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2022/23 National Tariff Payment System

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1. Introduction

1. This is the national tariff for the NHS in England. It specifies the following components that make up the National Tariff Payment System for 2022 to 2023 (the 2022/23 NTPS):
 - the local pricing and payment rules, including the rules for the 2022/23 aligned payment and incentive approach
 - currencies
 - national prices and unit prices
 - the method for determining those prices
 - the methods for determining local modifications
 - related guidance.
2. Since 1 April 2016, Monitor and the NHS Trust Development Authority have operated as a single integrated organisation known as NHS Improvement. Since 1 April 2019, NHS England and NHS Improvement have come together to act as a single organisation. This document is published in exercise of functions conferred on Monitor by section 116 of the Health and Social Care Act 2012 (the 2012 Act). The proposals which form the basis of this national tariff were agreed between NHS England and Monitor under section 118 of the 2012 Act. In the rest of this document, 'NHS Improvement' means Monitor, unless the context otherwise requires.
3. This 2022/23 NTPS has effect for the period beginning on 1 April 2022 and ending on 31 March 2023, or the day before the next national tariff published under section 116 of the 2012 Act has effect, whichever is the later.¹

¹ If a replacement national tariff was to be introduced before the end of this period, this tariff would cease to have effect when that new tariff takes effect.

4. The 2012 Act sets out that the national tariff must contain national prices and rules for those services not subject to national prices (known as “local pricing rules”). The 2022/23 aligned payment and incentive approach involves many more services being subject to such rules (specifically the aligned payment and incentive rules in Section 3), rather than national prices.²
5. For services without national prices, subject to the rules, we have continued to include in this document what are referred to as ‘unit prices’ – these are not mandatory national prices, but are produced to assist the pricing of services under the local pricing rules. We have continued to calculate unit prices for all services that had national prices in the 2017/19 NTPS (before the introduction of blended payment in 2019/20), using the same method as for the calculation of national prices. The unit prices are, in particular, available to use for activity outside the scope of the aligned payment and incentive approach, including activity commissioned under the NHS Increasing Capacity Framework, in accordance with the aligned payment and incentive rules (see Section 3).
6. The document is split into the following sections:
 - Section 2: the scope of the tariff
 - Section 3: aligned payment and incentive rules
 - Section 4: general local pricing rules
 - Section 5: currencies with national prices
 - Section 6: the method for determining national and unit prices
 - Section 7: national variations
 - Section 8: local variations and local modifications to national prices
 - Section 9: payment rules.
7. In summary, Sections 3 and 4 set out the rules which apply to services without national prices, while Sections 5 to 8 deal with national and unit prices (and variations/modifications to those prices).
8. There are five annexes, listed in Table 1.

² The 2022/23 NTPS contains a significant reduction in the scope of national prices, which apply to unbundled diagnostic imaging services only (see Section 5).

Table 1: 2022/23 NTPS annexes

Annex	Description
A	National tariff workbook, including national prices and unit prices
B	Guidance on currencies ³
C	Guidance on best practice tariffs
D	Method used to calculate prices
E	Guidance on local modifications to national prices

9. The national tariff is also supported by documents containing guidance and other information, listed in Table 2.

Table 2: Supporting documents to the 2022/23 NTPS

Title
Non-mandatory guide prices workbook
A guide to the market forces factor
Guidance on the aligned payment and incentive approach
Introduction to the 2022/23 national tariff

10. All annexes and supporting materials can be downloaded from the [NHS England and NHS Improvement website](#).⁴
11. The national tariff forms part of a set of materials that inform planning and payment of healthcare services. Related materials include [NHS Operational Planning and Contracting Guidance](#) and the [NHS Standard Contract](#).

³ As national prices are only for unbundled diagnostic imaging, guidance on these currencies is included in Section 5 of the NTPS. Guidance on services such as admitted patient care and the maternity payment pathway are included in Annex B.

⁴ www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/

2. Scope of the national tariff

12. As set out in the [2012 Act](#), the national tariff covers the pricing of healthcare services provided for the purposes of the NHS. Other than the exclusions described in Sections 2.1-2.7, this covers all forms of NHS healthcare provided to individuals, whether relating to physical or mental health and whether commissioned by local NHS commissioners,⁵ NHS England or local authorities acting on behalf of NHS commissioners under partnership arrangements.
13. Various healthcare services are, however, outside the scope of the national tariff. The rest of this section explains these exclusions.

2.1 Public health services

14. The national tariff does not apply to public health services that are:⁶
 - provided or commissioned by local authorities or United Kingdom Health Security Agency (formerly Public Health England)
 - commissioned by NHS England under its Section 7A public health functions agreement with the Secretary of State, including national immunisation programmes⁷
 - commissioned by NHS England or a local NHS commissioner on behalf of a local authority pursuant to a partnership agreement under section 75 of the National Health Service Act 2006.
15. Public health services commissioned by local authorities include local open access sexual health services and universal health visitor reviews. The

⁵ In this document, 'local NHS commissioners' refers to either clinical commissioning groups (CCGs) or integrated care boards (ICBs), should ICBs become statutory organisations during the period the tariff is in effect.

⁶ See the meaning of 'healthcare service' given in section 64 of the 2012 Act; and the exclusion of public health services in section 116(11).

⁷ For the Section 7A agreement, see www.gov.uk/government/collections/nhs-public-health-functions-agreements.

services commissioned by NHS England under Section 7A arrangements include public health screening programmes, sexual assault services and public health services for people in prison.

2.2 Primary care services

16. The national tariff does not apply to primary care services (general practice, community pharmacy, general dental practice and community optometry) where payment for the services is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the [National Health Service Act 2006](#) (the 2006 Act).⁸
17. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act then the 2022/23 NTPS rules on local price setting apply (see Section 4.2.3). For instance, local price-setting rules apply to minor surgical procedures performed by GPs and commissioned by local NHS commissioners.

2.3 Personal health budgets

18. A personal health budget (PHB) is a set amount of money to support the identified health and wellbeing needs of a particular patient, planned and agreed between that patient and their local NHS.
19. There are three types of PHB:
 - **Notional budget; no money changes hands:** the patient and their NHS commissioner agree how to spend the money; the NHS will then arrange the agreed care.
 - **Real budget held by a third party:** an organisation legally independent of the patient and their NHS commissioner will hold the budget and pay for the care in the agreed care plan.
 - **Direct payment for healthcare:** the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.

⁸ See chapters 4 to 7 of the 2006 Act: for example, the Statement of Financial Entitlements for GP Services, and the drug tariff for pharmaceutical services.

20. If an NHS commissioner uses a notional budget to pay providers of NHS services, this is in the scope of the 2022/23 NTPS. Payment will be governed by the national prices or rules applicable to the services in question.
21. A notional budget may also be used to buy integrated health and social care services to facilitate more personalised care planning. Where these services and products are not NHS services, the 2022/23 NTPS does not apply.
22. If a PHB takes the form of a direct payment to the patient or budget held by a third party, the payments for health and care services agreed in the care plan and funded from the PHB are not in the scope of the 2022/23 NTPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act.⁹
23. The following are not in the scope of the 2022/23 NTPS, as they do not involve paying for provision of NHS healthcare services:
 - Payment for assessing an individual's needs to determine a PHB.
 - Payment for advocacy (advice to individuals and their carers about how to use their PHB).
 - Payment for the use of a third party to manage an individual's PHB on their behalf.
24. More information about PHBs can be found on the [NHS Personal Health Budgets](#) page.

2.4 Integrated health and social care

25. Section 75 of the 2006 Act provides for the delegation of a local authority's health-related functions (statutory powers or duties) to its NHS partner, and vice versa, to help meet partnership objectives and create joint funding arrangements.

⁹ See the National Health Service (Direct Payments) Regulations 2013 (SI 2013/1617, as amended) www.legislation.gov.uk/ukSI/2013/1617/contents/made

26. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain in the scope of the 2022/23 NTPS even if commissioned by a local authority.¹⁰
27. Payment to providers of NHS services that are jointly commissioned are governed by the national prices and rules applicable to those services, as set out in this document.
28. Local authority social care or public health services commissioned under joint commissioning arrangements are outside the scope of the 2022/23 NTPS.

2.5 Contractual incentives and sanctions

29. In previous years, commissioners' application of CQUIN payments and contractual sanctions were based on provider performance, after a provider's income has been determined in accordance with the NTPS.
30. Nationally set financial sanctions for failure to achieve national standards have been removed from the NHS Standard Contract. However, the Contract continues to include certain provisions under which commissioners may withhold payment from providers. Where these contractual provisions are used and change the amount paid for the provision of an NHS service, this is permitted under the rules relating to the making of payments to providers (see Section 9).
31. As with 2021/22, CQUIN funding is included in the tariff. This has been given effect for aligned payment and incentive agreements (see rules 2 and 3 in Section 3). The cost base for 2022/23 unit and national prices includes the 1.25% increase made in 2021/22. Where local prices are agreed that are not based on the 2021/22 cost base, an additional 1.25% increase would be required (see general local pricing rule 2 in Section 4.2). All providers to which CQUIN applies will be expected to report CQUIN metric data, even if they implemented a local departure from the aligned payment and incentive rules.

¹⁰ This would also apply to NHS services commissioned by local authorities under arrangements made under the new section 65Z5 (joint working and delegation arrangements) proposed in the Health and Care Bill.

2.6 Devolved administrations

32. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, the 2022/23 NTPS applies in some but not all circumstances.
33. Table 3 summarises how the 2022/23 NTPS applies to various cross-border scenarios. ‘DA commissioner’ or ‘DA provider’ refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

Table 3: How the 2022/23 NTPS applies to devolved administrations

Scenario	NTPS applies to provider	NTPS applies to commissioner	Examples
DA patient treated in England and paid for by commissioner in England	✓	✓	A Scottish patient attends A&E in England
DA patient treated in England and paid for by DA commissioner	✗	✗	A Welsh patient, who is the responsibility of a local health board in Wales, has elective surgery in England which is commissioned and paid for by that local health board
English patient treated in DA and paid for by DA commissioner	✗	✗	An English patient, who is the responsibility of a CCG, attends A&E in Scotland
English patient treated in DA and paid for by commissioner in England	✗	✓	An English patient has surgery in Scotland which is commissioned and paid for by their CCG in England

34. In the final scenario above, the commissioner in England must follow the prices and rules in the 2022/23 NTPS, including the aligned payment and incentive rules in Section 3. However, there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally in the country in question, or use a different currency from that mandated by the national tariff. In such cases, the commissioner must follow the general rules for local pricing (see Section 4.2). If there is a national price for the service, a local variation would be required to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the commissioner should follow the rules for local pricing.
35. Providers and commissioners should also be aware of guidance relating to cross-border payment responsibility. The [England/Wales cross border healthcare services: statement of values and principles](#) sets out the values and principles agreed between the NHS in Wales and the NHS in England to ensure smooth and efficient interaction between NHS organisations for patients along the England-Wales border. NHS England also provides comprehensive [guidelines on payment responsibility in England](#).¹¹
36. The payment responsibility rules set out in these documents should be applied as well as any applicable provisions of the 2022/23 NTPS. The scope of the 2022/23 NTPS does not cover these rules.

2.7 Overseas visitors

37. Overseas visitors who are liable to pay a charge under the relevant regulations are NHS patients where the cost of treatment is to be recovered from the individual. As such, where they receive treatment that falls within the scope of the national tariff, they should be charged based on commissioned prices. This might be national prices, including relevant national variations, or any applicable local variations or local prices. The charges will either be 100% or 150% of the commissioned price, depending on country of residence.
38. For more details, please see the [overseas visitors charging rules](#).

¹¹ See the [Who pays?](#) guidance. For queries relating to commissioning responsibilities, you can also contact england.responsiblecommissioner@nhs.net

39. It is important to be aware of exemptions from charges. This may be services (for example accident and emergency or family planning services) or individuals (including vulnerable people such as refugees or asylum seekers). Please see Chapter 1 of the [Guidance on implementing the overseas visitor charging regulations](#) for details of exempt services and individuals.

3. Aligned payment and incentive rules

40. This section sets out the aligned payment and incentive rules for services without national prices for 2022/23. There are national prices for unbundled diagnostic imaging services only (see Section 5). This means that all secondary care services apart from diagnostic imaging are not in the scope of national prices.
41. Providers and commissioners must apply the rules set out here to agree the amounts payable for the specified services, subject to certain exceptions. In cases where the exceptions apply (eg where the contract is between a provider and a local NHS commissioner that are mapped to different ICSs for financial control purposes, and the expected annual contract value is less than £30 million), then the general position is that the general local pricing rules in Section 4 apply (but see detailed provisions in rule 4).
42. The aligned payment and incentive approach does not change the requirements to report activity data (see Section 9.2).
43. The aligned payment and incentive approach is a type of blended payment, based on the model introduced in the 2019/20 tariff. In line with the commitments in the [NHS Long Term Plan](#), a blended payment approach remains the direction of travel for the NHS payment system.

Rule 1 (general rule)

- a) Commissioners and providers must determine the prices payable for the provision of secondary care services in accordance with this rule, and rules 2 to 5 below, and having regard to guidance published by NHS England and NHS Improvement in relation to the pricing of those services.
- b) The local pricing rules specified in Section 4.2 (general local pricing rules) do not apply to those cases where the aligned payment and incentive specified in rule 2 applies.

- c) Subject to rule 4 (exceptions), rule 2 and the aligned payment and incentive specified in that rule applies to all secondary care services where one or more of the following conditions applies:
- i. the commissioner and provider have an expected annual contract value of £30 million or more,¹²
 - ii. the commissioner is a local NHS commissioner, and that both provider and commissioner are mapped to the same ICS for financial control purposes,
 - iii. the commissioner is NHS England for Specialised Commissioning services.¹³
- d) In these rules:

“CQUIN metrics” means Commissioning for Quality and Innovation (CQUIN) scheme metrics to be used in accordance with guidance issued by NHS England;

“expected annual contract value” means:

- i. the amount agreed by the commissioner and provider as the expected value of the contract between them for the provision of secondary care services for the financial year 2022/23, or
- ii. if no such contract has been agreed but the commissioner and provider accept that such services are to be provided by the provider (for the benefit of persons for which the commissioner is responsible) during some or all of that year, the amount agreed by the commissioner and provider as the expected amount to be paid for provision of those services if a contract was agreed, calculated on the same basis as referred to in paragraph (a);

¹² The intention is for the £30m or more threshold to apply at the level of the proposed ICB footprints. Should CCGs remain in place at April 2022, we expect contracts to take into account what an ICB-level contract value would be with the provider and use aligned payment and incentive agreements accordingly. See *Guidance on the aligned payment and incentive approach* for more information.

¹³ This includes where the NHS England commissions those services jointly with Integrated Care Boards under proposed joint working arrangements under the Health and Care Bill.

“elective activity” means the number of elective spells, first outpatient attendances and outpatient procedures which group to a non-WF HRG with a published HRG price;

“ICS” means an integrated care system;¹⁴

“secondary care services” means health care services provided for the purposes of the NHS,¹⁵ other than primary care services where the payments made to providers of those services are determined by, or in accordance with, regulations or directions, and related instruments, made under the primary care provisions of the National Health Act 2006 (chapters 4 to 7);

“Specialised Commissioning services” means the services specified in Schedule 4 to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012;¹⁶

“the value of elective activity” is, in relation to any period during the financial year 2022/23, the amount that would be payable for elective activity, calculated by reference to the number of elective spells, first outpatient attendances and outpatient procedures which group to a non-WF HRG with a published HRG price for that year, if that activity was priced using the unit prices set out in Annex A, along with the national variations which would have applied if they were national prices.

- e) These rules do not apply to services subject to national prices under this national tariff (unbundled diagnostic imaging services).

Rule 2 (agreeing the aligned payment and incentive)

- a) Where this rule applies, the price payable by a commissioner to a provider for the provision of secondary care services shall be a single payment for the financial year, calculated in accordance with the following paragraphs.¹⁷

¹⁴ www.england.nhs.uk/integratedcare/integrated-care-systems/

¹⁵ This includes hospital, community, mental health and ambulance services, but excludes services provided pursuant to the public health functions of local authorities or the Secretary of State

¹⁶ S.I. 2012/2996, as amended.

¹⁷ The supporting document *Guidance on the aligned payment and incentive approach* provides more detail on calculating this payment.

- b) The provider and commissioner must agree an initial fixed element representing funding for the provision of secondary care services for the financial year, applying the principles for local pricing specified in Section 4.1, and having regard to guidance published by NHS England and NHS Improvement,¹⁸ the cost uplift and efficiency factors for 2022/23 (as set out in Sections 6.6 and 6.7). This should include an expected value for the provision of high cost drugs, devices and listed procedures unless they are identified as not included in aligned payment and incentive fixed elements in Annex A (tabs 14a, 14b and 14c), and the implementation costs of the listed innovation products in tab 14c.
- c) The high cost drugs, devices and listed procedures, and innovative products that are not identified as included in aligned payment and incentive fixed elements in Annex A (tabs 14a, 14b and 14c) will be reimbursed in accordance with local pricing rule 3 (see Section 4.2.2) and, for devices commissioned by NHS England Specialised Commissioning, the [HCTED \(high cost tariff-excluded devices\)](#) programme.
- d) The initial fixed element must reflect assumed full achievement of CQUIN metrics and so needs to be increased by 1.25% if CQUIN funding is not already included. This produces the fixed payment.
- e) The provider and commissioner must also agree:
- i. the expected level of BPT criteria attainment which the provider will achieve in delivering those services,
 - ii. the expected level of elective activity for the financial year which is intended to be reflected in the initial fixed element,
 - iii. the expected level of advice and guidance activity for the financial year which is intended to be reflected in the initial fixed element.
- f) Subject to rule 3, the price payable shall be the fixed payment, varied as set out below:
- i. If the value of elective activity undertaken during the financial year is greater than the amount planned for and reflected in the initial fixed element, an amount equal to 75% of the difference between the value of

¹⁸ Including [2022/23 Operational Planning Guidance](#).

- actual elective activity and the value of planned elective activity must be added to the fixed payment.
- ii. If the value of elective activity undertaken during the financial year is less than the amount planned for and reflected in the initial fixed element, an amount equal to 75% of the difference between the value of planned elective activity and the value of actual elective activity must be deducted from the fixed payment.
 - iii. If the level of advice and guidance activity is different to that agreed pursuant to paragraph (e) above, the fixed payment should be increased or decreased as agreed by the commissioner and provider in accordance with guidance issued by NHS England.
 - iv. If the attainment of BPT criteria in relation to services delivered is different to that agreed pursuant to paragraph (e) above, the fixed payment should be increased or decreased by the difference in value between the expected and actual levels of activity meeting BPT criteria, calculated using the BPT and unit prices published in Annex A.
 - v. If the provider does not achieve required performance against the CQUIN metrics, the fixed payment should be decreased as agreed by the commissioner and provider in accordance with guidance issued by NHS England.

Rule 3 (locally agreed adjustments)

- a) The commissioner and provider may agree an adjustment to the price payable under rule 2, including a change as to how the fixed payment is calculated or a variation to the fixed payment other than as provided for in rule 2(f), provided that:
 - i. they comply with paragraphs (b) to (f), which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in Section 8.1; and
 - ii. the agreement is approved by NHS England and NHS Improvement following an application by the commissioner and provider.
- b) The commissioner and provider must apply the local pricing principles in Section 4.1.

- c) The agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers the services in question.
- d) The commissioner must maintain and publish a written statement of the agreement, using the template provided by NHS Improvement,¹⁹ within 30 days of the relevant contract being signed, or in the case of an agreement during the term of an existing contract, the date of the agreement.
- e) The commissioner must have regard to the guidance in Section 8.1 when preparing and updating the written statement.
- f) The commissioner must submit the written statement to NHS Improvement.

Rule 4 (exceptions – services outside the aligned payment and incentive)

- a) Rules 2 and 3 do not apply where:
 - i. a commissioner and provider of secondary care services (other than Specialised Commissioning Services) have an expected annual contract value of less than £30 million and are not mapped to the same ICS for financial control purposes; or
 - ii. the services are provided pursuant to a contract awarded under the NHS Increasing Capacity Framework²⁰
 - iii. the services have been subcontracted to a separate provider.
- b) In those cases, the prices payable for the provision of secondary care services for the financial year must be determined as follows:
 - i. in cases falling within paragraph (a)(i):
 - a. the prices agreed between the commissioner and provider in accordance with the general local pricing rules in Section 4.2, or
 - b. where no agreement can be reached between provider and commissioner, the unit and BPT prices set out in Annex A (to the extent those prices apply to the services), subject to the national variations which would have applied if they were national prices; or

¹⁹ Template available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/
²⁰ For details of the framework, see: www.ardengemcsu.nhs.uk/nhs-england-increasing-capacity-framework/

- ii. in cases falling within paragraph (a)(ii) or (a)(iii) (whether or not also falling within paragraph (a)(i)), the unit and BPT prices set out in Annex A (to the extent those prices apply to the services), subject to the national variations which would have applied if they were national prices, and any payment rules applicable under the Framework.

Rule 5 (additional requirements)

In addition to agreeing payment in accordance with rules 2, 3 and 4, providers of certain services must also comply with the following requirements:

- a) Where providers of mental health services covered by the care cluster currencies are clustering patients, they should record and submit the cluster data to NHS Digital as part of the Mental Health Services Dataset.
- b) All providers of IAPT services are required to submit the IAPT dataset to NHS Digital, whether or not the person receiving services is covered by a care cluster.
- c) Mental health providers and commissioners must ensure that any agreed payment approach enables appropriate patient choice.
- d) For ambulance services, quality and outcome indicators must be agreed locally and included in the commissioning contracts covering the services in question.
- e) All providers of services covered by the CQUIN metrics should record and report achievement against the relevant indicators.

4. General local pricing rules

44. National prices can sometimes be adjusted through local variations or, where they do not adequately reimburse efficient costs because of certain issues, through local modifications. Provisions relating to local variations and local modifications to national prices can be found in Section 8. Where there are no national prices, commissioners and providers must determine local prices in accordance with any rules specified in the national tariff.
45. Section 3 has set out the rules which apply in most cases to secondary care services without national prices. This section sets out:
 - the principles that apply to locally determined prices (Section 4.1)
 - the general local pricing rules which apply to cases where the aligned payment and incentive rules in Section 3 do not apply (Section 4.2).
46. Unbundled diagnostic imaging are the only services subject to national prices in 2022/23. The local prices for all other services are, however, to be determined in accordance with the detailed aligned payment and incentive rules in Section 3 and the general local pricing rules in Section 4.2.
47. This section is supported by the following annexes and supporting document:²¹
 - Annex A: National tariff workbook
 - Annex B: Guidance on currencies
 - Guidance on the aligned payment and incentive approach.

²¹ All available to download from: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/

4.1 Principles applying to local variations, local modifications and local prices

48. Subject to paragraph 50, commissioners and providers must apply the following three principles when agreeing a local payment approach:
- The approach must be in the best interests of patients.
 - The approach must promote transparency to improve accountability and encourage the sharing of best practice.
 - The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches
 - The provider and commissioner(s) should consider how the payment approach could contribute to reducing health inequalities.
49. These principles are explained in more detail in Sections 4.1.1 to 4.1.4 and are additional to other legal obligations on commissioners and providers. These obligations include other rules set out in the national tariff, and the requirements of competition law, procurement law, regulations under section 75 of the 2012 Act,²² and NHS Improvement's provider licence.
50. In relation to the 2022/23 aligned payment and incentive approach set out in Section 3, commissioners and providers must apply the principles when setting the fixed element of the payment (see rule 2(b)) or when agreeing local departures from the approach (rule 3(b)).
51. Providers and commissioners should maintain a record of how local payment approaches comply with the principles. The content and level of detail of this record will vary depending on the circumstances. For example, more information is likely to be required for high value contracts than for lower value contracts.

²² See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (SI 2013/500).

4.1.1 Best interest of patients

52. Local variations, modifications and prices must be in the best interests of patients today and in the future. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:
- **Quality:** how will the agreement maintain or improve the clinical effectiveness, patient experience and safety of healthcare today and in the future?
 - **Cost-effectiveness:** how will the agreement make healthcare more cost effective, without reducing quality, to enable more effective use of resources for patients today and in the future?
 - **Innovation:** how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interests of patients today and in the future?
 - **Allocation of risk:** how will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?
53. The extent to which, and way in which, these factors need to be considered will differ according to the characteristics of the services and the circumstances of the agreement.
54. To have considered a relevant factor properly, we would expect providers and commissioners to have:
- obtained sufficient information
 - used appropriately qualified/experienced individuals to assess the information
 - followed an appropriate process to arrive at a conclusion.
55. It is up to providers and commissioners to determine how to consider the factors set out above based on the matter in hand.

4.1.2 Transparency

56. Local variations, modifications and prices must be transparent. Increased transparency will make commissioners and providers more accountable to each other, patients, the general public and other interested stakeholders.

Transparent agreements also mean that best practice examples and innovation in service delivery models or payment approaches can be shared more widely. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

- **Accountability:** how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the public and other stakeholders?
- **Sharing best practice:** how will innovations in service delivery or payment approaches be shared in a way that spreads best practice?

4.1.3 Constructive engagement

57. Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that delivers the best value for patients in their local area. This process should involve clinicians, patient groups and other relevant stakeholders where possible. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time. Constructive engagement is intended to support better and more informed decision making in both the short and long term.
58. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:
 - **Framework for negotiations:** Have the parties agreed a framework for negotiating local variations, modifications and prices that is consistent with the existing guidelines in the [NHS Standard Contract](#) and procurement law (if applicable)?
 - **Information sharing:** Are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?
 - **Involvement of relevant clinicians and other stakeholders:** Are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
 - **Short- and long-term objectives:** Are clearly defined short- and long-term strategic objectives for service improvement and development agreed before starting price negotiations?

4.1.4 Health inequalities

59. Addressing health inequalities is a key priority for the NHS. When agreeing a locally determined price, commissioners and providers must ask how the agreement facilitates equitable access, excellent experience and optimal outcomes for seldom heard population cohorts. This should be underpinned by analysis of suitably disaggregated data, where available.
60. The agreement must not adversely affect other national and local initiatives which seek to tackle health inequalities. Where all or part of the agreement is specifically tailored to enhance equality of healthcare provision, commissioners and providers must jointly recognise both the expected cost of this and the anticipated benefit. This should be reflected in the locally determined price.
61. In agreeing a locally determined price, it is recommended commissioners and providers visit the [NHS Equality and Health Inequalities Hub](#)²³ to consider their legal duties with regard to health inequalities and to learn more on how the NHS aims to reduce health inequalities. Providers and commissioners should also consider using the [Core20PLUS5](#) approach to achieve better, more sustainable outcomes and reduce healthcare inequalities.

4.2 General local pricing rules

62. For 2022/23, most NHS services do not have national prices. Most secondary care services will be paid for using the pricing rules set out in Section 3. However, there are exceptions from those rules – in particular, where the commissioner and provider are mapped to different ICSs for financial control purposes and have a contract whose annual value is less than £30 million. In these cases, commissioners and providers must work together to agree prices, using the rules in this section.

4.2.1 General rules for all services without a national price

63. Rules 1 and 2 apply when providers and commissioners agree local prices (whether a single annual price for a bundle of services or unit prices for single items of treatment) for services without national prices, in cases where neither

²³ www.england.nhs.uk/about/equality/equality-hub/

the aligned payment and incentive approach nor the NHS Increasing Capacity Framework apply (see rule 4 in Section 3).

Local pricing rules: general rules for services without a national price and outside the scope of the aligned payment and incentive approach

Rule 1

(a) Providers and commissioners must apply the principles in Section 4.1 when agreeing prices for services without a national price.

(b) Where a commissioner and provider cannot agree a price, the price payable shall be that the applicable unit or BPT price for the service (if any such price is specified in Annex A), subject to any national variation which would have applied if the price was a national price.

Rule 2

Commissioners and providers should have regard to the cost uplift and efficiency factors for 2022/23 (as set out in Sections 6.6 and 6.7), and the transfer of CQUIN funding into the tariff in 2021/22, when setting local prices for services without a national price for 2022/23.

64. Where prices are determined locally, it is the responsibility of commissioners to negotiate and agree prices having regard to relevant factors,²⁴ including opportunities for efficiency and the actual costs reported by their providers. Providers and commissioners should also bear in mind the requirements set out in the [NHS Standard Contract](#), such as in relation to counting and coding. NHS England includes an adjustment in commissioner allocations to reflect the unavoidable pressures of rurality and sparsity. When adjusting prices agreed in previous years, commissioners and providers may agree to make price adjustments that differ from the adjustments for national prices where there are good reasons to do so.
65. The pricing of services under these rules can be supported by the unit prices published in Annex A (for example, where providers and commissioners are

²⁴ 'To have regard' requires commissioners to consider the guidance and take it into account when applying the rules and procedures relating to local variations, local prices or local modifications. Commissioners are not bound to follow the guidance, but must have good reasons for departing from it.

mapped to different ICSs and their expected contract value is below £30 million, and they chose to use an activity-based payment approach)

66. Rule 2 requires commissioners and providers to have regard to national price adjustments. In effect they should be used as a benchmark to inform local negotiations. However, these are not the only factors that should be considered. Other relevant factors may include, but are not restricted to:
- commissioners agreeing to fund service development improvements
 - additional costs incurred as part of any agreed service transformation
 - funding of initiatives to address health inequalities
 - taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
 - comparative information (eg benchmarking) about provider costs and opportunities for local efficiency gains
 - differences in costs incurred by different types of provider – for example, differences in indemnity arrangements (such as contributions to the Clinical Negligence Scheme for Trusts – CNST) or other provider specific costs (such as the effects of changes to pensions and changes to the minimum wage).

4.2.2 High cost drugs, devices and listed procedures, and listed innovative products

67. A number of high cost drugs, devices and listed procedures and listed innovative products are subject to special reimbursement arrangements. These items are listed in Annex A, tabs 14a, 14b and 14c (see also Section 5.5 below). The costs of all these items are not included in unit prices (see Section 6). For activity reimbursed by the aligned payment and incentive, the costs of the majority of these items are not included in fixed payment. For some listed high cost drugs, the cost of the product is covered by the aligned payment and incentive fixed element agreed by the commissioner and provider (see rule 2(b) and (e) in Section 3). These items are listed in tab 14b as 'Included in aligned payment and incentive fixed element'. For the listed innovation products in tab 14c, the implementation costs are also covered by the fixed element. In all other cases, the product is reimbursed separately and priced in accordance with rule 3 below.

Local pricing rules: rule for high cost drugs, devices and listed procedures and listed innovative products not reimbursed by national prices or under the aligned payment and incentive

Rule 3

(a) This rule applies to high cost drugs, devices and listed products and listed innovative products which are listed in Annex A and which:

- i. are commissioned by either NHS England or a local NHS commissioner and are not identified as being included in aligned payment and incentive fixed element in tab 14b of that Annex; or
- ii. are being commissioned as part of a service to which an aligned payment and incentive does not apply (see rules 1(c) and 4 in Section 3).

(b) A commissioner and provider must agree the price to be paid for a high cost drug, device or listed procedure or listed innovative product to which this rule applies. However, the price for that item must be adjusted to reflect any part of the cost already captured by a national or unit price or the fixed element of an aligned payment and incentive.

(c) The price agreed should reflect:

- i. in the case of a high cost drug for which a reference price has been set at a level to incentivise provider uptake of that drug, that reference price;
- ii. in the case of a listed innovative product for which a reference price has been set, that reference price;
- iii. in all other cases, the actual cost to the provider, or the nominated supply cost, or any other applicable reference price, whichever is lowest.

(d) As the price agreed should reflect either the actual cost, or the nominated supply cost, or a reference price, the requirement to have regard to efficiency and cost adjustments detailed in Rule 2 does not apply.

(e) The 'nominated supply cost' is the cost which would be payable by the provider if the high cost device, high cost drug or listed innovative product was

supplied in accordance with a requirement to use a supplier or intermediary, or via a framework, specified by the commissioner, pursuant to a notice issued under Service Condition 39 of the [NHS Standard Contract](#) (nominated supply arrangements). The reference prices are set by NHS England and are based on the current best procured price achieved for a product or group of products by the NHS, or set at a level to incentivise provider uptake of a particular drug.

4.2.3 Primary care services

68. Primary care is a core component of NHS care provision. It enables local populations to access advice, diagnosis and treatment. Primary care services cover a range of activities, including:
- providing co-ordinated care and support for general health problems
 - helping people maintain good health
 - referring patients on to more specialist services where necessary.
69. Primary care is also a key part of the provision of community-based health services, interacting with a number of other community-based health teams, such as community nurses, community mental health teams and local authority services.

Primary care payments determined by, or in accordance with, the NHS Act 2006 framework

70. The rules on the aligned payment and incentive approach (Section 3) and local price setting (as set out in Section 4.2.1) do not apply to the payments for primary care services which are determined by, or in accordance with, regulations or directions, and related instruments, made under the primary care provisions of the National Health Act 2006 (chapters 4 to 7). This includes, for example, core services provided by general practices under General Medical Services (GMS) contracts. For 2022/23, the national tariff will not apply to payments for these services.

Primary care payments that are not determined by, or in accordance with, the NHS Act 2006 framework

71. The national tariff covers all NHS services provided in a primary care setting where the price payable for those services is not determined by or in

accordance with the regulations, directions and related instruments made under the NHS Act 2006. Therefore, where the price for services is determined by agreement between NHS England, or a local NHS commissioner, and the primary care provider, the tariff rules for local payment must be applied (the rules in Section 3 or the rules in Section 4.2.1, as the case may be). This includes:

- services previously known as 'local enhanced services' and now commissioned by local NHS commissioners through the [NHS Standard Contract](#) (eg where a GP practice is commissioned to look after patients living in a nursing or residential care home)
- other services commissioned by a local NHS commissioner in a primary or community care setting using its power to commission services for its local population (eg walk-in or out-of-hours services for non-registered patients).²⁵

72. The price paid to providers of NHS services in a primary care setting in most of these instances will be locally agreed, and providers and commissioners of these services must therefore adhere to the general rules set out in Section 4.2.1.
73. The payment for these services could also be part of an aligned payment and incentive agreement, were a provider delivering a bundle of services including such primary care services.

4.2.4 Community services

74. Community health services cover a range of services that are provided at or close to a patient's home. These include community nursing, physiotherapy, community dentistry, podiatry, children's wheelchair services and primary care mental health services. The services provided by community providers are a vital component in the provision of care to older patients and those with long-term conditions.

²⁵ These are arrangements made under the NHS Act 2006, section 3 or 3A.

75. Community providers often work closely with other NHS and social care providers, such as GPs and local authority services, and are a key contributor to developing more integrated health and social care and new care models.
76. Payment for community health services will often use an aligned payment and incentive agreement, in accordance with the rules in Section 3. However, in cases falling outside those rules (eg provider and commissioner that are mapped to different ICSs with an expected annual contract value less than £30 million), payment must adhere to the general rules set out in Section 4.2.1. This allows continued discretion at a local level to determine payment approaches that support high quality care for patients on a sustainable basis.
77. NHS England and NHS Improvement and NHS Digital are testing new currency models for community healthcare, which could be used to support future funding for these services. These models focus on five currency areas: children and young people with disabilities; single episodes of care; long-term conditions; frailty; last year of life. We have published details of the first two of these currencies as non-mandatory models. See [Community services currency guidance: frailty and last year of life](#). More details on the project are available on the [NHS England and NHS Improvement website](#).

5. Currencies

78. A 'currency' is a unit of healthcare for which a payment is made. A currency can take many different forms; for example, it could involve a bundle of services for a group of patients or a particular population (eg the services covered by the fixed payment set out in Section 3), or an individual episode of treatment.
79. Currencies are one of the 'building blocks' that support the NTPS. They include the clinical grouping classification systems for which there are national prices and unit prices in 2022/23.
80. Under the 2012 Act, the national tariff must specify the NHS healthcare services for which a national price is payable.²⁶ The healthcare services to be specified must be agreed between NHS England and NHS Improvement.²⁷ The service specifications are referred to as currencies. The 2012 Act also provides that the national tariff may include rules for determining which currency applies where there is more than one currency and price for the same service. In addition to currencies for national prices, we also use currencies as the basis for the unit prices in the national tariff, which are used to facilitate local pricing (specifically the aligned payment and incentive approach in Section 3).
81. We are using healthcare resource group HRG4+ phase 3 currency design as the basis for setting national prices and unit prices for many services, including admitted patient care and outpatient procedures. The 2022/23 NTPS uses the version of the currency design that was used for 2018/19 reference costs.²⁸

²⁶ 2012 Act, section 116(1)(a).

²⁷ 2012 Act, section 118(7).

²⁸ Details available at <https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/costing---hrg4-2018-19-reference-costs-grouper>

82. This section describes the currencies with a national price, while Annex B contains details of some currencies with unit prices. It should be read in conjunction with the following:²⁹
- Annex A: National tariff workbook. This contains:
 - lists of national prices and unit prices (and related currencies)
 - lists of high cost drugs, devices and procedures and innovative products whose costs are excluded from national prices and unit prices (see Section 4.2.2 and Section 5.5).
 - Annex C: Guidance on best practice tariffs.

5.1 Classification, grouping and currency

83. The national tariff relies on data. To operate effectively, the payment system needs:
- **a way of capturing and classifying clinical activity:** this enables information about patient diagnoses and healthcare interventions to be captured in a standard format
 - **a currency:** the large number of codes for admitted patient activity in the primary classification system makes it impractical as a basis for payment; instead casemix groupings (healthcare resource groups – HRGs) are used as the currency for admitted patients, outpatient procedures and A&E. For outpatient attendances, the currency (treatment function codes – TFCs) is based on groupings that relate to clinical specialty and attendance type (eg first or follow-up attendance).
84. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2022/23 NTPS relies largely on two standard classifications to record clinical data for admitted patients. These are:
- the World Health Organization International Classification of Diseases, 10th revision (ICD-10) for diagnoses³⁰

²⁹ All available from: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/
³⁰ The 5th edition update of ICD-10 was published in April 2015.

- OPCS Classification of Interventions and Procedures (OPCS-4) for operations, procedures and interventions.³¹

85. 'Grouping' is the process of using clinical information such as diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E only) to classify patients to casemix groups structured around healthcare resource groups (HRGs). HRGs are groupings of clinically similar conditions or treatments that use similar levels of healthcare resources. The grouping is done using grouper software produced by NHS Digital.³² NHS Digital also publishes comprehensive documentation giving the logic and process behind the software's derivation of HRGs as well as other materials that explain and support the development of the currencies that underpin the national tariff.³³
86. The 2022/23 NTPS uses spell-based³⁴ HRGs as the currencies for the diagnostic imaging services with national prices. HRGs are also used for most admitted patient care, outpatient attendances and maternity services, for which unit prices or non-mandatory guide prices are set.
87. The HRG currency design used for the 2022/23 NTPS national prices and unit price is HRG4+ phase 3. HRG4+ is arranged into chapters, each covering a group of similar conditions or treatments. Some chapters are divided into subchapters. The specific design for the 2022/23 NTPS is that used to collect 2018/19 reference costs.
88. The currencies for outpatient attendances are counted based on coding to identify clinical specialty and attendance type, defined by TFC.

5.2 Currencies with national prices

89. This section describes the currencies for unbundled diagnostic imaging services, for which there are national prices.

³¹ https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=14270896#14270896

³² <http://digital.nhs.uk/casemix/payment>

³³ Any enquiries on the 'Code to grouper' software, guidance and confirmation of appropriate coding and the grouping of activities can be sent to enquiries@nhsdigital.nhs.uk

³⁴ A spell is a period from admission to discharge or death. A spell starts on admission of the patient.

90. Annex B includes details of the currencies for the following services, which used to have national prices:
- Admitted patient care
 - Chemotherapy and radiotherapy
 - Nuclear medicine
 - Post-discharge rehabilitation
 - Direct access
 - Cystic fibrosis pathway
 - Outpatient attendances
 - Looked-after children health assessments
91. The method we use to determine national prices and unit prices is set out in Section 6. The list of national prices, unit prices and related currencies is in Annex A.
92. In particular circumstances we specify services in different ways, and attach different prices – for example, setting best practice tariffs (BPTs) to incentivise improved outcomes for particular cohorts of patients. As well as specifying the currencies with national prices and unit prices, this section (in combination with Annexes A, B and C) includes the rules for determining which currencies and prices apply where a service is specified in more than one way.
93. Section 3 sets out the aligned payment and incentive rules. The general local pricing rules are set out in Section 4.2.

Changes to the scope of services with national prices

94. There are no changes to the scope of services with national prices from the 2021/22 NTPS. Only unbundled diagnostic imaging services retain national prices.

5.2.1 Unbundled diagnostic imaging services

95. National prices are set for diagnostic imaging services done in an outpatient setting for which there are unbundled HRGs in subchapter RD. These services are:
- magnetic resonance imaging scans

- computed tomography scans
- dual energy X-ray absorptiometry (DEXA) scans
- contrast fluoroscopy procedures
- non-obstetric ultrasounds
- simple echocardiograms.

96. This excludes plain film X-rays, obstetric ultrasounds, pathology, biochemistry and any other diagnostic imaging that generates an HRG outside subchapter RD.

97. Where patient data groups to a procedure-driven HRG without a national price, the diagnostic imaging national prices apply (see below).

Where diagnostic imaging costs remain included in national prices

98. Diagnostic imaging does not attract a separate payment in the following instances:

- where the patient data groups to a procedure-driven HRG that would be covered by an aligned payment and incentive agreement (that is, not from HRG4+ subchapter WF)
- where the national price is zero (eg LA97A, SB97Z and SC97Z, which relate only to the delivery of renal dialysis, chemotherapy or external beam radiotherapy), any diagnostic imaging is assumed to be connected to the outpatient attendance
- where diagnostic imaging is carried out during an admitted patient care episode or during an A&E attendance
- where imaging is part of a price for a pathway or year of care (eg the best practice tariff for early inflammatory arthritis)
- where imaging is part of a specified service for which a national price has not been published (eg cleft lip and palate).

99. For the avoidance of doubt, subcontracted imaging activity must be dealt with like any other subcontracted activity; that is, if provider A provides scans on behalf of provider B, provider B will pay provider A and provider B will charge its commissioner for the activity.

Processing diagnostic imaging data

100. It is expected that providers will use Secondary Uses Service (SUS) submissions as the basis for payment. Where there is no existing link between the radiology system and the patient administration system (PAS), the diagnostic imaging record must be matched to any relevant outpatient attendance activity – for example, using the NHS number or other unique identifier and scan request date. This will enable identification of which radiology activity must and must not be charged for separately. Where the scan relates to outpatient activity that generates a procedure-driven HRG with a national price, the scan must be excluded from charging.
101. The Terminology Reference-data Update Distribution Service (TRUD) provides a mapping between National Interim Clinical Imaging Procedure (NICIP) codes and OPCS-4 codes. NHS Digital publishes grouper documentation that sets out how these OPCS-4 codes map to HRGs.
102. Note that when using the ‘code-to-group’ documentation these diagnostic imaging data are subject to ‘preprocessing’. This means that some of the OPCS-4 codes relating to scans do not appear on the code-to-group sheet and need to be preprocessed according to the code-to-group documentation. This process will be carried out automatically by the grouper and SUS Payment by Results (PbR). It is necessary to map the NICIP codes to OPCS-4 codes, using the TRUD mapping. In some systems it may be necessary to map local diagnostic imaging codes to the NICIP codes before mapping to OPCS-4.
103. National clinical coding guidance, both for the OPCS-4 codes and their sequencing, must be followed. More than one HRG for diagnostic imaging will be generated where more than one scan has been done, and each HRG will attract a separate price. However, where a patient has a scan of multiple body areas under the same modality, this should be recorded using OPCS-4 codes to indicate the number of body areas and will result in one HRG that reflects the number of body areas involved. This means you would not generally

expect more than one HRG for any one given modality (eg MRI) on the same day.³⁵

104. A scan will not necessarily take place on the same day as an outpatient attendance. If there is more than one outpatient attendance on the day the scan was requested, and if local systems do not allow identification of which attendance the scan was requested from, follow these steps:
105. If the diagnostic imaging occurs on the same day as the outpatient activity, and there is more than one outpatient attendance, the scan should be assumed to be related to the activity it follows, using time to establish the order of events. If the scan occurs before any outpatient activity on that day, it should be assumed to be related to the first outpatient attendance that day.
106. If the diagnostic imaging occurs on a different day from the outpatient activity, the scan can be assumed to be related to the first attendance on the day the scan was requested.
107. The diagnostic imaging record should be submitted to SUS PbR as part of the outpatient attendance record, and it will generate an unbundled HRG in subchapter RD. SUS PbR will not generate a price for this unbundled HRG if the core HRG is a procedure-driven HRG covered by an aligned payment and incentive agreement (that is, not from HRG4+ subchapter WF).
108. If the diagnostic imaging is not related to any other outpatient attendance activity – for example, a direct access scan or a scan post-discharge – it must be submitted to SUS PbR against a dummy outpatient attendance of TFC 812 Diagnostic Imaging. As outpatient attendances recorded against TFC 812 are zero priced, this will ensure that no price is generated for the record apart from that for the diagnostic imaging activity.
109. If there is a practical reason why it is difficult to submit the diagnostic imaging record as part of an outpatient attendance record – for example, because the scan happens after the flex-and-freeze date for SUS relevant to the outpatient

³⁵ The MRI and Cardiac devices steering group have advised that providers funded using tariff prices for undertaking an MRI scan with pre- and post-scan device checks for cardiac devices are sometimes reimbursed at a level below the costs they incur. Where this happens, we recommend that providers and commissioners discuss this as part of their payment arrangements or use the option to agree a local price where this would be beneficial locally.

attendance – we recommend a pragmatic approach. For example, the scan could be submitted as for a direct access scan, using a dummy outpatient attendance of TFC 812 Diagnostic Imaging to ensure that no double payment is made for the outpatient attendance.

5.3 Pathway payments

110. Pathway payments are single payments that cover a bundle of services which may be provided by several providers for an entire episode or whole pathway of care for a patient. They are designed to encourage better organisation and co-ordination of care across a pathway and among different healthcare providers. Improving the co-ordination of care, including across different care settings (eg primary, secondary, community services and social care), can improve patient outcomes by reducing complications and readmissions.
111. For 2022/23, there are unit prices in Annex A for a pathway-based payment for patients with cystic fibrosis. See Annex B for details of the pathway.
112. A pathway-base system has previously been used for maternity services. For details of the pathway, see Annex B. For the 2022/23 NTPS, most maternity activity is likely to be in scope of the aligned payment and incentive rules (see Section 3). The document *Guidance on the aligned payment and incentive approach* includes an appendix specifically focussed on payment for maternity services. Unit prices for maternity services are also available in Annex A, while non-mandatory guide prices, which can support areas to agree aligned payment and incentive fixed elements, are available in the *Non-mandatory guide prices* workbook.

5.4 Best practice tariffs

113. A best practice tariff (BPT) is usually a unit price that is designed to incentivise quality and cost-effective care. In the 2022/23 NTPS, BPTs also form part of the aligned payment and incentive variable element. See Section 3 and *Guidance on the aligned payment and incentive approach* for details of the operation of BPTs under the aligned payment and incentive rules.

114. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review.³⁶ The service areas covered by BPTs are all:
- high impact (that is, high volumes, significant variation in practice, or significant impact on patient outcomes)
 - supported by a strong evidence base and clinical consensus on what constitutes best practice.
115. The aim of BPTs is to reduce unwarranted variation in clinical quality and spread best practice. BPTs may introduce an alternative currency, including a description of activities that are associated with good patient outcomes.
116. BPTs provide an incentive to move from usual care to best practice by creating a price differential between agreed best practice and usual care. See Section 6.2.2 for more detail on the method for setting BPT prices.
117. Where a BPT introduces an alternative currency for services with national or unit prices, that currency should be used in the cases described below and as set out in Annexes A, B and C.
118. Each BPT is different, tailored to the characteristics of clinical best practice for a patient condition and to the availability and quality of data. However, many BPTs share similar objectives, such as:
- avoiding unnecessary admissions
 - delivering care in appropriate settings
 - promoting provider quality accreditation
 - improving quality of care.
119. Some BPTs relate to specific HRGs (HRG-level), while others are more detailed and relate to a subset of activity in an HRG (sub-HRG). The BPTs that are set at a more detailed level are identified by 'BPT flags'. For sub-HRG level BPTs, there will be other activity covered by the HRG that does not relate to the BPT activity and so a 'conventional' price is also published for

³⁶ [High quality care for all](#), presented to Parliament in June 2008.

these HRGs to reimburse the costs of the activity unrelated to the BPT. For more information relating to the BPT flags see Annex A, tab 6b.

120. Top-up payments for specialised services and long-stay payments apply to all relevant BPTs. The short stay emergency adjustment (SSEM) may apply to BPTs that are in part or in whole related to emergency care.
121. Full details of all BPTs and guidance on implementation and eligibility criteria are available in Annex C.

5.5 High cost exclusions

122. Several high cost drugs, devices and listed procedures are subject to special reimbursement arrangements. Their costs are not included in either national prices or unit prices. For some items, their cost may be included in the aligned payment and incentive (see rule 2 in Section 3). For other items, or where an item is used in activity outside the aligned payment and incentive, local prices must be agreed by the commissioner and provider in accordance with rule 3 in Section 4.2.2.
123. The relevant drugs, devices and procedures can be found on the high cost lists in Annex A (tabs 14a and 14b). For items not on these lists that are part of a priced treatment or service, the cost of the drug, device or listed procedure is covered by the national price or unit price, or under the aligned payment and incentive.
124. High cost drugs are excluded either individually or as a group exclusion, as indicated in Annex A, tab 14b. A number of high cost devices directly commissioned by NHS England are reimbursed via the [Specialised Commissioning High Cost Tariff-Excluded Device \(HCTED\)](#) programme.
125. For the 2022/23 NTPS we have updated the lists of high cost drugs, devices and procedures.
126. Annex A (tabs 14a and 14b) gives the details and includes the lists of excluded high cost drugs, devices and listed procedures. Tab 14b also lists those items whose costs are covered by the aligned payment and incentive fixed element, where that applies.

127. Annex A, tab 14c, contains an exclusion list for innovative products to support the [MedTech Funding Mandate](#). These products will be commissioned by local NHS commissioners and reimbursed under local pricing arrangements – provided for in local pricing rule 3 (see Section 4.2.2). As part of these arrangements, NHS England and NHS Improvement Innovation team may publish ‘reference prices’ to be used for some of these listed products.
128. For the 2022/23 NTPS, we have added seven items to the list of innovative products.

6. Method for determining national prices and unit prices

129. Our aim in setting prices is to support the highest quality patient care, delivered in the most efficient way.

130. We use the following principles for setting national prices and unit prices:

- Prices should reflect efficient costs. This means that the prices set should:
 - reflect the costs that a reasonably efficient provider ought to incur in supplying services at the quality expected by commissioners
 - not provide full reimbursement for inefficient providers.
- Prices should provide appropriate signals by:
 - giving commissioners the information needed to make the best use of their budgets and enabling them to make decisions about the mix of services that offer most value to the populations they serve
 - incentivising providers to reduce their unit costs by finding ways of working more efficiently
 - encouraging providers to change from one delivery model to another where it is more efficient and effective.

131. Collaboration across systems is of increasing importance as the NHS continues to evolve. Organisations should work closely together to make the most effective and efficient use of resources to improve quality of care and health outcomes for the entire health care system.

6.1 Overall approach

132. The 2022/23 NTPS sets national prices for unbundled diagnostic imaging services only. However, we have included all services that had national prices in the 2017/19 NTPS (ie before the introduction of blended payment in 2019/20) in price calculations and related adjustments. The resulting prices,

while not national prices, are unit prices and are available to use for activity outside the scope of the aligned payment and incentive approach or commissioned under the NHS Increasing Capacity Framework (see rule 4 in Section 3). They are also used in the aligned payment and incentive variable element (see rule 3 in Section 3) and can be a useful reference point for systems, alongside other tools such as Model System, in considering the opportunities to improve efficiency.

133. National prices and unit prices for 2022/23 are modelled from the currency design set out in Section 5 of this document, with 2018/19 cost and activity data. The methodology for 2022/23 prices closely follows that used in past national tariffs and, up to 2013/14, by the then Department of Health Payment by Results (PbR) team.³⁷ Annex D contains a step-by-step description of the method we are proposing to use, including details of the changes that have been made to the PbR method.

134. We have continued to use the software package SAS to run the tariff calculation model. We have reviewed and improved the code for the 2022/23 NTPS. This SAS code is available on request – please contact pricing@england.nhs.uk.

135. Section 6.2 explains the method for setting prices for 2022/23.

6.2 The method for setting prices

6.2.1 Modelling prices for 2022/23

136. Our modelling approach for 2022/23 involves the following steps:³⁸

- Undertake initial processing work on the model inputs to ensure the accuracy of the data used. This includes applying data cleaning rules, converting from episode to spell and linking episode level PLICS costs to HES (see Section 6.3).
- Determine initial price relativities, using the cost and activity data to calculate average costs for each currency (eg HRG).

³⁷ For a description of the 2013/14 PbR method, please see [Payment by results, step by step guide: calculating the 2013/14 national tariff](#).

³⁸ For more details of the steps involved in setting prices, see Annex D.

- Adjust the price relativities to an appropriate base year. As price relativities are based on 2018/19 cost data, we need to adjust them to the current year (2021/22) before we can make any forward-looking adjustments. To do this we adjust the initial price relativities by applying the efficiency, inflation and CNST adjustment factors from the 2018/19, 2019/20 and 2020/21 NTPS. At this point we also reduce all admitted patient care prices by the same percentage (a top-slice) to be reallocated for top-up payments for specialised services (see Section 7.2).
- Make manual adjustments to modelled prices, based on clinical advice, to reduce the number of instances where price relativities are implausible, illogical or distorted (see Section 6.4)
- Apply the first element of the cost base adjustment factors to prices to ensure prices reimburse a total amount of cost equal to the previous tariff (see Section 6.5).
- Use adjustment factors to increase or decrease the total amounts allocated to specific areas (clinical sub-chapters and/or points of delivery), where appropriate, in line with agreed policy decisions or clinical advice and applied using a cash in/cash out approach (see Annex D).
- Apply cash in/cash out adjustments to account for changes in high cost drugs and devices lists, and to manage year-on-year volatility of prices (see Annex D and Section 6.4).
- Adjust prices to proposed 2022/23 levels to reflect cost uplifts (2.8% – see Section 6.6) and an estimate of the minimum level of efficiency that we expect providers to be able to achieve in 2022/23 (1.1% – see Section 6.7).

6.2.2 Setting prices for best practice tariffs for 2022/23

137. For 2022/23, we have used the same method for setting BPTs that was used for 2021/22. This means that, as far as possible, we have applied a standard method of pricing BPTs. This involves:

- using the modelled price, without adjustments, as the starting point
- setting a fixed differential between the BPT and non-BPT price (either a percentage or absolute value)
- setting an expected compliance rate that would be used to determine final prices

- calculating the BPT and non-BPT price so that the BPT would not add to or reduce the total amount paid to providers at an aggregate level.

138. As set out in Section 3, the way BPTs operate is subject to the aligned payment and incentive rules. However, we have not changed the approach to calculating BPT prices.

139. All BPT prices are included in Annex A, tab 6a. Details of the compliance rates and implementation of BPTs are available in Annex C.

6.3 Managing model inputs

6.3.1 Overall approach

140. The two main data inputs used to generate prices for the 2022/23 NTPS are:

- costs – 2018/19 PLICS cost data
- activity – 2018/19 Hospital Episode Statistics (HES)³⁹ and 2018/19 PLICS.

141. The PLICS costs dataset contains cost and activity data for many, but not all, healthcare service providers. The data is collected from all NHS trusts and foundation trusts and therefore covers most healthcare costs. We do not currently collect cost data from the independent sector.

142. The HES activity dataset contains the number of admitted patient care (APC) spells, outpatient appointments and A&E attendances in England from all providers of secondary care services to the NHS. It is mainly needed for the APC tariff calculation because the APC currencies are paid on a spell basis, while the activity data contained in the reference cost dataset are based on finished consultant episodes (FCEs).

Cost dataset used

143. We use 2018/19 PLICS cost data for the prices for the 2022/23 NTPS. We use this cost dataset because it is closely aligned with the currency design⁴⁰ of the 2022/23 NTPS.

³⁹ See <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics>

⁴⁰ We have used the HRG4+ currency system (see Section 5).

Cost data cleaning

144. One of our main objectives in setting prices is to reduce unexplained tariff price volatility.
145. We consider that using cleaned data (ie raw reference cost data with some implausible records removed) will, over time, reduce the number of illogical cost inputs (for example, fewer very low-cost recordings for a particular service and fewer illogical relativities). This, in turn, should reduce the number of modelled prices that require manual adjustment and therefore increase the reliability of the tariff. We believe this benefit outweighs the disadvantage of losing some data points as a result of the data cleaning process.
146. The data cleaning rules exclude:
- outliers from the raw reference cost dataset, detected using a statistical outlier test known as the Grubbs test (also known as the ‘maximum normed residual test’)
 - providers that submitted costs more than 50% below the national average for more than 25% of HRGs as well as 50% higher than the national average for more than 25% of HRGs submitted.
147. We merged data where prices would have been based on very small activity numbers (fewer than 50) unless we were advised otherwise by the EWGs. This was done to maintain stability of prices over time. A review of orthopaedic services found that most trusts have small numbers of cases with anomalous costs for the HRG to which they are allocated, and that these costs are often produced by data errors. Small activity numbers increase the likelihood that prices can be distorted by such errors.
148. We also merged data where illogical relativities were found – for example, where a more complex HRG had a lower cost than a less complex HRG.

6.3.2 HES data inputs

149. In our modelling of the prices for the 2022/23 NTPS, we used 2018/19 HES data, grouped by NHS England and NHS Improvement using the 2018/19 (HRG4+) various groupers and the 2020/21 engagement grouper.

150. Using NHS England and NHS Improvement grouping is a deviation from the 2013/14 PbR method, which used HES data grouped by NHS Digital. However, we use this grouping because it allows us more flexibility in the timing of grouping the data, as well as effective quality assurance of the activity data used to calculate tariff prices.

151. The NHS Improvement grouping method aims to follow, as closely as possible, the NHS Digital grouping method. Analysis indicates that the differences between the two grouping methods are very small.

6.4 Making post-modelling adjustments to prices

152. The method for setting prices involves making some manual adjustments to the modelled prices. This is done to minimise the risk of setting implausible prices (eg prices that have illogical relativities) based on cost data of variable quality.

153. For the 2022/23 NTPS we applied manual adjustments where price relativities are likely to be affected by very low activity numbers that could result in less robust cost data. Specifically, we set prices to the weighted average of day-case/elective (DC/EL) and non-elective prices (NE) in any of the following scenarios:

- DC/EL activity is less than 50.
- NE activity is less than 50.
- DC/EL is less than 3% of DC/EL and NE total activity.
- NE is less than 3% of DC/EL and NE total activity.

154. For an HRG that could involve a high cost device that is excluded from tariff prices (see Section 5.5), we applied manual adjustments based on set values suggested by NHS Digital National Casemix Office. If the modelled price was significantly higher than the suggested value, it was likely to include the device cost and was adjusted downward accordingly. Similarly, where the modelled price was lower than suggested, and the device should be covered by the tariff prices, we applied manual adjustments to set it to the suggested value.

155. We also considered clinical feedback we had received on the draft prices for previous tariffs. Where appropriate, we made adjustments to address the comments before seeking feedback on the updated prices.
156. We subsequently shared the prices with the NHS Digital National Casemix Office and with representatives of medical colleges, associations and societies through their respective EWGs.
157. We then manually adjusted the prices based on the feedback received. Adjustments were also made to address illogical relativities across HRGs, and to ensure that prices were reflective of clinical resource requirements.
158. Where manual adjustments increased the total amount allocated to a particular service, these were offset through a reconciliation process that ensures the total amount allocated to each HRG chapter remains consistent (see Annex D).
159. However, we have increased the amount of money in the Nuclear Medicine chapter following feedback on the increased cost of importing isotopes.
160. We also used the cash in/cash out process⁴¹ to make adjustments to the initially modelled prices for 52 HRGs and points of delivery. This was done where the initially modelled 2022/23 prices were significantly lower than the 2021/22 NTPS prices and some providers might be disproportionately affected by the changes. The increase in prices was funded by a slight reduction to prices in subchapters with large increases between 2021/22 and the initially modelled 2022/23 prices. For details of the cash in/cash out adjustments, see Annex D.
161. These adjustments mean that there is no separate volatility adjustment for 2022/23.

⁴¹ Cash in/cash out is used to increase or decrease the total amounts allocated to specific areas (clinical sub-chapters and/or points of delivery), in line with agreed policy decisions or clinical advice. Details of all cash in/cash out moves are included in Annex D.

6.5 Cost base

162. The cost base is the level of cost that the tariff will allow providers to recover, before adjustments are made for cost uplifts and the efficiency factor is applied.
163. For 2022/23, we have maintained our historic method for setting the tariff cost base. This equalises the cost base to that which was set in the previous tariff, adjusted for activity and scope changes.
164. As with many other parts of tariff setting, the previous year's tariff is a starting point for the following tariff. As such, we used 2021/22 prices and revenue as our starting point for calculating the cost base for both national prices and unit prices. The cost base for national prices only includes prices for unbundled diagnostic services.
165. After setting the starting point, we considered new information and several factors to form a view on whether an adjustment to the cost base is warranted.
166. Information and factors that we considered include:
- historical efficiency and cost uplift assumptions
 - latest cost data
 - additional funding outside the national tariff (including additional funding for direct COVID-19 costs)
 - changes to the scope of the national tariff
 - any other additional revenue that providers use to pay for tariff services
 - our pricing principles and the factors that legislation requires us to consider, including matters such as the importance of setting cost-reflective prices and the need to consider the duties of commissioners in the context of the budget available for the NHS.
167. In judging where to set the cost base, we consider the effect of setting the cost base too high or too low:
- If we set the cost base too low (ie we set too high an expectation that providers will be able to catch up to past undelivered efficiency), providers would be at greater risk of deficit, service quality could decrease below the

level that would otherwise apply (eg increased emergency waiting times), and some providers might cease providing certain services.

- However, if we set the cost base too high, commissioners, who have an obligation to stay within their budgets, are likely to restrict the volumes of commissioned services and could cease commissioning certain services entirely. This would reduce access to healthcare services.

168. For 2022/23, it is our judgement that it is appropriate to keep the cost base equal to the revenue that would be received under 2021/22 prices, adjusted for activity and scope changes.

169. The same cost base methodology is used for setting unit prices as it is for national prices. Unit prices are calculated on the same basis and to the same standard and we believe that there is no reason to calculate these prices using a different methodology.

170. As described in Section 2.5, since 2021/22, CQUIN funding has been integrated into the tariff. As such, the cost base has been increased by around 1.25% to reflect the equivalent amount reallocated from CQUIN. For 2022/23, this increase is reflected in the tariff prices. Local pricing rule 2 requires providers and commissioners to have regard to the transfer of CQUIN funding into the tariff when agreeing local prices (see Section 4.2). In addition, the aligned payment and incentive rules also describe how CQUIN should be incorporated in aligned payment and incentive agreements (see Section 3).

6.6 Cost uplifts

171. Every year, the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. We therefore make a forward-looking adjustment to the modelled prices to reflect expected cost changes in future years deemed outside providers' control. We refer to this as the cost uplift factor. For 2022/23, the cost uplift factor applies to national prices and unit prices. It should also be considered as part of aligned payment and incentive agreements (see Section 3) and other local pricing arrangements (see Section 4).

172. The cost uplift factor for 2022/23 is 2.8%. The cost uplift factor does not reflect changes in costs as a result of COVID-19.

173. We have used broadly the same methodology to set the cost uplift factor for 2022/23 as we used for 2021/22. We have not made an adjustment to the cost uplift factor to reflect COVID-19 costs. Additional funding for direct COVID-19 costs is distributed outside of the tariff – see the [2022/23 Operational Planning Guidance](#). Funding to support elective recovery will form part of the aligned payment and incentive variable element (see Section 3).

6.6.1 Inflation

174. In determining the inflation cost uplift, we considered six categories of cost pressures. These are:

- pay costs
- drugs costs
- other operating costs
- changes in the cost associated with CNST payments
- revenue consequences of capital costs (ie changes in costs associated with depreciation and private finance initiative payments)
- costs arising from new requirements in the Mandate to NHS England. We call these changes ‘service development’ costs. There are no adjustments from the mandate for service development in 2022/23.

175. We gathered initial estimates across these cost categories and then reviewed them to set an appropriate figure for the tariff, which in some instances requires an adjustment to the initial figure. The adjustments are included in a total cost uplift factor that is then applied to the modelled prices.

176. In setting the general cost uplift factor, each cost category is assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure from published 2018/19 financial accounts. Table 4 shows the weights applied to each cost category.

177. For the cost weights, we used previous NTPS cost uplift factors to adjust the 2018/19 consolidated accounts data to produce a projected set of 2022/23 cost weights.

Table 4: Elements of inflation in the cost uplift factor

Cost	Estimate	Cost weight	Weighted estimate
Pay	3.0%	68.9%	2.1%
Drugs	0.9%	2.5%	0.0%
Capital	2.7%	7.1%	0.2%
CNST	-0.1%	2.3%	0.0%
Other	2.7%	19.2%	0.5%
Total			2.8% ⁴²

178. The following costs are excluded from the calculation of cost weights:

- Purchase of healthcare from other bodies, which includes a combination of costs and cannot be discretely applied to one specific category.
- Education and training costs relating to placements which have been funded directly by Health Education England (trainee salaries are included within pay costs).
- High cost drugs, which are not reimbursed through Specialised Commissioning arrangements or tariff prices (see Section 5.5).

179. Below, we describe our method for estimating the level of each inflation-related cost uplift component and the CNST adjustments.

Pay

180. Pay costs are a major component of providers' aggregate input costs. Therefore, it is important that we reflect changes in these costs as accurately as possible when setting national prices.

181. Pay-related inflation has three elements:

- Pay settlements – the increase in the unit cost of labour reflected in pay awards for the NHS.
- Pay drift – the tendency for staff to move to a higher increment or to be upgraded; this also includes the impact of overtime.
- Extra overhead labour costs.

⁴² Note: calculations are done unrounded – only one decimal place displayed.

182. As Table 4 shows, total indicative pay cost change is estimated at 3.0% for 2022/23. This includes a 2% headline pay award assumption for 2022/23, as well as impacts for previously agreed multi-year pay awards. The pay cost estimate also includes the impact of the Health and Social Care Levy. The consultation document stated that if the pay settlement for 2022/23 were agreed before the publication of the 2022/23 NTPS, these rates would be revised and the cost uplift factor updated, where it is practical to do so.

183. For local price-setting, commissioners should have due regard to the impact of the AfC reforms on actual cost inflation, where this can be shown to have a significant differential impact (for example on ambulance services).

Drugs costs

184. The drugs cost uplift is intended to reflect increases in drugs expenditure per unit of activity.

185. We used the 2022/23 GDP deflator rate published in October 2021 (2.7%)⁴³ to estimate price growth in generic drugs included in the tariff. We also assumed that price growth for branded medicines will remain flat for tariff purposes.

186. This results in assumed drugs cost inflation of 0.9% for 2022/23.

Other operating costs

187. Other operating costs include general costs such as medical, surgical and laboratory equipment and fuel.

188. We again used the 2022/23 GDP deflator rate published in October 2021 (2.7%) as the basis of the expected increase in costs.

Clinical Negligence Scheme for Trusts

189. The CNST is an indemnity scheme for clinical negligence claims. Providers contribute to the scheme to cover the legal and compensatory costs of clinical negligence.⁴⁴ NHS Resolution administers the scheme and sets the

⁴³ The GDP deflator is a broad measure of general inflation, estimated by the Office for Budget Responsibility (OBR). Published at www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2021-budget-and-spending-review

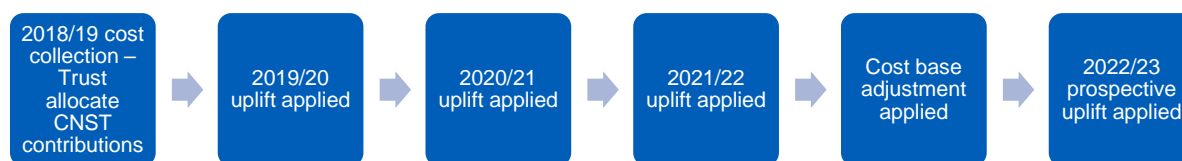
⁴⁴ CCGs and NHS England are also members of the CNST scheme.

contribution that each provider must make to ensure the scheme is fully funded each year.

190. We have allocated the change in CNST costs to core HRG subchapters, to the maternity delivery tariff and A&E services, in line with the average cost increases that will be paid by providers. This approach is different to other cost adjustments, which are estimated and applied across all prices. Each relevant HRG is adjusted based on the change in CNST cost across specialties mapped to HRG subchapters. This means that our cost adjustments reflect, on average, each provider's relative exposure to CNST cost changes, given their individual mix of services and procedures.⁴⁵ In 2022/23, CNST adjustments are applied to national prices and unit prices.

191. Figure 1 sets out our approach to including CNST in the national tariff prices.

Figure 1: Including CNST in the national tariff



192. A provider's CNST contributions are included in the costs it submits as part of the national cost collection. For the 2022/23 NTPS, these are 2018/19 patient-level costs (PLICS). The cost uplift (including CNST) and efficiency factors for 2019/20, 2020/21 and 2021/22 are then applied, as part of the process of bringing prices up to the cost base for the current year (ie the level of the year in which the prices are set). Cost base adjustments are then made to scale prices to the agreed payment levels (as set out in Section 6.2) before applying the prospective CNST adjustment, the other cost uplifts and adjustments and the efficiency factor for the tariff year. The prospective adjustment is the difference between the total amount of CNST included in 2021/22 NTPS national and unit prices and the total amount of CNST included in 2022/23 prices.

⁴⁵ For example, maternity services have been a major driver of CNST costs in recent years. For this reason, a provider delivering maternity services as a large proportion of its overall service mix would probably find that its CNST contributions (set by NHS Resolution) have increased more quickly than the contributions of other providers. However, the cost uplift reflects this, since the CNST uplift is higher for maternity services. This is consistent with the approach previously taken by DHSC.

193. Table 5 lists the percentage changes that we have applied to each HRG subchapter to reflect the change in CNST costs.

194. Most of the changes in CNST costs are allocated at HRG subchapter level, maternity or A&E, but a small residual amount is unallocated at a specific HRG level. This unallocated figure is redistributed as a general adjustment across all prices. The amount of unallocated CNST reduced by about £2.7 million between 2021/22 and 2022/23. We have therefore calculated the adjustment due to this pressure as -0.1% in 2022/23.

Table 5: CNST tariff impact by HRG subchapter

HRG sub chapter	2022/23 uplift (%)	HRG sub chapter	2022/23 uplift (%)	HRG sub chapter	2022/23 uplift (%)
AA	-0.05%	JA	-0.02%	PP	-0.09%
AB	-0.02%	JC	-0.04%	PQ	-0.03%
BZ	-0.04%	JD	-0.03%	PR	-0.08%
CA	-0.03%	KA	-0.05%	PV	-0.07%
CB	-0.03%	KB	-0.02%	PW	-0.10%
CD	-0.02%	KC	-0.02%	PX	-0.07%
DZ	-0.02%	LA	-0.02%	SA	-0.03%
EB	-0.02%	LB	-0.02%	VA	-0.06%
EC	-0.02%	MA	0.10%	WH	-0.03%
ED	-0.02%	MB	0.05%	WJ	-0.02%
EY	-0.02%	PB	-0.05%	YA	-0.11%
FD	-0.04%	PC	-0.09%	YD	-0.01%
FE	-0.03%	PD	-0.10%	YF	-0.04%
FF	-0.05%	PE	-0.05%	YG	-0.03%
GA	-0.06%	PF	-0.08%	YH	-0.05%
GB	-0.04%	PG	-0.07%	YJ	-0.01%
GC	-0.04%	PH	-0.07%	YL	-0.02%
HC	-0.07%	PJ	-0.09%	YQ	-0.04%
HD	-0.04%	PK	-0.07%	YR	-0.04%
HE	-0.07%	PL	-0.06%		
HN	-0.06%	PM	-0.02%	VB	-0.27%
HT	-0.07%	PN	-0.05%	Maternity	-0.62%

Capital costs (changes in depreciation and private finance initiative payments)

195. Providers' costs typically include depreciation charges and private finance initiative (PFI) payments. As with increases in operating costs, providers should have an opportunity to recover an increase in these capital costs.
196. As with pay, drugs costs and other operating costs, we used the 2022/23 GDP deflator rate published in October 2021 (2.7%) to calculate assumed capital cost inflation.

Service development

197. The service development uplifts reflect expected extra unit costs to providers of major initiatives that are included in the Mandate.⁴⁶ However, there are no major initiatives anticipated in the Mandate to be funded through the national tariff in 2022/23, and no uplift is applied.

6.7 Efficiency

198. National prices are adjusted up by the cost uplift factor (see Section 6.6), reflecting our estimate of inflation, and down by the efficiency factor, reflecting our estimate of the average efficiency providers can be expected to achieve year-on-year. This approach is consistent with other sectors where prices are regulated centrally. For 2022/23, the efficiency factor applies to national prices and unit prices. It should also be considered as part of aligned payment and incentive agreements (see Section 3) and other local pricing arrangements (see Section 4).
199. The efficiency factor for 2022/23 is 1.1%. The efficiency factor does not reflect changes in costs as a result of COVID-19.
200. In previous years, the decision on the efficiency factor was informed by an econometric model of cost variations between providers over time explained by i) the outputs they produce and ii) factors outside their control. The remaining trend over time is interpreted as trend efficiency. Residual differences between trusts are used to estimate the distribution of efficiency

⁴⁶ The Mandate to NHS England sets out objectives for the NHS and highlights the areas of healthcare where the government expects to see improvements.

across the sector. The model includes data from 168 acute trusts for the period between 2008/09 and 2017/18.

201. For 2022/23, the model was not run as any updated data would be affected by the impact of COVID-19. Instead, we have used the previous run of the model.
202. This modelling suggested that trusts have become 0.9% more efficient each year on average. Around this trend, we estimate that there is substantial variation in efficiency that could justify an efficiency factor greater than 0.9% (ie if poorer performers, with greater efficiency opportunities, improved their efficiency at a greater rate). For instance, if the average performer catches up to the 60th centile we estimate that this would release 1.4% efficiency in addition to trend efficiency.
203. However, adjusting the time period of the model highlighted that the delivery of efficiencies has slowed in recent years.
204. We have set an efficiency factor of 1.1% for 2022/23. We regard this as challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure.
205. As with the cost uplift factor, we have not made an adjustment to the efficiency factor to reflect changes in costs as a result of COVID-19. While we acknowledge that COVID-19 is likely to have a significant impact on the costs of routine healthcare delivery during 2022/23 as a result of the changes to the way many services are delivered, it is not clear to what extent those changes would increase or decrease costs. The efficiency factor reflects pre-COVID activity. Any adjustments would need to be agreed locally between the provider and commissioner.
206. More detail on reimbursement of COVID-19 related costs, and distribution of additional government funding outside the tariff is included in the [2022/23 Operational Planning Guidance](#).

7. National variations to national and unit prices

207. In some circumstances, it is appropriate to make national adjustments to national prices. For example, adjustments may reflect local differences in costs that the formulation of national prices has not taken account of, or they may share risk more appropriately among parties.
208. We refer to these nationally determined adjustments as ‘national variations’ to national prices. We refer to the price, after application of national variations, as the ‘nationally determined price’.
209. Specifically, national variations 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.
210. This section sets out the national variations specified in the 2022/23 NTPS.
211. While national variations apply to services with national prices, they should be considered as part of aligned payment and incentive agreements (see Section 3 and *Guidance on the aligned payment and incentive approach*). When unit prices are being used as part of the variable element or for payments outside the scope of aligned payment and incentive agreements, national variations should continue to be applied to adjust the prices as if they were national prices.
212. For national prices, national variations sit alongside local variations and local modifications. Providers and commissioners should note:
- if a commissioner and a provider choose to bundle services that have a mix of national prices and locally determined prices, national variations can in

effect be disapplied or modified by local variations agreed in accordance with the applicable rules (see Section 8.1)

- in the case of an application or agreement for a local modification (see Section 8.2), the analysis must reflect all national variations that could alter the price payable for a service (ie it is the price after any national variations have been applied that should be compared with a provider's costs)

213. The rest of this section covers two types of national variation:

- variations to reflect regional cost differences
- variations to reflect patient complexity

214. The 2022/23 NTPS has removed two national variations to support different payment approaches, relating to evidence-based interventions and the best practice tariff for primary hip and knee replacements. The effect of these variations is instead achieved through the aligned payment and incentive rules and guidance (see Section 3 and *Guidance on the aligned payment and incentive approach*) and updated guidance for the BPT (see Annex C).

7.1 Variations to reflect regional cost differences: the market forces factor

215. The purpose of the market forces factor (MFF) is to compensate providers for unavoidable cost differences in providing healthcare services. Unavoidable costs include variations in capital, building, business rates and labour costs.

216. The MFF takes the form of an index. This allows a provider's location-specific costs to be compared with every other organisation. The index is constructed so that it always has a minimum value of 1.00. The MFF payment index operates as a multiplier to each unit of activity.

217. Further information on the calculation and application of the MFF is provided in the supporting document, *A guide to the market forces factor*.

218. In 2019/20 we revised the calculation method and data used for the MFF, assigning new MFF values to all organisations. The new values are being phased in over a five-year period in equal steps.

219. For 2022/23, MFF values for each NHS provider represent the fourth step of this transition. All MFF values for 2022/23 are available in Annex A, tab 13.
220. Moving to the third step of the transition further reduces the total amount of money that would have been paid through the MFF if all activity was reimbursed using national prices and unit prices, with compensating increases in the prices. The resulting increase in 2022/23 prices, compared to using 2021/22 MFF values, is 0.38%. Providers and commissioners can consider how to take account of changes in provider MFF values when agreeing their aligned payment and incentive fixed element.
221. The MFF value for independent sector providers should be the MFF value of the NHS trust or foundation trust nearest to the location where the services are being provided.
222. Where NHS providers outsource the delivery of entire services to other providers, consideration needs to be given to the MFF that is applied. For example, if provider A seeks to outsource the delivery of a service to provider B in such a way that the patient is recorded as provider B's activity (ie provider B will bill the commissioner for the activity) but the activity is still delivered at the provider A site, then the relative MFFs of the two providers must be considered:
- If provider B has a higher MFF than provider A, discussion with the commissioner is needed to agree an appropriate price in the light of the lower unavoidable costs they will incur.
 - Conversely, if provider B has a lower MFF than provider A, discussion with the commissioner is needed to ensure the provider is adequately compensated for the delivery of the service.
223. Organisations merging or undergoing other organisational restructuring after the publication of the 2022/23 NTPS will not have a new MFF set during the period covered by this tariff. For further guidance in these circumstances see the supporting document, *A guide to the market forces factor*.
224. Providers should notify NHS England and NHS Improvement of any planned changes that might affect their MFF value. Please contact pricing@england.nhs.uk

7.2 Variations to reflect patient complexity

7.2.1 Top-up payments

225. National prices and unit prices in this national tariff are calculated on the basis of average costs. This means they do not take account of cost differences between providers because some providers serve patients with more complex needs. The purpose of top-up payments for some specialised services has been to recognise these cost differences and to improve the extent to which prices paid reflect the actual costs of providing healthcare when this is not sufficiently differentiated in the HRG design.
226. Specialised service top-ups have been part of the payment system since 2005/06. The current list of qualifying specialised services, and the design and calculation of specialised top-ups for these services, are informed by research undertaken in 2011 by the Centre for Health Economics at the University of York.⁴⁷
227. Only a few providers are commissioned to deliver such specialised care. The list of eligible providers is contained within the prescribed specialised services (PSS) operational tool.⁴⁸
228. Top-ups are funded through an adjustment (a top-slice) to remove money from the total amount allocated to national prices and unit prices. This money is then able to be reallocated to providers of specialised services.
229. As set out in Section 3, the aligned payment and incentive rules apply to all activity commissioned by NHS England Specialised Commissioning. When agreeing the fixed element, commissioners and providers should consider the top-ups previously received.
230. For 2022/23, the national prices and unit prices have been adjusted by the top-slice, reducing the total amount allocated to prices by £485.9 million. Were the top-ups to be paid through prices, Table 6 shows the amount we have calculated different specialist areas would receive. This includes the second

⁴⁷ [Estimating the costs of specialised care](#) and [Estimating the costs of specialised care: updated analysis using data for 2009/10](#).

⁴⁸ <https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools>

step in the transition of the difference in income for some services as a result of the move to PSS and HRG4+. However, the aligned payment and incentive approach means that specialist providers are unlikely to be paid on the basis of national or unit prices and so the amounts providers receive may vary.

Table 6: Potential top-up impact by specialist area 2022/23

Top-up area	Top-up amounts
Cancer	£19.7m
Cardiac	£74.5m
Children	£171.9m
Neurosciences	£117.1m
Orthopaedics	£3.1m
Other	£17.1m
Respiratory	£72.2m
Spinal	£10.3m
All top-up areas	£485.9m

231. We have used the same the top-up rates for 2022/23 as 2021/22.

232. A list of the services eligible for top-ups, the adjustments and their flags can be found in Annex A, tab 15.

Payment approach for complex knee revision surgery

233. In 2022/23, we are continuing with the payment approach for knee revision surgery introduced in 2020/21. This aims to support orthopaedic providers to deal with complex activity. The approach involves the following:

- Transferring £12.9 million to NHS England Specialised Commissioning from the total amount allocated by the tariff to orthopaedic and trauma services. Specialised Commissioning will then fund, in addition to the national tariff prices and top-ups, providers of knee revision surgery for complex activity. Providers will receive a core payment, based on historical activity levels and national and unit prices. They will then receive additional payments for complex activity, funded by the transferred amount.
- A 'hub and spoke' network of specialist providers is being established, leading local systems to support the delivery of best practice clinical standards defined by GIRFT.

- A multidisciplinary (MDT) referral service, led by GIRFT, will determine which cases are managed by the specialist centres' regional hubs and which are undertaken by local hospitals (the spokes).

234. We will assess the impact of the approach for knee revision surgery in 2022/23.

8. Local variations and local modifications to national prices

235. This section is supported by the following annexes:⁴⁹

- Annex A: National tariff workbook
- Annex B: Guidance on currencies
- Annex F: Guidance on local modifications to national prices

236. It is also supported by the following documents:⁵⁰

- local variations and local prices template (relevant to Section 8.1)
- local modifications template (relevant to Section 8.2).

8.1 Local variations

237. Local variations are adjustments to a national price or a currency for a nationally priced service (or both), agreed by one or more commissioners and one or more providers.⁵¹ They only affect services specified in the agreement and the parties to that agreement. A local variation can be agreed for more than one year, although it must not last longer than the relevant contract. Each variation applies to an individual service with a national price. However, commissioners and providers can enter into agreements that cover multiple variations to several related services.

238. Local variations allow a flexible approach and can be considered in many different situations, where providers and commissioners feel that it would be appropriate to adopt a local pricing arrangement. Local variations can be used to adopt a wide variety of payment approaches. Examples could include:

⁴⁹ All available from: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/

⁵⁰ All available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

⁵¹ Local variations are covered by sections 116(2) and (3) and 118(4) of the 2012 Act.

- payment based on an agreed level of activity and associated spend, overlaid with a gain and loss share
- combining nationally priced services in a wider package of services with an aligned payment and incentive agreement, overlaid with a gain and loss share.

239. However, this is not an exhaustive list and it is for commissioners and providers to determine the approaches that would be most appropriate locally.

240. When agreeing local variations, providers and commissioners need to have regard to the locally determined pricing principles (see Section 4.1) and the rules set out below. In addition, it is not appropriate for local variations to be used to introduce price competition that could create undue risks to the safety or the quality of care for patients.

8.1.1 Rules for local variations

241. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.⁵²

Rules for local variations

1. The commissioner and provider must apply the principles set out in Section 4.1 when agreeing a local variation.
2. The local variation must be documented in the commissioning contract between the commissioner and provider for the service to which the variation relates.
3. The commissioner must submit a written statement of the local variation to NHS Improvement using the local variations template.⁵³ NHS Improvement will publish the templates it receives on behalf of the commissioner.
4. The deadline for submitting the statement is 30 days after the agreement.

⁵² The rules in this section are made under the 2012 Act, section 116(2).

⁵³ Available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

242. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.⁵⁴ They should publish each statement no later than 30 days after the variation agreement. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.⁵⁵ Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.
243. Commissioners are required to make a written statement of each local variation and submit these to NHS Improvement. Commissioners should use the template provided by NHS Improvement to prepare the written statement.⁵⁶ The completed template should be included in the commissioning contract (Schedule 3 of the [NHS Standard Contract](#)).
244. NHS Improvement will publish the information submitted in the templates on its [Locally determined prices](#) web page so that all agreed local variations are accessible to the public from a single location. Where NHS Improvement publishes the information, it will do so on behalf of the commissioner for the purposes of section 116(3) of the 2012 Act (the commissioner's duty to publish a written statement). Commissioners may take other additional steps to publish the details of the local variations (eg making the written statement available on their own website).

8.2 Local modifications

8.2.1 What are local modifications?

245. Local modifications apply to a single service with a national price. Only unbundled diagnostic imaging services have national prices in the 2022/23 NTPS (see Section 5), meaning that local modifications are not available for any other services.
246. Under the 2012 Act, NHS Improvement is required to publish in the national tariff its methods for deciding whether to approve local modification agreements or grant local modification applications.

⁵⁴ 2012 Act, section 116(3).

⁵⁵ 2012 Act, section 116(3)(b).

⁵⁶ Available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

247. Local modifications are intended to ensure that healthcare services can be delivered where they are required by commissioners for patients, even if the nationally determined price for the services would otherwise be uneconomic.
248. Local modifications can only be used to increase the price for an existing currency or set of currencies. Each local modification applies to a single service with a national price. In practice, several services could be uneconomic as a result of similar cost issues.
249. There are two types of local modification:
- Agreements: where a provider and one or more commissioners agree a proposed increase to a nationally determined price for a specific service. For local modification agreements, NHS Improvement requires commissioners and providers to prepare joint submissions.⁵⁷
 - Applications: where a provider is unable to agree an increase to a nationally determined price with one or more commissioners and instead applies to NHS Improvement to increase that price.
250. Local modifications are subject to approval (in the case of local modification agreements) or grant (in the case of local modification applications) by NHS Improvement.⁵⁸ To be approved or granted, NHS Improvement must be satisfied that providing a service at the nationally determined price would be uneconomic without the local modification.

8.2.2 Overview of our method for determining local modifications

251. NHS Improvement's method is intended to identify cases where a local modification is appropriate for a provider with costs of providing a service (or services) that are higher than the nationally determined price(s) for that service (or services). Applications and agreements⁵⁹ must be supported by sufficient evidence to enable NHS Improvement to determine whether a local modification is appropriate, based on our method.

⁵⁷ Submission templates can be found at: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

⁵⁸ The legislation governing local modifications is set out in the 2012 Act, Part 3, Chapter 4. The legal framework for local modifications is principally described in sections 116, 124, 125 and 126.

⁵⁹ The 2012 Act, section 124(4), requires that an agreement submitted to Monitor must be supported by such evidence as Monitor may require.

252. NHS Improvement's method requires that commissioners and providers:

- apply the principles outlined in Section 4.1
- demonstrate that services are uneconomic in accordance with Section 8.2.3
- comply with our conditions for local modification agreements and applications set out in Sections 8.2.4 to 8.2.6.

253. NHS Improvement will determine the circumstances or areas in which the modified price is to be payable (subject to any restrictions on the circumstances or areas in which the modification applies).

254. NHS Improvement may take into account previously agreed local modifications when considering an agreement to extend a local modification, in cases where it can be demonstrated that the underlying issues have not changed.

8.2.3 Determining whether services are uneconomic

255. NHS Improvement's method involves determining whether the provision of the service at the nationally determined price would be uneconomic and applying additional conditions. In relation to determining whether the provision of the service is uneconomic, local modification agreements and applications must demonstrate the following:

- The provider's average cost of providing each service is higher than the nationally determined price.
- The provider's average costs are higher than the nationally determined prices as a result of issue(s) that are:
 - **specific**: the higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable; for example, we would not normally consider an issue to be specific if a large number of providers have costs that are similarly higher than the national price
 - **identifiable**: the provider must be able to identify how the issue(s) it faces affect(s) the cost of the services
 - **non-controllable**: the higher costs should be beyond the direct control of the provider, either currently or in the past. Previous investment decisions that continue to contribute to high costs for particular

services may reflect management choices that could have been avoided (for example private finance initiatives – PFI). Similarly, antiquated estate may reflect a lack of investment rather than an inherent feature of the local healthcare economy. In both such cases, we will not normally consider the additional costs to be non-controllable. This means that higher costs as a result of previous investment decisions or antiquated estate are unlikely to be grounds for a local modification. Any differences between a provider’s costs and those of a reasonably efficient provider when measured against an appropriately defined group of comparable providers would also be considered to be controllable. NHS Improvement also considers CNST costs to be controllable and therefore unlikely to be the grounds for a local modification

- **not reasonably reflected elsewhere:** the costs should not be adjusted elsewhere in the calculation of national prices, rules or variations, or, for example, reflected in sustainability funding.

256. Local modification agreements and applications must also propose a modification to the nationally determined prices of the relevant services that specifies the circumstances or areas in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the relevant period (which must not exceed the period covered by the national tariff).

8.2.4 Additional condition for local modification agreements

257. The agreement must specify the services that will be affected, the circumstances or areas in which the modification is to apply, the start date of the local modification and the expected volume of activity for the period of the proposed local modification (which must not exceed the period covered by the national tariff).⁶⁰

⁶⁰ The start date for a local modification can be earlier than the date of the agreement, but no earlier than the date the national tariff takes effect (as required by the 2012 Act, section 124(2)).

8.2.5 Additional conditions for local modification applications

258. For local modification applications, five additional conditions must also be satisfied. The applicant provider must:

- demonstrate it has a deficit equal to or greater than 4% of revenues at an organisational level in 2021/22; see Annex F (Section 2.6) for guidance on how providers should calculate deficits for the purpose of this condition
- demonstrate that the services are commissioner-requested services (CRS)⁶¹ or, in the case of NHS trusts or other providers that are not licensed, that the provider cannot reasonably cease to provide the services
- demonstrate it has first engaged constructively with its commissioners⁶² to try to agree alternative means of providing the services at the nationally determined price and, if unsuccessful, has engaged constructively to reach a local modification agreement before submitting an application⁶³ to NHS Improvement
- specify the services affected by the proposed local modification, the circumstances or locations in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the current financial year
- submit the application to NHS Improvement by 30 September 2022, unless there are exceptional circumstances (for example, where there is a clear and immediate risk to patients).

259. NHS Improvement reserves the right to grant an application, in exceptional circumstances, even if the conditions set out above have not been met.

8.2.6 Dates

Applications

260. If an application for a local modification is successful, NHS Improvement will determine the date from which the modification will take effect. In most cases, applications will be effective from the start of the following financial year,

⁶¹ See: [Guidance for commissioners on ensuring the continuity of health services: Designating commissioner requested services and location specific services](#), 28 March 2013.

⁶² Constructive engagement is also required by condition P5 of the provider licence, in cases where a provider believes that a local modification is required.

⁶³ Submission templates can be found at: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

subject to any changes in national prices, to allow commissioners to take account of decisions in planning their budgets.

261. In exceptional cases (particularly where delay would cause unacceptable risk of harm to patients), NHS Improvement will consider making the modification effective from an earlier date.

Agreements

262. The terms of a local modification agreement should be included in the relevant commissioning contract (using the [NHS Standard Contract](#) where appropriate)⁶⁴ once they are agreed between the provider and commissioner. If the terms of a local modification agreement are included in the commissioning contract before NHS Improvement approves the local modification, the contract may provide for payment of the modified price pending a decision by NHS Improvement. But if NHS Improvement subsequently decides not to approve the modification, the modification would not have effect and the national price would apply. The provider and commissioner must then agree a variation to the commissioning contract to stop the modification and they may agree a mechanism for adjustment and reconciliation in relation to the period before the refusal, or possibly a local variation to the national price.
263. The start date for a local modification can be earlier than the date of the agreement, but no earlier than the date the national tariff takes effect (as required by the 2012 Act, section 124(2)).

⁶⁴ Providers and commissioners should refer to the latest available guidance on the NHS Standard Contract: www.england.nhs.uk/nhs-standard-contract.

9. Payment rules

264. The 2012 Act allows for the setting of rules relating to payments to providers where health services have been provided for the purposes of the NHS (in England).⁶⁵

9.1 Billing and payment

265. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the [NHS Standard Contract](#). Application of provisions within the NHS Standard Contract may lead to payments to providers being reduced or withheld.

9.2 Activity reporting

266. For NHS activity where there is no national price, providers must adhere to any reporting requirements set out in the [NHS Standard Contract](#).

267. For services with national prices, providers must submit data as required under SUS guidance.⁶⁶

268. The dates for reporting activity and making the reports available will be published on the NHS Digital website.⁶⁷ NHS Digital will automatically notify subscribers to its e-bulletin when these dates are announced.

269. NHS England has approval from the Secretary of State to allow CCGs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online⁶⁸ about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

⁶⁵ 2012 Act, section 116(4)(c).

⁶⁶ <https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance>

⁶⁷ <https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance>

⁶⁸ See: www.england.nhs.uk/ig/in-val/invoice-validation-faqs/

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