obliged to use them unless they agreed to vary or modify them using the procedures for local variations or modifications (see Locally determined prices below).

However, the 2021/22 tariff introduced new aligned payment and incentive rules to cover most secondary care activity and removed almost all national prices, with most published prices now being 'unit prices' which generally are not mandatory (see Section 3, The aligned payment and incentive approach). National prices continue to apply to diagnostic imaging services.

The tariff also allows providers and commissioners to determine prices locally in different ways (see Locally determined prices in Section 5).

In addition, other non-mandatory prices are published alongside the tariff. Non-mandatory prices are set where data is not robust enough to create a national or unit price and are intended as a guide or benchmark to help set local prices (see also Section 5, Scope).

The NHS Standard Contract, that providers and commissioners must use, allows for aligned payment and incentive agreements, national prices, national prices adjusted by a local variation or local modification, or local pricing arrangements. However, the Contract is not itself a part of the tariff.

That National Tariff Payment System comprises a number of separate documents and annexes, available from the NHS England and NHS Improvement website.

Currencies

A currency is a unit of healthcare for which a payment is made.

Different types of currencies support different models of service delivery. Currencies can range from an annual block contract basis (paying for all activity within a service for a year) to episodic or activity-based payments (where a price is determined for each consultation or treatment). Aligned payment and incentive agreements use a single currency, defined as all the services covered by the fixed payment, while national and unit prices are based on healthcare resource group (HRG) or treatment function code (TFC) currencies.

In addition, providers and commissioners can use tariff rules to agree alternative currencies, or variations to national currencies, where needed.

Locally determined payments

Aligned payment and incentive agreements use a specific set of local pricing rules. However, the tariff also includes some general local pricing rules. These are used for local payment where the aligned payment and incentive rules or remaining national prices do not apply, where services do not have nationally-set prices, or providers and commissioners want to move away from them. The tariff specifies that locally determined prices must:

- be in patients' best interests
- promote transparency
- result from providers and commissioners engaging with each other constructively.

Full details and guidance on locally determined prices can be found in Sections 3, 4 and 8 of the 2021/22 National Tariff.

Services outside the tariff's scope

Some healthcare services fall outside the national tariff's scope and are funded under different arrangements. These include:

- public health services such as local open access sexual health services, universal health visitor reviews, public health screening programmes, sexual assault services and public health services for people in prisons
- primary care services such as general practice, community pharmacy, dental practice and community optometry, where payment for these services is governed by the legislation relating to primary care

Social care and care homes are also not covered by the tariff.

3. Developing the tariff

Producing the national tariff is a complex process and the tariff development cycle involves several stages. NHS England and NHS Improvement also work on longer-term development of the payment system, for example to support the NHS Long Term Plan.

The key aspects of the tariff development cycle are:

- review of current tariff and consideration of aims and objectives for the payment system
- initial policy design and price modelling
- policy proposals and draft prices discussed with experts and key stakeholders
- feedback considered and policies and prices refined
- open engagement on proposed policies and prices with all interested stakeholders
- further refinement of policies and prices following consideration of feedback
- statutory consultation on proposed tariff policies and prices, and assessment of their likely impact
- analysis of feedback before decision to publish final tariff
- publication of new tariff.

Each new tariff is usually intended to be published so that it takes effect from 1 April. However, if the publication is delayed (as happened in 2020/21 and 2021/22 as a result of COVID-19), the tariff in place continues to apply. For example, the 2019/20 tariff was in effect until the 2020/21 tariff was published in November 2020.

Detailed operational guidance is reviewed and updated for each tariff and is a key component of the national tariff package. It describes how the tariff rules and prices should be implemented. The current national tariff documents and guidance, including the national tariff workbook (Annex A) which contains the national and emergency care prices, can be found here: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/

For each tariff cycle NHS England and NHS Improvement work to review and update the existing tariff to ensure it achieves the intended outcomes. For 2021/22, the focus of the tariff shifted away from national prices and instead most activity is now covered by local payment rules for aligned payment and incentive agreements. This approach is described in Section 4. Section 5 gives details of tariff prices.

4. The aligned payment and incentive approach

The NHS Long Term Plan commits to introducing blended payments for all services. Blended payment comprises a fixed element plus at least one of a variable element, a risk share and a quality or outcomes-based payment. It was initially introduced for urgent and emergency care in 2019/20.

Blended payments aim to:

- support local health systems in managing their collective financial resources and using those resources to maximise quality of care and health outcomes
- provide shared incentives for reducing avoidable or low-value activity and redirecting resources to higher-value interventions, properly reimbursing these
- support a rigorous, transparent approach to coding, counting and costing activity, allowing it to be analysed alongside data on needs and outcomes to support continuous improvements in efficiency and the effectiveness of resource utilisation
- reduce unnecessary transactions and free up administrative resource.

Further blended payments, for outpatient attendances and maternity services were introduced in the 2020/21 tariff. However, due to Covid-19, providers and commissioners have agreed block payment arrangements from the start of 2020/21, as a departure from national prices and any national blended payment arrangements. As such, the blended payments have not operated in practice during 2020/21, with blended payments for outpatients and maternity services not implemented at all.

The 2021/22 tariff looked to move away from a blended payment on a service-by-service basis and instead introduced a type of blended payment: the aligned payment and incentive approach. This was designed to achieve a stable transition from the 2020/21 emergency payment arrangements and set the foundation for the development of the payment system for 2022/23 and beyond.

The aligned payment and incentive approach covers the following:

- It applies to all secondary healthcare services (including acute, maternity, community, mental health and ambulance services) commissioned by CCGs with providers who are members of the same ICS.
- For providers and commissioners who are not members of the same ICS:
  - aligned payment and incentive arrangements apply to all CCG-commissioned activity above an annual contract threshold of £10 million

  - payment arrangements for contracts below £10 million would be determined by local agreement.
- All NHS England Specialised Commissioning activity is covered by the aligned payment and incentive approach, with no threshold. Other secondary healthcare commissioned by NHS England is subject to the £10 million threshold.
- All contracted activity using the NHS Increasing Capacity Framework is subject to unit prices rather than the aligned payment and incentive approach.

Aligned payment and incentive agreements comprise two elements:

- A **fixed element**, expected to cover funding for all activity, including:
  - the costs of delivering services within the agreed system plan
  - agreed levels of best practice tariff (BPT) performance (see Section X) and full achievement of CQUIN criteria
  - CCG-commissioned high cost drugs and devices and other items previously excluded from 2020/21 national prices, such as excess bed day payments.
- A **variable element**, which mean payments or deductions are made for:
  - activity over or under a baseline for elective activity
  - BPT attainment above or below that assumed as part of the fixed element
  - CQUIN indicator attainment less than 100%.

See Section 3 of the 2021/22 tariff and Guidance on the aligned payment and incentive approach for more details.

5. Prices

The national tariff sets prices for day cases, admitted patient care, some outpatient procedures and some services accessed directly by primary care. As discussed earlier, from 2021/22 the vast majority of these are no longer ‘national’ prices (ie mandated for use); instead, they are unit prices that can be used for activity outside of the scope of aligned payment and incentive agreements. However, national and unit prices are calculated in the same way, and to the same standard. This section describes how these tariff prices are set and calculated.

Many services do not have prices published as part of the tariff and providers and commissioners must work together to agree prices for them – see Locally determined prices below. The tariff includes rules that apply when a local price is set for services without national prices and for services with a national currency but no national price.

Exclusions

Prices are not set for all activity. This is for various reasons, including:

- services outside the scope of reference costs (which are used to calculate prices)
- some services either have not yet had currencies developed for them, or do have currencies but the costs associated with them are not robust enough to be used to set prices
- some medical devices represent a high and disproportionate cost relative to the cost covered under the relevant HRG
- some drugs are typically specialist and are used by a relatively small number of centres rather than evenly spread across all providers that carry out activity in the relevant HRGs. The cost of the drugs would not be fairly reimbursed if funded through the tariff.

Annex A of the tariff lists high cost drugs and devices excluded from tariff prices.

Locally determined prices

There are three types of locally determined pricing:

- **Local variations** – adjustments to national prices and/or currencies agreed between a provider and commissioner.
- **Local modifications** – increases in national prices for specific currencies where providing the service would otherwise be uneconomic. These can be

an agreement (between provider and commissioner) or application (if there's no agreement, providers can apply to NHS Improvement for a modification).

- **Local prices** – agreed between providers and commissioners for services without a national price, following the tariff's aligned payment and incentive rules or general local pricing rules.

National variations

National variations are adjustments to tariff prices that aim to either:

- improve the extent to which the actual prices paid reflect location-specific costs
- improve the extent to which the actual prices paid reflect the complexity of patient need
- share the financial risk appropriately following (or during) a move to other payment approaches.

One of the most widely used variations is the market forces factor (MFF), which accounts for unavoidable cost differences between organisations in different parts of the country. Some organisations have higher costs because labour, land and buildings cost more in these areas.

The MFF is an index that compares each organisation's unavoidable costs. Organisations can then be ranked according to the level of unavoidable costs they face.

The MFF includes both:

- the underlying index, which is used to adjust funding flows and advise CCG allocations
- the payment index, used in the national tariff to adjust prices at the local level. It is this that is published as part of the national tariff.

Where tariff prices are used, the price a provider receives is multiplied by the organisation's MFF value (ie income = activity x price x MFF). With aligned payment and incentive agreements, which do not use prices in the same way (see Section 4), providers' MFF values, and particularly any changes in values, need to be considered when setting the fixed element.

For more information about the MFF, see *A guide to the market forces factor*.

Non-mandatory prices

Non-mandatory prices can be used as a guide or starting point for local negotiation. Non-mandatory prices exist in two different categories:

- Prices which are derived in the same way as national prices (ie calculated based on reference costs) – these are usually intended to be included as national prices in future tariffs but are currently non-mandatory for various reasons, such as lack of confidence in the accuracy of reference costs (if the cost data has only started to be collected recently, it is advisable to wait for a few collections to allow a stable price to emerged).
- Benchmark prices – these are intended to be used as a starting point in local price setting. Benchmark prices are set where appropriate information to set national prices (such as reference cost data) is not available, but we have been told that prices would be helpful to inform local discussions. Each benchmark prices includes a short description of how the price was calculated to help local areas decide how best to use it.

Providers and commissioners are not obliged to use non-mandatory prices and do not need a local variation or modification to move away from them.

Structure of prices

Tariff prices are designed to create appropriate incentives and achieve policy goals. With the move away from national prices in 2021/22, the impact of prices is less than in previous years, with the aligned payment and incentive approach supporting the desired incentives and goals. However, prices remain a valuable piece of information, allowing comparison with previous years and supporting activity-based payments where required. This section describes the structure of prices.

Elective care

Elective care is care scheduled in advance (as opposed to non-elective – or emergency – care, which is unplanned). The patient's journey often begins in primary care (for example, with a GP), before they are referred to a secondary care provider (such as a hospital) for treatment.

The tariff aims to support patient experience and provider efficiency – for example by encouraging day cases rather than a stay in hospital where clinically appropriate. Tariff prices are based on the average of ordinary elective and day case costs, weighted according to the proportion of activity in each (see Table 2).

This means the price will reward providers achieving higher than average levels of day cases and under-reward providers whose day case rate is lower than the average. This is because, where clinically appropriate, day cases represent a better experience for the patient and greater value and efficiency to the NHS.

Table 2: Setting a combined day case and elective price

	Activity	Cost
Day case	4,000	£500
Ordinary elective	1,000	£1,000
Combined tariff		£600

There is also an increasing focus on developing outpatient care and moving care and treatments outside hospital where clinically appropriate. HRG4+ allows capture of cost information for procedures that occur in an outpatient setting. This, in turn, allows setting of prices that reward moving care to outpatient settings, where clinically appropriate.

Long stays

The actual cost of treating individual patients will inevitably vary slightly above or below the average. Sometimes the cost will vary by a large amount. This may be related to length of stay or to providing complex care.

For patients who, for clinical reasons, remain in hospital beyond an expected length of stay, the tariff includes an additional reimbursement called a long stay payment (sometimes referred to as an excess bed day payment). For each HRG with tariff prices, an expected length of stay trim point is also set (and included in the national tariff workbook, Annex A). If a patient stays for more days than the trim point, a per day amount is added to the price set for the HRG.

There are separate trim points for elective and non-elective admissions, although the long stay payment amount is the same. A shorter length of stay would usually be expected for elective rather than non-elective admissions, so elective usually has a shorter trim point.

Specialised services

Tariff prices are calculated based on average costs. This means they do not always take account of the additional costs of patients with complex needs. The tariff therefore uses top-up payments to recognise these additional costs, when they are

not sufficiently differentiated in HRG design. Top-ups are an example of a national variation and are applied as a percentage increase to the relevant price.

The top-up rates, and providers' eligibility for them, are based on the prescribed specialised services (PSS) definitions from NHS England's specialised commissioning team. The list of eligible providers is contained in the PSS operational tool. For more details, see NHS England's *Manual for Prescribed Specialist Services*.

When setting aligned payment and incentive fixed payments, commissioners and providers should consider the specialist top-up amounts that have been paid in previous years.

Unbundling

So that HRGs can better represent activity and costs, some significant elements can be identified separately. This means that they are "unbundled" from the core HRGs that reflect the primary reason for a patient admission or treatment. These unbundled HRGs better describe the elements of care that comprise the patient pathway within a hospital admission or outpatient attendance. Unbundled HRGs can be commissioned, priced and paid for separately. A single patient record can be assigned more than one HRG if it includes any unbundled elements.

Details of unbundled HRGs are available in the national tariff workbook, Annex A.

Pathway payments

Pathway payments are single payments covering a bundle of services that may be delivered by several providers (eg primary, secondary, community services and social care) for a patient's entire pathway of care. They are designed to encourage better organisation and coordination of care, improving patient outcomes and cost effectiveness. There are two pathway-based payment systems related to the tariff:

- maternity healthcare services
- healthcare for patients with cystic fibrosis.

Best practice tariffs

Best practice tariffs (BPTs) encourage patient care that is both high quality and cost effective. They were introduced in 2010/11 and marked a significant departure from setting national prices based on reference costs alone. They are intended to reduce unexplained variation in clinical quality and encourage best practice in high volume

areas. There are currently 21 BPTs – for details, see Annex D of the 2021/22 National Tariff.

BPTs are set up with help from clinicians to incentivise new ways of working, or ways of working shown to produce the best clinical outcomes. When a BPT is set up for an HRG it will often contain two prices: one for those meeting the BPT criteria and a lower price for those that do not. Some BPTs do not have different prices but trigger an additional payment for meeting the criteria. To show they have met the BPT criteria, providers often must submit information to a separate database (such as a patient data registry) reported nationally. Commissioners can then use this data to determine BPT compliance and pay accordingly.

As set out in Section 3, BPTs are also used in aligned payment and incentive agreements, which should reflect agreed levels of BPT achievement in the fixed payment. If actual achievement differs from the agreed levels, a variable payment would then be paid/deducted.

Price inputs

National tariff prices are driven by data. Specifically, three building blocks are required, shown in Figure 2.

Figure 2: The building blocks of the national tariff

Classifications	Currencies	Cost and activity data
Information about patient diagnoses and healthcare interventions in a standard format	Units of healthcare for which payment is made	What it cost to deliver care and how much of each type of activity is delivered

Classification and grouping

When a patient is discharged from hospital, a clinical coder translates the clinician's notes about the patient into codes. This documents the patient's diagnosis and treatment in a standard format. This is necessary for creating clinical data in a format suitable for analysis.

Two standard clinical classifications are used to process clinical data on acute care. The classifications cover diagnoses (ICD-10) and interventions (OPCS-4).

- ICD-10 stands for the ‘International Statistical Classification of Diseases and Related Health Problems (10th Revision)’. It is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization.
- OPCS-4 stands for the ‘Office of Population, Censuses and Surveys Classification of Surgical Operations and Interventions (4th revision)’. It provides an alphanumeric code for operations and interventions a patient undergoes during a spell of care. OPCS-4 is owned and maintained by NHS Digital.

Together, ICD-10 and OPCS-4 contain tens of thousands of clinical codes. This means a huge number of combinations could be documented. Paying at this level would be very complex.

As a result, the national tariff uses healthcare resource groups (HRGs) as the units of healthcare for which payment is made (currencies) for many prices.

HRGs are standard groupings of clinically similar interventions and diagnoses which use comparable levels of healthcare resources. The grouping collates diagnosis and intervention codes in HRG codes and is done using ‘grouper’ software, published by NHS Digital.

The following section give more details on currencies.

Currencies

A currency is a unit of healthcare for which a payment is made.

Different types of currencies support different models of service delivery. Currencies can range from block contracts (paying for all activity within a service for a year) to episodic or activity-based payments (where a price is determined for each consultation or treatment). Aligned payment and incentive agreements use a single currency, defined as all the services covered by the fixed payment, while national and unit prices are based on healthcare resource group (HRG) or treatment function code (TFC) currencies.

HRGs are the currency for admitted patient care and outpatient procedures.

TFCs are used to set unit prices for outpatient attendances. TFCs are based on attendance and clinic type or consultant specialty (for example, TFC 130 is for ophthalmology).

In addition, providers and commissioners can use tariff rules to agree alternative currencies, or variations to national currencies, where needed.

How HRG codes are constructed

An HRG code contains five characters – two letters, then two numbers, then a letter:

- the first letter represents the chapter (body system)
- the second letter represents the sub-chapter (specific part of the body system)
- the two-digit number represents the diagnosis or intervention
- the last letter represents a 'split' for age, complications and comorbidities (CC) or length of stay (Z is used where there is no split).

The first four characters are the HRG root. Figure 3 illustrates how an HRG is built.

Figure 3: Breakdown of HRG ED24B (Complex, Single Heart Valve Replacement or Repair, with CC Score 6-10)

Chapter	Subchapter	Number	Split
E	D	24	B
Cardiology	Cardiac disorders		CC score between 6 and 10

Table 1 gives prices for the ED24 root HRG in the 2021/22 National Tariff. This demonstrates how prices differ depending on the split used (reflecting complexity) and whether the care delivered was elective (planned) or non-elective (non-planned).

Table 1: Examples of HRG prices

HRG code	HRG description	Combined day case and elective tariff	Non-elective tariff
ED24A	Complex, Single Heart Valve Replacement or Repair, with CC Score 11+	£15,140	£20,880
ED24B	Complex, Single Heart Valve Replacement or Repair, with CC Score 6-10	£10,931	£16,296
ED24C	Complex, Single Heart Valve Replacement or Repair, with CC Score 0-5	£9,935	£12,896

Cost and activity data

Cost data is crucial for evaluating how effectively and efficiently care is delivered to patients. Accurate, consistent cost information helps providers and commissioners

understand how to make the best possible use of resources, evaluate clinical practice and compare different ways of working.

Costing involves providers collecting and recording the cost they incurred in providing services. Costs collected include expenditure on equipment, the cost of staff needed to provide the service and other categories.

2021/22 tariff prices are based on reference costs – the average costs of services. Reference costs use currencies (HRGs and TFCs) and are submitted by NHS organisations annually.

Reference costs also include details of the volume of activity, measured by the number of attendances, bed days, episodes, tests, or other unit of activity appropriate to the service. The national tariff also uses hospital episode statistics (HES) activity data.

In recent years, there has been a move to collecting patient-level costing data (known as PLICS). Since 2018/19, this has been mandatory for acute services. As such, PLICS data is likely to be used to set prices in future tariffs.

Calculating tariff prices

Each price is several years in the making. Cost and activity data from Year 1 is collected in Year 2, analysed in Year 3 and then used to set prices for payments in Year 4. For example, prices for 2019/20 followed the path outlined in Figure 5. (Please note: the 2021/22 National Tariff prices use 2020/21 tariff prices as initial relativities, rather than calculating them from new cost and activity data).

Figure 5: Development of national tariff prices

2016/17 (year 1)	2017/18 (year 2)	2018/19 (year 3)	2019/20 (year 4)
Healthcare delivered to patients	Cost and activity data for 2016/17 collected and published	2016/17 data analysed and used to set national prices for 2019/20 tariff	New national tariff come into effect

The price setting process

Calculating prices involves many steps. Full details are available in Section 6 of the 2021/22 National Tariff. The main calculation steps are as follows:

- **Producing draft price relativities**
  We take the latest available reference costs and combine them with the latest available hospital episode statistics (HES) activity data to produce draft price relativities – the relationship between average unit costs for individual currencies. Sources of funding from outside the tariff (eg winter pressures) are removed from the reference costs to ensure they are not reimbursed twice.

- **Making manual adjustments**
  Sometimes prices are produced that seem illogical (such as more complex procedures being given a lower price than less complex ones). This may be due to quirks in the reference cost data or large changes in year-on-year activity levels. To guard against errors, draft price relativities are shared with clinical experts and interested stakeholders. Where illogical prices are reported, these are reviewed and manually adjusted where appropriate.

- **Scaling prices to the allocated budget**
  The national tariff must work within the budget allocated for healthcare services. The budget for national tariff services is referred to as the cost base (see below for details). After draft price relativities are initially calculated, they are adjusted to fit the cost base. The prices' relative values remain the same (ie the price of an HRG will remain 10% higher than another, regardless of the cost base figure).

- **Making price adjustments for inflation and efficiency**
  This updates the prices for the year the national tariff will apply to. See the following section for more details.

Price adjustments: cost uplift and efficiency factors

Every year, the efficient cost of providing healthcare changes because of differences in wages, prices and other issues providers have limited control over. Therefore, as part of the calculation process, draft prices are adjusted to reflect expected inflation in future years. This is known as the cost uplift.

The cost uplift includes changes in pay costs, drugs costs, other operating costs, capital costs and payments to the Clinical Negligence Scheme for Trusts (CNST).

The efficiency factor reduces prices by a set amount and is intended as an achievable challenge for providers to improve their efficiency each year.

For the 2021/22 National Tariff, the cost uplift was set at 3.1% and the efficiency factor was 1.1%. In addition, CQUIN funding was transferred into the tariff,

increasing prices by 1.25%. These adjustments do not reflect funding for COVID-19 costs, which has been distributed outside of the tariff.

Cost base

The cost base is the level of cost that providers can recover from the national tariff before adjustments are made for cost uplifts and the efficiency factor. It signifies the total budget allocated to services within the scope of the national tariff.

The amount of money set aside for the tariff does not necessarily equate to the full reported cost of delivering healthcare. There are several reasons for this, including:

- the existence of different funding sources, which mean that trusts can receive clinical income on top of that provided by the national tariff
- the fact that costs will exceed income if providers have not been able to achieve efficiency savings equal to or greater than the efficiency requirement used in the national tariff.

The starting point for setting the cost base is the revenue that would be received under the previous tariff. In other words, no adjustments are made to the cost base other than those to recognise changes in the scope of services covered by the tariff. New information is then considered to form a view of whether an adjustment to the cost base is warranted.

Information and factors considered include:

- historical efficiency and cost uplift assumptions
- latest cost data
- additional funding outside the national tariff
- any other additional revenue that providers use to pay for tariff services.

6. Find out more

The documents relating to the national tariff currently in effect are available from: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system

We regularly provide updates about national tariff and wider payment system developments: www.england.nhs.uk/pay-syst/national-tariff/developing-the-national-tariff/

You can also sign up for email updates by submitting your details here: www.engage.england.nhs.uk/pricing-and-costing/tariff-and-costing-updates/

For any further questions about the national tariff, please contact pricing@england.nhs.uk

7. Glossary of useful terms and abbreviations

The glossary below defines terms relevant to the national tariff.

30-day readmission rule
The 30-day readmission rule used to be in the tariff to incentivise hospitals to reduce avoidable unplanned emergency readmissions within 30 days of discharge. It was removed by the 2019/20 National Tariff as part of the move to blended payment for emergency care.

Admitted patient care
A hospital's activity (patient treatment) after a patient has been admitted.

Aligned payment and incentive approach
A payment approach introduced in 2021/22, aligned payment and incentive builds on the blended payment design and comprises a fixed and variable element. Aligned payment and incentive rules cover the majority of services in scope of the tariff.

Best practice tariffs (BPTs)
Tariffs designed to encourage providers to deliver best practice care and reduce variation in the quality. Different BPTs with different types of incentives cover a range of treatments and types of care.

Blended payment
Blended payment was initially introduced in 2019/20 to move payment away from a purely episodic basis to one that combines both a fixed and a variable component. Blended payment was introduced for individual services (emergency care and adult mental health in 2019/20; outpatient attendances and maternity in 2020/21). For 2021/22, blended payment has evolved into the aligned payment and incentive approach, covering almost all services.

Block contracts
The main method of funding acute hospitals before PbR/the national tariff (still in use for some services), block contracts are a fixed sum based largely on historic funding patterns and locally negotiated annual increases.

Casemix
A system whereby the complexity (mix) of the care provided to a patient (cases) is reflected in an aggregate secondary healthcare classification. Casemix adjusted payment means that providers are not just paid for the number of patients they treat in each specialty, but also for the complexity or severity of the mix of patients they treat.

CQUIN
CQUIN stands for Commissioning for Quality and Innovation. It is a system that makes a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. In 2021/22, CQUIN funding was transferred into the tariff.

Currency
A currency is the unit of healthcare for which a price is paid.

Day cases
A 'day case' is a patient who has an elective admission to a hospital or other provider but does not remain overnight.

Finished consultant episode
A finished consultant episode (FCE) is a completed period of care for a patient requiring a hospital bed, under the care of one consultant within one provider. If a patient is transferred from one consultant to another, even within the same provider, the episode ends, and another begins.

Healthcare resource groups (HRGs)
Groupings of clinically similar treatments that use similar levels of healthcare resource for which payment is made for admitted patient care, outpatient procedures and A&E attendances.

Hospital episode statistics (HES)
A data warehouse containing non-identifiable patient details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. This data is collected during a patient's treatment at a hospital to enable hospitals to be paid for the care they deliver.

Market forces factor (MFF)
An index used in tariff payment and commissioner allocations to estimate the unavoidable regional cost differences of providing healthcare.

Marginal Rate Emergency Rule (MRET)
MRET set a baseline value for income from emergency admissions for each provider. For each emergency admission above this baseline, the provider received 70% of the normal price. The remaining 30% was retained by the commissioner to spend on initiatives to manage demand for emergency care. MRET was removed by the 2019/20 National Tariff as part of the move to blended payment for emergency care.

Outpatients
When a patient attends hospital for an appointment but does not stay overnight.

Payment by Results (PbR)
An approach to paying providers based on activity undertaken, in accordance with a national tariff. The term is often used to refer to the tariff published by the then Department of Health before 2014/15.

Patient administration system (PAS)
The patient administration system is used in hospitals to record information about patients.

PLICS
Patient-level information and reporting systems, that support the collection and recording of patient-level costs. The term PLICS is also used to refer to patient-level cost data.

Provider
An organisation which provides healthcare services, such as a hospital.

Reference costs
The national average unit cost of an HRG or similar unit of healthcare activity, reported as part of the annual mandatory collection of reference costs from all NHS organisations in England, and published each year since 1997/98. Since 2018/19, reference costs are being replaced by patient-level cost data (PLICS).

Spell
The period from patient admission to discharge within a single healthcare provider. A spell may comprise of more than one finished consultant episode or FCE.

Secondary Uses Service (SUS+)
Secondary Uses Service. A national data warehouse managed by NHS Digital. It provides anonymous patient-based data for purposes other than direct clinical care.

Treatment function code (TFC)
Groupings of clinically similar treatments that use similar levels of healthcare resource for which payment is made for outpatient attendances, based on attendance type and clinic type.

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