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Introduction to the 2022/23 National Tariff

31 March 2022

Contents

1. About this guide

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

The national tariff is published by NHS England and NHS Improvement and includes detailed guidance on its operation and a wide range of other information. These resources are available on National Tariff Payment System web page. The Developing the national tariff web page contains regular updates about the payment system, as well as providing access to past national tariff documents.

This guide describes the tariff for 2022/23. However, the tariff, and the wider payment system, will continue to evolve. The NHS Long Term Plan sets out the intended direction for the payment system. In particular, the Plan commits to moving away from activity-based payments to ensure a majority of funding is population based, and to introduce blended payment for all services.

As part of the NHS response to Covid-19, providers and commissioners used nationally set block payment arrangements during 2020/21 and 2021/22, as a departure from national prices and any national blended payment arrangements. The 2022/23 tariff is intended to provide a pragmatic transition from block payments to locally determined payment arrangements.

The Health and Care Bill currently being considered by Parliament includes proposed provisions for a new ‘NHS Payment Scheme’ to replace the ‘National Tariff Payment System’. This guide and supporting material will be updated as developments are made.

Please contact pricing@england.nhs.uk if you have any questions about any aspects of the payment system.

2. What is the national tariff?

Background

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

The national tariff has its roots in the Payment by Results (PbR) system that was introduced in England by the then Department of Health in 2003. Before PbR, commissioners tended to agree block contracts with hospitals. This meant the amount of money a hospital received was fixed, regardless of the number of patients it treated. Under PbR and, from 2014/15, the national tariff, payments were made based on activity delivered. In more recent years, the tariff has introduced a blended payment approach, comprising both fixed and variable payments (see Section 4 for more details).

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

What is the national tariff?

A set of rules, guidance and prices

The 2012 Act introduced a statutory national tariff and led to a transfer of responsibility for the pricing system from the then Department of Health to Monitor and the NHS Commissioning Board (now known as NHS Improvement and NHS England respectively).

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

The tariff contains a set of rules that must be followed, as well as currencies (units of healthcare for which payment is made), prices and variations that apply to prices when they are used. The tariff also allows providers and commissioners to locally determine prices (see Section 5).

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

The tariff provisions are also referenced in NHS Operational planning guidance.

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

Services outside the tariff's scope

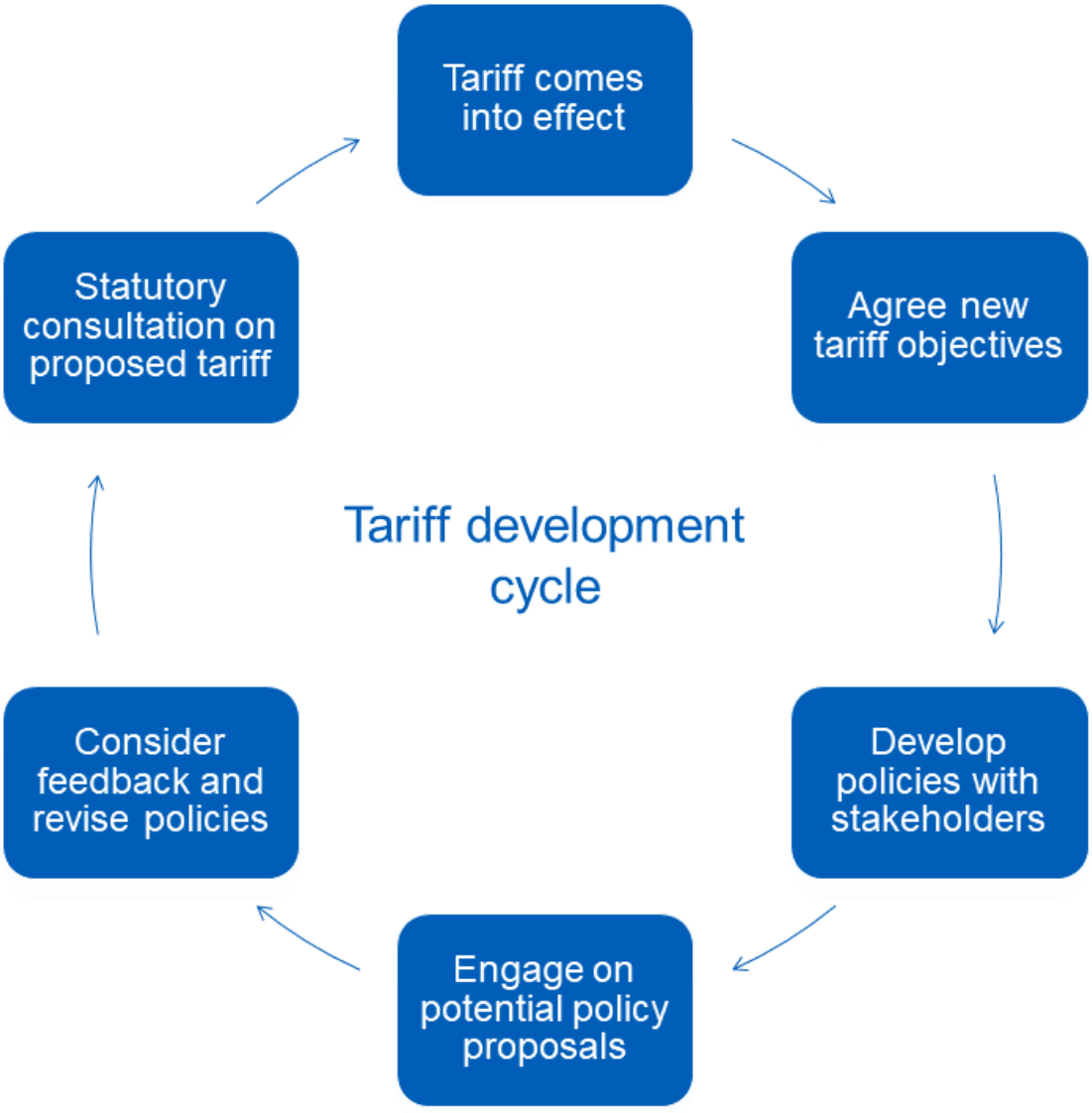
Some healthcare services fall outside the national tariff's scope and are funded under different arrangements. These include:

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

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

3. Developing the tariff

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



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

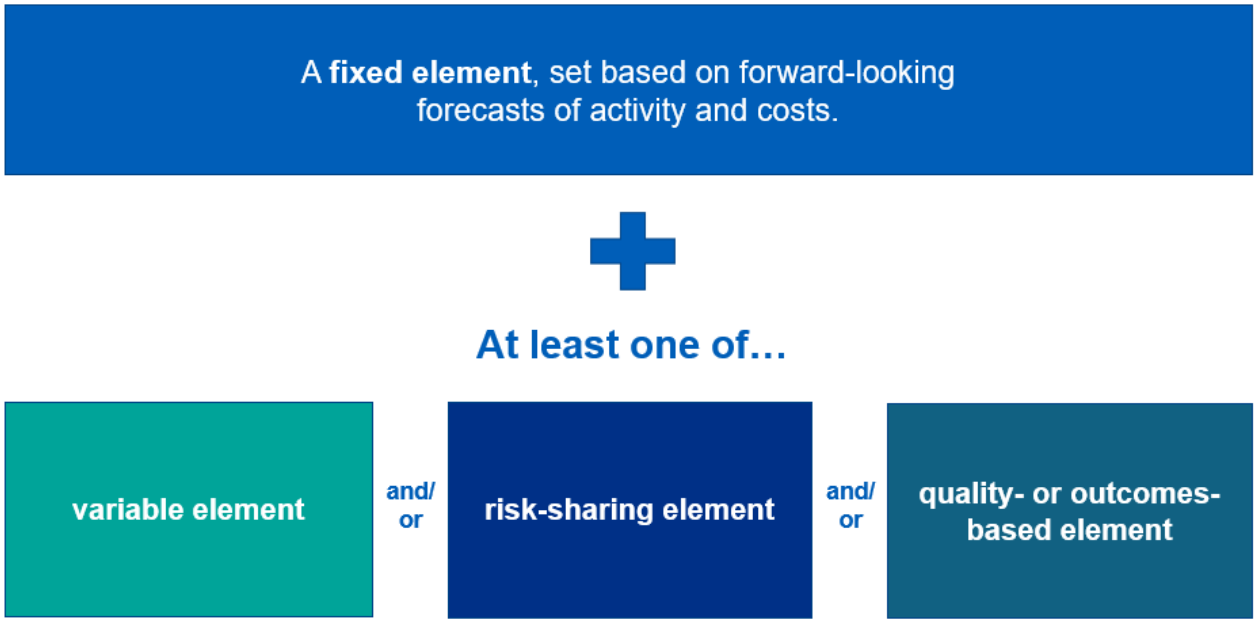
Detailed guidance is reviewed and updated for each cycle and is a key component of the national tariff package. It describes how the tariff rules and prices should be implemented. The current national tariff documents and guidance can be found here: www.england.nhs.uk/pay-syst/national-tariff/national-tariff-payment-system/

There is also an enquiries function (pricing@england.nhs.uk) who will answer any questions about the payment system during the year.

For each tariff cycle NHS England and NHS Improvement work to review and update the existing tariff to ensure it achieves the intended outcomes. The 2022/23 tariff was largely based on 2021/22, which introduced the aligned payment and incentive blended payment for almost all activity (although the COVID-19 block payment arrangements meant that it was not used in practice).

4. Blended payment

The NHS Long Term Plan commits to introducing blended payments for all services. Blended payment comprises a fixed element plus at least one of a variable element, a risk share and a quality or outcomes-based payment.



Blended payments aim to:

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

Blended payment was initially introduced for urgent and emergency care and adult mental health services in 2019/20. Blended payments for outpatient attendances and maternity services were then introduced in the 2020/21 tariff, although the Covid-19 block payment arrangements meant they have not operated in practice during 2020/21 or 2021/22.

The 2021/22 tariff introduced aligned payment and incentive (API) to cover almost all activity. API is a relatively simple blended payment, comprising fixed and variable elements. It is intended to provide a stable transition from block payment arrangements and set the foundation for longer-term payment system development.

API involves the following:

- It applies to all secondary healthcare services (including acute, maternity, community, mental health and ambulance services) commissioned by local NHS commissioners with providers who are members of the same ICS.
- For providers and commissioners who are not members of the same ICS:
  - API applies to all commissioned activity above an annual contract threshold of £30 million
  - payment arrangements for contracts below £30 million are determined by local agreement.
- All NHS England Specialised Commissioning activity is covered by API, with no threshold. Other secondary healthcare commissioned by NHS England is subject to the £30 million threshold.
- All activity using the NHS Increasing Capacity Framework, and activity subcontracted to other providers, is subject to unit prices rather than API.

API agreements comprise two elements:

- A **fixed element**, expected to cover funding for all activity, including:
  - the costs of delivering services within the agreed system plan, including elective recovery and outpatient transformation plans
  - agreed levels of best practice tariff (BPT) performance and full achievement of CQUIN criteria
  - some high cost drugs and devices and implementation costs for innovative products covered by the MedTech Funding Mandate.

- A **variable element**, which mean payments or deductions are made for:
  - activity over or under a baseline for elective activity
  - levels of advice and guidance and BPT attainment above or below that assumed in the fixed element
  - CQUIN indicator attainment less than 100%.

See Section 3 of the 2022/23 tariff and *Guidance on the aligned payment and incentive approach* for more details. In addition, our FutureNHS workspace contains details of products being developed to support fixed payments.

5. Prices

The national tariff sets prices for day cases, admitted patient care, some outpatient procedures and some services accessed directly by primary care. These prices are published in Annex A, the National Tariff Workbook.

Following the introduction of API in 2021/22, the vast majority of tariff prices are no longer 'national' prices (ie mandated for use); instead, they are unit prices that can be used for activity outside of the scope of API. National prices are set for unbundled diagnostic imaging services only. National and unit prices are calculated in the same way, and to the same standard.

Many services do not have prices published as part of the tariff. This is for various reasons, including:

- services outside the scope of national cost collections (which provide the cost data used to calculate prices)
- services that don't have currencies, or have currencies but the associated cost data are not robust enough to be used to set prices.

Where the tariff does not set prices, providers and commissioners must work together to agree prices for them – see Locally determined prices below.

Structure of prices

Tariff prices are designed to create appropriate incentives and achieve policy goals. The move away from national prices following the introduction of API has reduced the direct impact of prices. However, prices remain a valuable piece of information, allowing comparison with previous years and supporting activity-based payments where required. This section describes the structure of the tariff's prices.

Elective care

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

Tariff prices aims to support patient experience and provider efficiency – for example by encouraging day cases rather than a stay in hospital where clinically appropriate. Tariff prices are based on the average of ordinary elective and day case costs, weighted according to the proportion of activity in each (see Table 1).

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

Table 1: Setting a combined day case and elective price

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

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

Long stays

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

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

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

Specialised services

Tariff prices are calculated based on average costs. This means they do not always take account of the additional costs of patients with complex needs. The tariff therefore uses top-up payments to recognise these additional costs, when they are not sufficiently differentiated in HRG design. Top-ups are an example of a national variation and are applied as a percentage increase to the relevant price.

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

When setting an API fixed element, commissioners and providers should consider the specialist top-up amounts that have been paid in previous years.

Unbundling

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

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

Pathway payments

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

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

Best practice tariffs

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

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

As set out in Section 3, BPTs are also part of API agreements, which should reflect agreed levels of BPT achievement in the fixed payment. If actual achievement differs from the agreed levels, a variable payment is then paid/deducted.

Price inputs

Tariff prices are driven by data. Specifically, three building blocks are required:

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

Classifications

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

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

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

Together, ICD-10 and OPCS-4 contain tens of thousands of clinical codes. This means a huge number of combinations could be documented. Paying at this level would be very complex. As a result, the national tariff uses healthcare resource groups (HRGs) for many prices.

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

Currencies

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

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

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

Providers and commissioners can agree alternative currencies, or variations to national currencies, where needed.

New currency models for community healthcare are currently being tested, focusing on five currency areas: children and young people with disabilities; single episodes of care; long-term conditions; frailty; last year of life. More details on the project are available on the NHS England and NHS Improvement website. The currencies could be used to support future funding for these services.

Cost and activity data

Cost data is crucial for evaluating how effectively and efficiently care is delivered to patients. Accurate, consistent cost information helps providers and commissioners understand how to make the best possible use of resources, evaluate clinical practice and compare different ways of working.

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

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

The 2022/23 tariff uses patient-level costing data (known as PLICS) for the first time. Previous tariffs had been calculated using reference costs.

Calculating tariff prices

Each price is several years in the making, as illustrated in Figure 1.*

* The 2022/23 national tariff prices are calculated based on 2018/19 cost and activity data. This is because this was the most recent full year where the data was unaffected by COVID-19.

Figure 1: Development of national tariff prices

Year 1	Year 2	Year 3	Year 4
Healthcare delivered to patients	Cost and activity data for Year 1 collected and published	Year 1 data analysed and used to set national prices for Year 4 tariff	New national tariff comes into effect

The price setting process

Calculating prices involves many steps. Full details are available in Section 6 and Annex D of the 2022/23 national tariff. The main calculation steps are as follows:

- **Producing draft price relativities**
  We take the latest available national cost collection cost data and combine them with the latest available hospital episode statistics (HES) activity data to produce draft price relativities – the relationship between average unit costs for individual currencies. Sources of funding from outside the tariff (eg winter pressures) are removed from the cost data to ensure they are not reimbursed twice.
- **Making manual adjustments**
  Sometimes prices are produced that seem illogical (such as more complex procedures being given a lower price than less complex ones). This may be due to quirks in the cost data or large changes in year-on-year activity levels. To guard against errors, draft price relativities are shared with clinical experts and interested stakeholders. Where illogical prices are reported, these are reviewed and manually adjusted where appropriate.
- **Scaling prices to the allocated budget**
  The national tariff must work within the budget allocated for healthcare services. The budget for national tariff services is referred to as the cost base. After draft price relativities are initially calculated, they are adjusted to fit the cost base. The prices' relative values remain the same (ie the price of an HRG will remain 10% higher than another, regardless of the cost base figure).
- **Making price adjustments for inflation and efficiency**
  This updates the prices for the year the national tariff will apply to.

Exclusions from prices

The costs of some drugs, devices and procedures are excluded from tariff prices. This is done when the items represent a high and disproportionate cost relative to the cost covered under the relevant HRG.

In addition, innovative products covered by the MedTech Funding Mandate are also excluded from tariff prices.

While all these items are excluded from tariff prices, the API fixed element should contain funding for some of them, where usage is likely to be predictable.

Annex A of the tariff includes lists of the items excluded from tariff prices and when funding should be included in API fixed elements.

Price adjustments: cost uplift and efficiency factors

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

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

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

As well as adjusting prices, the cost uplift and efficiency factors should be considered as part of local pricing arrangements.

National variations

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

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

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

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

The MFF includes both:

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

Where tariff prices are used, the price a provider receives is multiplied by the organisation's MFF value (ie income = activity x price x MFF). With API agreements, providers' MFF values, and particularly any changes in values, need to be considered when setting the fixed element.

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

Locally determined prices

The tariff includes rules that apply when a local price is set for services without national prices and for services with a national currency but no national price.

There are three types of locally determined pricing:

- **Local variations** – adjustments to national prices and/or currencies agreed between a provider and commissioner.
- **Local modifications** – increases in national prices for specific currencies where providing the service would otherwise be uneconomic.
- **Local prices** – agreed between providers and commissioners for services without a national price, following the tariff's local pricing rules.

All local pricing arrangements must adhere to the following principles. Local prices must:

- be in patients' best interests
- promote transparency
- result from providers and commissioners engaging with each other constructively
- consider how the payment approach could contribute to reducing health inequalities.

Full details and guidance on locally determined prices can be found in Sections 3, 4 and 8 of the 2022/23 national tariff.

Non-mandatory guide and benchmark prices

Non-mandatory prices can be used as a starting point for local negotiation. There are two categories of non-mandatory prices:

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

Providers and commissioners are not obliged to use non-mandatory prices and do not need a local variation or modification if they chose not to.

6. Glossary of useful terms and abbreviations

The glossary below defines terms relevant to the national tariff. Some of these refer to items that have been removed from more recent tariffs.

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

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

Aligned payment and incentive (API)
A type of blended payment, first introduced in 2021/22, API comprises fixed and variable elements. API rules cover the majority of services in scope of the tariff.

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

Blended payment
Blended payment is a framework that involves a fixed payment plus at least one of variable, quality or outcomes, and risk share elements. It moves payment away from a purely episodic basis. Blended payment was initially introduced for individual services (emergency care and adult mental health in 2019/20; outpatient attendances and maternity in 2020/21). Since 2021/22, the API blended payment covers almost all services.

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

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

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

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

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

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

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

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

Hospital episode statistics (HES)
A data warehouse containing non-identifiable patient details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. This

data is collected during a patient's treatment at a hospital to enable hospitals to be paid for the care they deliver.

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

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

National cost collection
The national cost collection comprises aggregated costs (the average unit cost of providing defined services to NHS patients in England) and patient-level costs/PLICS (a cost based on the specific interactions a patient has, and the events related to their healthcare activity).

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

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

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

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

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

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

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

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

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

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