2021/22 National Tariff Payment System – a consultation notice

March 2021

Please note:

Part A of this document is the statutory consultation notice. It starts on page 3.

Part B of this document is the proposed 2020/21 National Tariff Payment System. This is shown as it would appear in final form. It starts on page 74

Contents – Part A

1. About this document

1. This is the statutory consultation notice for the 2021/22 National Tariff Payment System (NTPS).[1]

2. The document is in two parts:

   - Part A – policy proposals. This contains:
     - an introduction that sets the context for the 2021/22 NTPS and explains how you can respond to this consultation notice
     - a summary of how we have engaged with stakeholders in developing the proposals in this notice
     - an explanation of our proposals and what we expect to change from the 2020/21 NTPS.
   - Part B – draft tariff. This contains a draft of the proposed 2021/22 NTPS, shown as it would appear in its final form. This includes sections on:
     - the scope of the tariff
     - rules for 2021/22 aligned payments and incentives
     - general local pricing rules
     - the currencies used for national prices[2]
     - the method for determining national prices and unit prices
     - national variations to national prices
     - local variations and local modifications to national prices
     - payment rules.

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[1] The notice is published by Monitor. References in this document to "NHS Improvement" are, unless the context otherwise requires, references to Monitor. This notice sets out proposals agreed by NHS England and NHS Improvement.

[2] **Please note**: our proposals involve a significant reduction the scope of national prices, which would apply to unbundled diagnostic imaging services only (see Section 6). 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). These unit prices are not mandatory national prices, but are produced to assist the pricing of services under the local pricing rules. They would also be used in the variable element of aligned payment and incentive agreements and would be 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 of the draft 2021/22 NTPS in Part B). In this document, we refer to national prices and unit prices.

3. This document should be read in conjunction with its annexes and supporting documents. The consultation notice (Cn) annexes form part of this notice. The draft tariff (Dt) annexes form part of the proposed 2021/22 NTPS. The impact assessment gives detailed estimates of the likely impact of our proposals.

4. Table 1 lists the annexes and supporting documents comprising the statutory consultation package.

Table 1: Annexes and supporting documents[3]

Applies to	Document
Consultation notice (Cn)	Annex CnA: Summary of feedback on proposals
Cn	Annex CnB: How to respond to this consultation and the statutory objection process
Draft tariff (Dt)	Annex DtA: National tariff workbook (including national prices and unit prices)
Dt	Annex DtB: Guidance on currencies
Dt	Annex DtC: Guidance on best practice tariffs
Dt	Annex DtD: Mental health clustering tool
Dt	Annex DtE: Models used to calculate prices
Dt	Annex DtF: Guidance on local modifications to national prices
Supporting document (SD)	Impact assessment
SD	Non-mandatory guide prices workbook
SD	Guidance on the aligned payment and incentive approach
SD	A guide to the market forces factor
SD	Payment and the Long Term Plan
SD	Community services currency guidance: frailty and last year of life

[3] All materials are available from: www.england.nhs.uk/publication/2021-22-tariff-consultation/

2. Context

5. There are two key drivers for the proposals presented here: the NHS Long Term Plan and the COVID-19 pandemic.

6. 2020/21 has been an exceptional year as the NHS has responded to the impact of COVID-19. This has radically altered the short-term priorities of the NHS, the services delivered and the approaches to giving care.

7. The changes and challenges the pandemic has brought about are ongoing. Some of the changes are time-limited as the NHS responds to the crisis; other developments, such as the increased use of virtual outpatient appointments, are likely to become a common way of operating. At the same time, the NHS is continuing to evolve and work towards the Long Term Plan goals, with the development of integrated care systems (ICSs) and acceleration of collaborative working between systems and their constituent organisations.[4]

8. During 2020/21, as part of the response to COVID-19, the NHS adopted special payment arrangements under which most providers and commissioners moved to block contract payments. The NTPS continued to have effect, with the block payments agreed as local variations/departures in accordance with the national tariff rules set out in Sections 6 and 7 of the 2019/20 and 2020/21 NTPS.

9. As a result of the pandemic, publication of the 2020/21 NTPS was delayed until November 2020. The use of the special payment arrangements during 2020/21 also meant that some of the provisions in the tariff, such as blended payments for outpatient attendances and maternity services, were never implemented in practice.

10. Given the ongoing pressures on the service of COVID-19, the planning guidance for 2021/22 has been delayed, with the emergency payment arrangements continuing into the first part of 2021/22.

[4] For more details about the planned developments of ICSs, see *Integrating care: Next steps to building strong and effective integrated care systems across England*.

11. This move away from activity-based payments for acute services to block payment arrangements for the majority of services has fundamentally changed the starting point for our proposals for the 2021/22 NTPS. We have considered how best to move on from the block payment arrangements, while also bearing in mind the commitments set out in the NHS Long Term Plan. These include: reforming the payment system to move away from activity-based payments; reforming CQUIN; establishing ICSs across the country; reducing health inequalities; supporting personalised care and patient choice.

12. Our proposals for 2021/22 therefore represent a pragmatic step forward, to ensure that the payment system is able to operate more effectively in the context of developing ICSs and recovery from COVID-19. The proposals intend to move away from the previously fragmented range of payment approaches to introduce a consistent overall approach for both acute and non-acute services. However, the proposals do not represent a final payment system design and we anticipate increasing the sophistication and rigour of the payment system in future tariffs. Rigorous counting, costing and coding of activity would continue to be essential. For more details of the rationale for changing the payment system, and discussion of the key considerations for the longer-term, please see the supporting document *Payment and the Long Term Plan*.

13. Our principal proposals for the 2021/22 NTPS are to:

    - use nationally set rules to introduce an aligned payment and incentive approach for almost all services in scope of the NTPS (see Section 6)
    - limit national prices to unbundled diagnostic imaging services (ie diagnostic imaging not part of an inpatient spell)
    - set national prices and unit prices by rolling over price relativities from 2020/21, updating the prices for efficiency and inflation.

14. Our proposals also align with developments for the 2021/22 NHS Standard Contract.[5] We are proposing to integrate CQUIN funding into the NTPS, featuring a limited number of clinical indicators, focused on clinical priorities which are fully relevant in the context of COVID-19 recovery. We are also proposing that a requirement in the proposed 2021/22 NHS Standard Contract – for all organisations that are members of an ICS/STP, as well as NHS

[5] For details, see www.england.nhs.uk/nhs-standard-contract/21-22/

England as commissioner where relevant, to be parties to a System Collaboration and Financial Management Agreement (SCFMA) – can be used to improve transparency and effectively share risks, rather than including a specific risk share as part of the payment system design.

15. The impact assessment that accompanies this notice provides analysis of the impact of the changes in national prices and unit prices compared to 2020/21. It also considers the impact of our proposals in relation to equality and patient choice, and explains how we have discharged out statutory duties in developing the policies presented here.

3. Responding to this consultation

3.1 Statutory consultation on the national tariff and the objection process

16. The proposals for the 2021/22 NTPS are subject to a statutory consultation process as required by the Health and Social Care Act 2012 (the 2012 Act). As well as enabling parties to provide views on the proposals, which we consider before the final decision on the tariff, the consultation allows clinical commissioning groups (CCGs) and providers of services with national prices to object to the method we have proposed for determining national prices. The statutory consultation period is 28 days, ending on **20 April 2021**.

17. You can find further information on the statutory consultation, objection process and relevant legislation in Annex CnB.

Objections to the method

18. While we welcome comments on all our proposals, the 2012 Act makes it clear that the statutory objection process applies only to objections to the "method or methods it [NHS Improvement] proposes to use for determining the national prices" of NHS healthcare services.[6]

19. The method includes the data, method and calculations used to arrive at the proposed set of national prices and unit prices. It also includes the cost adjustments set out in Sections 8.7 and 8.8. It does not include the prices themselves.

20. The proposed method does **not** include:

    - the rules for determining local prices, including the rules for the aligned payment and incentive approach
    - the proposed national currencies

[6] Health and Social Care Act 2012, Sections 118(3)(b) and 120(1)

- the proposed national variations, such as the market forces factor
- the rules for agreement of local variations
- the methods for approving or determining local modifications.

3.2 Other responses to the consultation

21. In addition to consulting on the method for setting national prices, we are asking for feedback on all the proposals in the consultation notice. We welcome comments on any of these proposals and will consider your responses before making a final decision on the content of the 2021/22 NTPS.

22. Please submit your feedback through the online survey.[7] **The deadline for submitting responses is midnight at the end of 20 April 2021.**

23. Please contact pricing@improvement.nhs.uk if you have any questions.

[7] www.engage.england.nhs.uk/pricing-and-costing/2021-22-tariff-consultation

4. How we worked with stakeholders to develop our proposals

24. We have engaged with providers, commissioners, representative bodies and other appropriate stakeholders throughout the development of our proposals for the 2021/22 NTPS.

25. The impact of COVID-19 meant that our approach has been different to previous years, with limited access to clinicians in the early part of the development cycle, in particular. However, we have discussed our proposals with a number of clinicians and have worked hard to ensure that the clinical perspective has been considered.

4.1 Engagement overview

26. Our engagement included:

- regular discussions with representative bodies and their members
- taking part in external events relevant to payment policy development
- holding regular meetings with our payment system advisory group, comprising members from providers, commissioners and representative bodies, to discuss policies as they were developed
- conducting a series of co-design sessions with stakeholders from regions, ICSs, STPs, providers, commissioners and think tanks to explore developing policy proposals
- running a series of virtual workshops, and accompanying online survey, to get feedback on initial policy proposals in October 2020
- publishing a tariff engagement document, and accompanying survey to gather feedback, in November 2020.

27. Annex CnA provides details of the feedback we received from the workshops and surveys.

28. We did not undertake a clinical review of draft price relativities for 2021/22. This was because of a lack of clinical availability due to COVID-19 pressures which meant that the clinical expert working groups (EWGs) did not meet until late in the year. However, we are proposing to set prices by rolling over 2020/21 prices (see Section 8.2). The EWGs have reviewed and endorsed these relativities for 2019/20 and 2020/21.

29. While the EWGs did not meet until late in the year, we have engaged with clinicians as we developed our proposals. This has included working with clinical representatives on our payment system advisory group and discussing proposals with NHS England and NHS Improvement clinical policy teams.

4.2 Co-design of the proposed aligned payment and incentive approach

30. Over May, June and July 2020 we held co-design sessions with a range of stakeholders, exploring options for policy proposals in 2021/22. We spoke with individuals from across England representing the views of regions, ICSs and STPs, as well as CCGs, NHS England Specialised Commissioning and acute and non-acute providers. We also spoke with representatives from health think tanks including The King's Fund and the Health Foundation.

31. These discussions played an important role in shaping our policy proposals for the 2021/22 NTPS, in particular the shift to an aligned payment and incentive approach covering a wide scope of services and providers (see Section 6). The discussions also informed the approach to 2021/22 as a transitional year, supporting the sector's recovery from the COVID-19 emergency, with the potential development of a more sophisticated payment approach from 2022/23 onwards. As we develop our proposals for 2022/23 and beyond, we will seek to continue this co-design approach and will aim to engage an even wider range of stakeholders. Please contact pricing@improvement.nhs.uk if you would like to find out more.

4.3 Virtual workshops on initial policy proposals

32. During October 2020, we held 20 virtual workshops to discuss our initial policy proposals. The sessions gave an overview of the potential financial framework for 2021/22 and then discussed in more detail the proposals for the aligned

payment and incentive approach (described as ‘blended payment’ in the sessions). Other areas of potential tariff proposals were also discussed. We also held a workshop for members of representative bodies in October 2020.

33. More than 950 people took part and provided feedback and questions on the policies proposed. During the sessions, an online engagement tool was used to allow attendees to show their level of support (from 1-10) for the policies. Attendees were also sent an online survey after the workshops where they could provide more detailed responses. The survey received 85 responses. Annex CnA contains a summary of the feedback we received during the workshops and from the survey sent to attendees after the events.

4.4 Tariff engagement document

34. In November 2020, we published Developing the payment system for 2021/22, setting out some key areas where we were considering proposals for the 2021/22 NTPS. The document was accompanied by an online survey to gather feedback on the policies.

35. We received 157 responses to the survey, as well as letters from representative bodies giving feedback on behalf of their members, including the British Orthopaedic Association. The majority of the survey responses were from acute providers (58) and clinical commissioning groups (CCGs) (31), with three responses from commissioning support units (CSUs). Annex CnA contains details of the feedback we received.

4.5 Conclusion

36. Our engagement activities yielded a large amount of information and helped to improve the proposals contained in this statutory consultation. Thank you to everyone who gave their time. We have carefully considered the feedback received and used it to shape the policies presented here.

37. As we develop the 2022/23 NTPS, we will continue to undertake proactive engagement on our work throughout the development cycle. Please contact pricing@improvement.nhs.uk if you have any questions about this.

38. The rest of this document sets out our proposals for the 2021/22 NTPS.

5. Duration of the tariff

5.1 Duration of the tariff

Proposal
We propose to set the tariff to come into effect from its publication in 2021 until 31 March 2022 – the 2021/22 NTPS.

About this proposal

39. As described in Section 2, the context for 2021/22 is unique. The COVID-19 pandemic is continuing to radically alter the short-term priorities of the NHS, the services delivered and the approaches to giving care. At the same time, the NHS continues to work towards the objectives set out in the NHS Long Term Plan, all the while mitigating several large system risks.

40. In this context, the proposed 2021/22 NTPS forms part of the wider financial arrangements introduced to act as a bridge from the current emergency to longer-term ways of operating.

41. To allow this package of policies to effectively support the sector, the NTPS must develop in coordination with the wider financial architecture. In addition, due to the transitional nature of these proposals, there are a number of elements of the proposed payment system that may need to be reviewed for 2022/23, including the design and scope of the aligned payment and incentive approach, the information used to set fixed payments, and the data used to set forward-looking adjustments for inflation and efficiency.

42. We therefore propose that the tariff would have effect from its publication date in 2021 until 31 March 2022 – the 2021/22 NTPS. We would expect a new tariff to then come into effect from 1 April 2022.

Why we think this is the right thing to do

43. In our engagement on policies, there was strong support for setting the tariff for one year. Stakeholders understood the uncertainty COVID-19 has

introduced and the need to continue to respond to the issues and challenges it raises for services.

44. There was also agreement that the proposed 2021/22 aligned payment and incentive approach is likely to need to evolve beyond its initial design.

45. In addition, the proposal to roll over price relativities from 2020/21 (which were themselves rolled over from 2019/20) would mean that prices are again based on cost and activity data from 2016/17. Setting a longer-term tariff would increase the gap between the source data and the services being reimbursed through the tariff.

46. The delay to the 2021/22 planning round has meant the continuation of the 2020/21 emergency financial arrangements into 2021/22. It has also delayed publication of this statutory consultation, meaning that the 2021/22 NTPS would not be published and come into effect until after 1 April 2021. We anticipate that the 2021/22 NTPS would be published during 2021 and then a new tariff would come into effect on 1 April 2022.

6. The aligned payment and incentive approach

47. In this section, we describe our proposals to introduce an aligned payment and incentive approach, comprising fixed and variable elements, for almost all secondary healthcare services. This would cover services commissioned by CCGs with providers who are members of the same ICS/STP, and services commissioned by CCGs with providers who are members of different ICS/STPs where the expected annual contract value is £10 million or more. For services provided under lower value contracts, or in other exempt categories, payment would be determined in accordance with the general local pricing rules, with the option to apply an activity-based approach using 'unit prices', rather than national prices. National prices would be retained for unbundled[8] diagnostic imaging services only (ie diagnostic imaging services not undertaken as part of an inpatient spell).

48. As there are a number of different components to the proposed approach, we have broken the proposals down into subsections.

49. During the engagement on proposals for 2021/22, the payment approach was described as blended payment. However, there was some confusion about how the proposals related to the blended payments introduced in previous years. We want to be clear that our proposals are significantly different to the previous blended payment model, and incorporate elements of existing financial incentive mechanisms. We therefore refer to an aligned payment and incentive approach in this document and the draft 2021/22 NTPS.

50. We have produced a supporting document: *Guidance on the aligned payment and incentive approach.* We recommend reading that alongside this section.

[8] To enable HRGs to represent activity and costs more accurately, some significant elements can be "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 and can be commissioned, priced and paid for separately.

6.1 Overview of the proposed payment approach

About the payment approach

51. We are proposing to introduce an aligned payment and incentive approach for the 2021/22 NTPS. This would involve the following:

- It would apply to all secondary healthcare services commissioned by CCGs with providers who are members of the same ICS/STP.[9]
- For providers who are not members of the same ICS/STP:
  - aligned payment and incentive arrangements would apply to all CCG-commissioned activity above an annual contract threshold of £10 million
  - payment arrangements for contracts below £10 million would be determined by local agreement.
- All NHS England Specialised Commissioning activity would be covered by the aligned payment and incentive approach, with no threshold. Other secondary healthcare activity commissioned by NHS England would be subject to the £10 million threshold.
- All activity contracted for under the NHS Increasing Capacity Framework would be subject to unit prices rather than the aligned payment and incentive approach.
- The payment would comprise a fixed element, based on funding an agreed level of activity, and a variable element to support elective activity and to reflect achievement of best practice tariff (BPT) and CQUIN criteria.
- Funding for certain high cost drugs commissioned by CCGs and other specialised drugs with steady levels of uptake and no additional incentive or data requirements, specified in Annex DtA, would be included in the fixed element. Cancer Drugs Fund, Hep C and the majority (by value) of other high cost drugs would be funded on a cost and volume basis. Funding for CCG-commissioned high cost devices would also be included in the fixed element.
- As part of the Standard Contract, all members of an ICS, as well as NHS England where it is the commissioner, would be required to sign up to a System Collaboration and Financial Management Agreement (SCFMA).

[9] For details of ICS/STP coverage, please see: https://digital.nhs.uk/services/organisation-data-service/data-downloads/other-nhs-organisations

Why we think this is the right thing to do

52. The NHS Long Term Plan committed that the whole of England would be covered by ICSs by April 2021. It also describes the goal of moving to a blended payment model for all services, as part of a move away from activity-based payments, and instead ensuring that the majority of funding is population-based.

53. Blended payment was initially introduced in the 2019/20 NTPS for emergency care and adult mental health services. This blended payment model comprised a fixed element, plus at least one of: a variable element, a quality or outcomes element and a risk share. The 2020/21 NTPS included blended payments for outpatient attendances and maternity services. However, due to COVID-19, providers and commissioners have agreed block payment arrangements for the year, as a departure from national prices and any national blended payment arrangements. As such, the blended payments for outpatient and maternity services have not, in practice, been implemented.

54. In our engagement on policies for the 2021/22 NTPS, we described a revised blended payment approach. However, much of the feedback we received said that this was confusing as it was not clear how it related to the previous blended payments or other payment approaches already being used, such as aligned incentive contracts.

55. We want to be clear that what we are proposing for 2021/22 builds on the financial arrangements for 2020/21, and supports commissioners and providers to work collaboratively within ICSs. It represents a significant simplification of the previous blended payment approach, while continuing to provide financial incentives for quality. We therefore describe our proposals as an aligned payment and incentive approach.

56. As described in Section 2, the context of 2021/22 and the COVID-19 pandemic means it is essential for the payment system to support elective recovery. In particular, it needs to:

    - support system management of waiting lists, which may include changing where elective activity is currently undertaken
    - allow radical redesign of patient pathways and redistribution of hospital specialties

- encourage demand reduction/diversion in order to release capacity
- ensure that elective recovery is not shaped by income generation but by local health and care strategic plans and by the need to address health inequalities.

57. We feel that the proposed aligned payment and incentive approach would effectively deliver these requirements through the greater role for system-level plans, the more pronounced focus on the true cost of service provision and the enhanced scope for locally determined funding distribution. It should better support systems to use their resources collectively to drive increases in allocative efficiency and drive up the quality of care delivered.

58. Alongside the payment approach, the SCFMA in the NHS Standard Contract supports all parties who are members of an ICS/STP to agree how best to share financial risk across the system.

59. Sections 6.2-6.5 describe the components of the proposed aligned payment and incentive approach in more detail.

6.2 Scope and threshold

About the scope and thresholds

60. We propose the payment approach would apply to almost all secondary healthcare services – including acute, community, mental health and ambulance. Other than unbundled diagnostic imaging, which would retain national prices, these services would no longer be subject to national prices.[10] Instead they would be subject to the following rules for determining how payments are to be agreed:

    - For services delivered by a provider that is a member of the same ICS as the CCG, and for activity CCGs commission with providers who are not members of their ICS where the annual contract value is £10 million or above, a payment would be made. This payment would be calculated in accordance with the NTPS aligned payment and incentive rules.

[10] In previous national tariffs, most acute services have had national prices. National prices are mandatory for providers and commissioners to use unless they agree a local variation (see Section 6.2 of the 2020/21 NTPS).

- For other contracts, payments would be locally agreed or determined, often by reference to unit prices published in the national tariff.

61. We propose that all NHS England Specialised Commissioning services would be subject to the aligned payment and incentive approach. Other secondary care activity commissioned by NHS England would be subject to the £10 million threshold.

62. We propose that all activity under the NHS Increasing Capacity Framework would not be subject to the payment approach.

63. We propose that only unbundled diagnostic imaging services would have national prices. Diagnostic imaging which forms part of an inpatient spell would be reflected in the fixed element or unit price.

64. The national tariff would, however, continue to include unit prices for other services. Unit prices would be used for the variable element of the aligned payment and incentive approach (see Section 6.4). They would also be available for use where the aligned payment and incentive approach would not apply – eg local agreements and for services contracted under the NHS Increasing Capacity Framework. Unit prices and national prices would be calculated using the same method (see Section 8.2).

65. We propose that for contracts between commissioners and providers who are not members of the same ICS, where the expected annual contract value is below £10 million, the price(s) payable should be determined by local agreement. We do not propose setting a default payment approach. Prices would be agreed subject to the general local pricing rules set out in Section 4 of the NTPS.

66. In our engagement, we discussed potential NHS Standard Contract arrangements for low-volume activity flows. This would have introduced a threshold of £200,000, below which host CCGs would pay for activity undertaken on behalf of more distant CCGs, with compensatory adjustments made to allocations. The NHS Standard Contract consultation engaged on these arrangements in more detail. We remain determined to avoid a return to burdensome invoicing and validation arrangements. As such, we will engage further with systems to establish a workable and sustainable way of implementing a more streamlined system from the point at which the COVID-

19 payment arrangements end and the NHS reverts to locally negotiated contractual arrangements. See our response to the NHS Standard Contract consultation for further details on the next steps for these arrangements.

Why we think this is the right thing to do

67. As outlined in Section 6.1, the aim of the aligned payment and incentive approach is to effectively build on the 2020/21 payment arrangements introduced in response to the COVID-19 pandemic, while also supporting the NHS Long Term Plan. We feel that the development of ICSs increases the importance of moving all sectors to the same payment approach. However, we recognise the different starting points of acute services compared to ambulance, community and mental health.

68. We feel that the proposed threshold would ensure that the majority of services, by value, are subject to the aligned payment and incentive payment approach, while limiting the number of such wide-ranging agreements that would be required.

69. During the October engagement events, we discussed the proposed scope and thresholds. Attendees at the events were relatively supportive of the scope (average engagement tool score, 6.2/10) and £10 million threshold (6.8/10). However, there was some concern about the proposed move away from national prices, and particularly the risk to data quality if counting and coding were given less prominence than under an activity-based system. There were also concerns about not including a default payment approach for contracts below the threshold.

70. In the survey sent to workshop attendees, respondents were more supportive of the scope of the payment arrangements, while the threshold continued to receive strong support.

71. Respondents to the survey that accompanied the tariff engagement document were also generally supportive of the proposed scope and threshold. There were some concerns that specialist providers, whose footprints are bigger than system level, may be disadvantaged by a payment system more closely tied to system planning.

72. Since engagement, we have revised our proposals so that the aligned payment and incentive approach is the default for all contracts between providers and commissioners that are members of the same ICS/STP. This would reduce the number of contracts affected by the threshold.

73. We are proposing to set no default payment approach for contracts with providers who are not a member of a CCG's ICS/STP and below £10 million because it covers such a wide range of scenarios. Any default approach would be likely to be inappropriate to capture the detail of a significant proportion of contracts. However, providers and commissioners in this situation would be able to consider the approach that they have used in previous years (whether block-based or activity-based). The supporting document, *Guidance on the aligned payment and incentive approach,* provides further details on possible approaches to take.

74. We are proposing to retain national prices for unbundled diagnostic imaging We feel that national prices would support increasing activity in this area as a result of COVID-19 recovery work, as well as direct access to these services from GPs and shifting the service model to delivery via diagnostic hubs. Systems would be able to choose, by agreeing local variations, to include diagnostic imaging within their aligned payment and incentive contracts.

75. We propose to continue to calculate national prices and unit prices to the same standard as previously (see Section 8.2). While the move away from activity-based payments would remove a direct link between coding of activity and reimbursement, the importance of providers counting, coding and costing their activity in a rigorous way continues. In order to make the ambitious allocative efficiency and transformation changes needed over the next few years, systems will need to access detailed, high quality information about the activities they are undertaking and the cost of delivering those services to the population they serve. Systems with good quality data should be able to build up aligned payment and incentive agreements in more sophisticated ways to help drive service redesign for their population.

6.3 The fixed element

About the fixed element

76. We are proposing that providers and commissioners are required to locally agree their aligned payment and incentive fixed element. In agreeing this they need to engage constructively, act transparently and agree an approach which is in the best interests of patients.

77. To help providers and commissioners agree the fixed element, the supporting document, *Guidance on the aligned payment and incentive approach*, gives examples of methods that could be used.

78. The fixed element would be expected to cover funding for all activity, including:

    - the costs of delivering services within the system plan covered by the aligned payment and incentive agreement, including funding for new ways of delivering services, such as the creation of Maternal Medicine Networks for specialist maternity activity
    - agreed levels of BPT performance (see Section 7.4)
    - some high cost drugs and devices (see Section 6.5) and other items currently excluded from 2020/21 national prices, such as excess bed day payments.

79. We are proposing that CQUIN is integrated into the NTPS. As such, once a fixed element has been agreed, 1.25% should be added to reflect assumed full attainment of CQUIN metrics. Where actual CQUIN attainment is less than that, payments would be deducted from the provider as part of the variable element (see Section 6.4).

80. The transfer of funding from CQUIN into the national tariff means that the proposed national prices and unit prices have been increased by around 1.25% (see Sections 8.2, 8.6 and 8.7). For payment arrangements that rely on these prices, increases to reflect CQUIN funding would not be needed.

81. The 2020 Comprehensive Spending Review announced additional money to support the NHS, including for mental health services and elective recovery.

However, this would be distributed outside of the tariff and so should not be incorporated in the fixed element.

Why we think this is the right thing to do

82. During our engagement on potential policies for 2021/22, we suggested that an appropriate starting point for calculating the fixed element might be the 2020/21 block values, but that we would not mandate or prescribe a particular method for local areas to follow. While the feedback on the proposals was generally positive, a number of stakeholders raised concerns that local areas would find reaching agreement difficult for a variety of reasons, including:

    - COVID-19 making it difficult to accurately understand the current clinical operating model
    - a lack of clarity about what cost information is available to base the fixed element on
    - different systems being at different stages of development and so may find agreement harder or easier.

83. Although there was consistent feedback that having a default calculation approach would be helpful, there was no overriding consensus on what this default should be. Given the increased uncertainties that have developed, and the additional pressures COVID-19 has placed upon systems since the engagement took place, we feel that prescribing a default could potentially hinder rather than help local discussions around the appropriate level of the fixed element.

84. Having considered the feedback from the engagement, and the other developments, we have developed examples of approaches that could be used to calculate the fixed element – see *Guidance on the aligned payment and incentive approach*. We will consider whether a default calculation approach should be set in future years.

85. Our proposals would mean that the approach to agreeing fixed elements for ambulance, community and mental health providers could be similar to how they have agreed payments in previous years. However, aligning the approach that non-acute providers use to agree their fixed element with that of

acute providers should support collaboration and system working, as well as supporting a move towards parity.

86. We are proposing to integrate CQUIN within the NTPS, as part of the aligned payment and incentive approach. This was not something that we discussed during our engagement on potential policies, but we did ask workshop participants and survey respondents questions on CQUIN and streamlining of incentives.

87. Workshops attendees were asked ‘To what extent would you support retaining CQUIN?’, on a scale of 1-10 (10 being strong support; 1 being strong opposition). There was relatively little support for retaining CQUIN, with only 22% of attendees giving a score between 7 and 10. There was slightly stronger opposition from commissioners (41% giving a score of 1-4) than providers (36%). Discussions during the workshops suggested that the reasons for the opposition often related to the administrative burden of the scheme, relative to its value, and questions around whether the incentives actually have a significant effect on clinical behaviour.

88. In the survey sent to workshop attendees, and the one that accompanied the tariff engagement document, respondents were asked to what extent they supported integration and streamlining of financial incentives in future years. There was very strong support for this (162 of 205 responses either supported or strongly supported). Responses again highlighted the administrative burden of CQUIN, and strongly highlighted the need for financial incentives to be simplified and more clearly aligned to NHS Long Term Plan objectives.

89. We have discussed this feedback carefully with colleagues in the NHS Standard Contract team and feel that integrating CQUIN into the NTPS would be a useful step towards the Long Term Plan commitment to simplifying and integrating financial incentives. We are proposing to do this in a way that should not increase the burden of implementing CQUIN.

90. It is important to note that the integration of CQUIN into the aligned payment and incentive approach would mean that there aren’t any CQUIN requirements for activity outside the scope of aligned payment and incentive agreements. The proposed national prices and unit prices have been uplifted by 1.25% to reflect the transfer of CQUIN funding.

6.4 The variable element

About the variable element

91. We propose that aligned payment and incentive agreements must include a variable payment for some elective activity and for BPT and CQUIN performance.

92. The default design of the variable element would be as follows:

    - Activity over or under a baseline for elective activity, set out in the agreement, would be paid/deducted at 50% of national or unit prices after national variations (eg MFF) have been applied.
    - BPT attainment above or below that assumed as part of the fixed element would be paid/deducted as per the published BPT rules.
    - CQUIN indicator attainment less than 100% (assumed as part of the fixed element) would mean payment deducted from the provider.

93. Providers and commissioners who want to agree alternative arrangements may do so by varying from this default. Areas that do want to not apply a variable element would need to apply to NHS England and NHS Improvement for approval, with a justification of how the local system plan will deliver the aims of supporting elective recovery and improving quality.

94. The 2020 Comprehensive Spending Review allocated an additional £1 billion in funding for elective activity. However, this funding will not be distributed through the tariff. Further details will be provided in guidance on planning for 2021/22.

Why we think this is the right thing to do

95. While the aligned payment and incentive fixed element is intended to fund delivery of an agreed level of provider activity consistent with the ICS system plan, the variable element would serve to ensure funding flows to providers in proportion to where elective activity is actually taking place. It would also seek to uphold and drive quality improvements.

96. During our engagement, the variable element probably received the widest range of feedback. While there was broad understanding of the reasons to

have a variable element to help with elective recovery, there was a mix of feedback as to whether this should be locally determined or nationally mandated, and then what any national model may look like.

97. We feel that it is important to allow local areas the flexibility to construct an approach that reflects their local situation and priorities. However, we received a lot of feedback raising concerns about the potential for conflict and disagreement if there were no national default. As such, we are proposing the default payment/deduction of 50% of tariff unit prices for over/under performance and adjustments for BPT and CQUIN achievement.

98. A variable element would allow money to flow to and from providers to reflect where elective activity is actually being undertaken, therefore better matching reimbursement with the costs of undertaking activity. We estimate that around 25% of the costs of undertaking elective activity is purely variable (eg consumables, drugs) and a further 50% is accounted for by semi-fixed staff costs. Some providers may be able to undertake extra activity at purely variable cost, but others may need to reflect extra staffing costs.

99. 50% is therefore a pragmatic mid-way point between the two. By setting a rate of 50% for activity over plan and 50% for activity under plan, this would also not create a cost pressure to commissioners in the system if aggregate activity is as planned, but the profile across providers is different.

100. Where 50% is not deemed appropriate for a system, they can choose to use a different percentage by agreeing to vary away from the 50% default. If not, or additionally, this may also be identified as an area to reflect in the SCFMA, where providers and commissioners within the system can share any financial risks which may arise as a result of different activity profiles where cost pressures are not adequately reflected in the 50% default rate.

101. For BPTs and CQUIN, the variable element is intended to flow money to and from providers where actual performance is different from plan. This should reinforce the financial incentive to maintain or improve quality in these priority areas.

102. There was a mix of feedback from engagement on the extent to which local areas were previously applying BPT payments to their reimbursements and which BPTs may be more relevant for some providers compared to others.

There was consistent feedback that the BPT process of validating performance and applying top-ups was overly burdensome.

103. Therefore, we have set out a default approach in the variable element which maintains the coverage of BPTs, but providers and commissioners will have the ability to vary away from these arrangements to suit their local circumstances. See Annex DtC for more details of the BPT approach.

104. As mentioned in Section 6.3, we did not discuss the proposal to integrate CQUIN into the NTPS in our engagement. However, we did ask about retaining CQUIN in its current form and to what extent there would be support for streamlining financial incentive schemes in the future. There was a lot of feedback suggesting that CQUIN should not continue in its current form, and very strong support for streamlining of financial incentives. A lot of the feedback stressed the importance of making sure that the administrative burden of any scheme was proportionate to its value.

105. Overall, the variable element seeks to maintain the financial incentive to support elective recovery and maintain and improve service quality in the areas covered by BPTs and CQUIN, but allows variations where agreed locally.

106. We feel it is important that the payment system actively supports reducing the elective backlog and improving quality, and that providers who do so should receive additional reimbursement. As such, if a provider and commissioner wish to vary away from the default variable element arrangements, such that there is no additional reimbursement available for these activities, we would require additional assurance that the local system plan provides adequate provision to achieve this. Areas would be required to submit an application to vary in this way, which would be considered by NHS England and NHS Improvement before being approved.

6.5 High cost drugs and devices

About the approach to reimbursing high cost drugs and devices

107. We propose to use largely the same arrangements for reimbursing high cost drugs and devices as were in place during in the second half of 2020/21, as part of the financial arrangements introduced in response to COVID-19.

108. For aligned payment and incentive agreements, this would involve:

- using a cost and volume approach to funding Cancer Drugs Fund, Hep C and the majority of other high cost drugs provided as part of specialised services commissioned by NHS England[11]
- the fixed element including funding for other specialised drugs which are not expected to be volatile in terms of uptake, and where there are no requirements for additional incentives to encourage uptake or additional data requirements to support commercial arrangements
- the fixed element including funding for CCG-commissioned high cost drugs and devices.

109. Other high cost exclusions (see Section 7.3) would continue to be funded outside of the tariff.

110. We are also proposing some minor shifts of drugs between these categories from those set out in the 2020/21 arrangements. The high cost lists in Annex DtA include details of the items included and whether funding should be included in aligned payment and incentive fixed elements. The high cost drugs list contains two tables – one of drugs excluded from tariff price calculations; one of items commissioned by NHS England Specialised Commissioning. Both tables indicate if the funding for the drugs should be included in the fixed element.

111. As in 2020/21, reimbursement to providers will be contingent on accurate reporting of high costs drugs data.

112. For activity not covered by aligned payment and incentive agreements, all high cost exclusions (drugs, devices, listed procedures and innovative products) would be subject to the local pricing rules in Section 4 of the draft 2021/22 NTPS. Devices commissioned by NHS England Specialised Commissioning are expected to be managed via the High Cost Tariff-Excluded Devices (HCTED) programme.

[11] To support and incentivise delivery of medicines optimisation schemes, reimbursement of specific drugs funded on a cost and volume basis would be set at a level which incentivises behaviour to secure best value for the NHS.

Why we think this is the right thing to do

113. In our initial engagement with stakeholders on policies for 2021/22, we discussed the possibility of all high cost drugs and devices being funded through the fixed element. However, there was extremely strong resistance to this idea, with concerns that providers would have to bear significant risks if an unexpected number of high cost items were required in-year.

114. This issue continued to be raised as a concern in the feedback to the tariff engagement document, where we proposed using the arrangements introduced in the second half of 2020/21, rather than including all funding in the fixed element.

115. Having considered the feedback from engagement, and from colleagues in NHS England Specialised Commissioning, we are proposing to continue with the reimbursement arrangements for high cost drugs and devices introduced in the second half of 2020/21. We feel that this option offers the most stability and strikes an appropriate balance between providers receiving funding in a timely manner and the additional risk they may face from high cost drug and device usage. This would represent a pragmatic option for 2021/22 but we would work to develop a more robust approach for future tariffs.

116. There were also requests for clarity around the commissioning and reimbursement routes for each of the items on the high cost exclusions lists. Annex DtA includes details of the reimbursement approach for each item. See also Section 7.3 for details of the proposed high cost exclusion lists.

7. Currency design and specification

117. To assist the design of payment for healthcare, we group activity in a clinically meaningful way. These groupings can be used as the basis for the service specifications or ‘currencies’ that may be used to set prices.

118. The proposed aligned payment and incentive approach would introduce a new currency – the entire bundle of secondary care services subject to the payment, as provided by an individual provider during the financial year – for which a single annual price is paid (see Section 6). This section discusses the currencies used to set prices for individual services, whether that is the basis of a national price (in the case of unbundled diagnostic imaging services) or a unit price (which would be used in calculating the variable element of the aligned payment and incentive agreements and available for agreeing prices outside of such payments).

119. For 2021/22 we are proposing rolling over the 2020/21 price relativities and currency design used for national or unit prices. However, as set out in Section 6.2, we are proposing that all services apart from unbundled diagnostic imaging are removed from the scope of national prices. Healthcare resource groups (HRGs) and treatment function codes (TFCs) would continue to be the basis of the unit prices calculated to be used for activity outside the scope of aligned payment and incentive agreements, whether for local agreement or for contracts under the NHS Increasing Capacity Framework.

120. In this section we explain our proposals on the currencies for national and unit prices for the 2021/22 NTPS.

7.1 Currency design

Proposal
The proposed aligned payment and incentive approach would introduce a global currency for the bundle of services within the scope of payment, as provided by an individual provider during the financial year. The tariff rules would determine when this applied and when individual unit currencies apply.

For the individual unit currencies, we propose to continue using the HRG4+ phase 3 currency design used for 2016/17 reference costs to set national prices and unit prices.

We propose to add 25 new TFCs.

About this proposal

122. The proposed aligned payment and incentive approach, set out in Section 6, would involve a single currency consisting of the services within the scope of the payment as provided by an individual provider during the financial year. The tariff rules would determine when this applied and when individual unit currencies apply.

123. In addition to currencies for national prices, we also use currencies as the basis for the unit prices in the national tariff, which can be used to facilitate local pricing (when the aligned payment and incentive approach does not apply). For the individual unit currencies, we propose to continue using the HRG4+ phase 3 currency design used for 2016/17 reference costs to set national prices and unit prices (see Section 7.2 for the scope of currencies). This was the currency design initially used for the 2019/20 NTPS national prices and then used with minor updates for the 2020/21 NTPS.

124. As we are proposing to roll over the price relativities from 2020/21, the currency design would also be largely maintained (albeit applied largely to unit prices rather than national prices), with a small number of minor changes.

125. We are proposing are to add the following new TFCs:

TFC	Description	TFC	Description
109	Bariatric Surgery Service	347	Sleep Medicine Service
111	Orthopaedic Service	431	Orthogeriatric Medicine Service
113	Endocrine Surgery Service	348	Post-COVID-19 Syndrome Service
115	Trauma Surgery Service	451	Special Care Dentistry Service
145	Oral and Maxillofacial Surgery Service	461	Ophthalmic and Vision Science Service
200	Aviation and Space Medicine Service	504	Community Sexual and Reproductive Health Service
230	Paediatric Clinical Pharmacology Service	505	Fetal Medicine Service
240	Paediatric Palliative Medicine Service	670	Urological Physiology Service
250	Paediatric Hepatology Service	673	Vascular Physiology Service
270	Paediatric Emergency Medicine Service	675	Cardiac Physiology Service
326	Acute Internal Medicine Service	677	Gastrointestinal Physiology Service
333	Rare Disease Service	730	Neuropsychiatry Service
335	Inherited Metabolic Medicine Service		

126. We reviewed the new TFCs to see if they mapped into existing TFCs to understand if any would require a price and, if so, what would be an appropriate price. The review established that five of the new TFCs mapped onto existing ones:

    - TFC 111 and 115 map onto TFC 110 (Trauma and Orthopaedic services). We propose that all three TFCs have the same price.
    - TFC 113 maps onto TFC 100 (General Surgery Service). We propose that both TFCs have the same price.
    - TFC 145 maps onto TFC 140 (Oral Surgery Service) and TFC 144 (Maxillofacial Surgery Service). We propose that TFC 145 is given a price based on a weighted average of the prices for TFCs 140 and 144
    - TFC 347 maps onto the existing TFC 341 (Respiratory Physiology Services). We propose that TFC 347 has the same price as TFC 341.

127. We are proposing the prices for the new TFCs would be non-mandatory guide prices. The remaining 20 new TFCs would not have a price set. We have also reviewed the names assigned to TFCs and updated the lists in Annex DtA and

the *Non-mandatory guide prices* workbook to ensure they are consistent with the NHS Digital definitions.

128. We are proposing to update the currencies for wheelchairs, looking to cover the specialised element of wheelchair service provision and simplify the currency structure to reflect how wheelchair services are provided. Annex DtB contains the updated currencies.

129. We are in the process of developing currencies for community services, with an initial focus on five patient population groups: children and young people with disabilities, long term conditions, single episodes of care, frailty, and last year of life. We have published the frailty and last year of life non-mandatory currencies in the supporting document *Community services currency guidance: frailty and last year of life.* More information about the project is available on the NHS England and NHS Improvement website.

130. We are also working on a review of the mental health clusters. For details, see *Mental health currency review*, published alongside the November 2020 tariff engagement document. However, we are not proposing to make any changes to mental health currencies for 2021/22.

Why we think this is the right thing to do

131. As we are proposing to roll over the price relativities from 2020/21 (see Section 8.2), the currency design for these prices needs to remain largely the same, with only exceptional changes.

132. The proposed new TFCs were introduced by NHS Digital as part of the update to the DCB0028: Treatment Function and Main Speciality Standard. The Information Standards Notice requires that providers be fully conformant with the standard from 1 April 2021. As such, we are proposing adding them to the currency design for 2021/22.

133. Where we have identified that new TFCs cover activity that would previously have been reported under existing TFCs, we have proposed an appropriate non-mandatory guide price based on the existing TFCs.

134. Currencies for wheelchair services were first introduced in 2017. However, due to changes in the way services are commissioned, we have been working

with the NHS England and NHS Improvement Personalised Care Group to review the currencies available for wheelchair services. This review found that the existing currencies did not allow providers of wheelchair services to understand their entire service, including specialised provision. We therefore proposed updating the currencies (provided in Annex DtB) to support structured commissioning discussions and improved benchmarking.

135. We are working to develop the community currencies with a group of subject matter experts, including members of the royal colleges, to reflect the clinically led needs and outcomes against resource use. The currencies and the process for their development is published on the NHS England and NHS Improvement website. They include the introduction of psychosocial factors such as patient activation, functional status and the complexity of wider need into the currency model. We believe this would support a more personalised and holistic approach to provision which would have further value in supporting future currency development for population health.

136. We had intended to work with pilot partner organisations to test the currencies. However, due to COVID-19 this was suspended. Instead, we have developed an alternative approach to testing the currencies, using information previously used for other related projects. Using this methodology, we have published the frailty and last year of life currencies as non-mandatory currencies – see the supporting document *Community services currency guidance: frailty and last year of life*. We will work with partner organisations to validate the use of these currencies during 2021/22 and will make any necessary amendments to the currencies for use in April 2022. We will also continue to develop and test the others, while considering other population groups where currencies would support commissioning based on needs and outcomes.

7.2 Scope of currencies

Proposal

We propose to:

- set national prices reflecting the HRG4+ phase 3 currency design used for 2016/17 reference costs

- exclude from national prices (and therefore from the currencies for national prices) all services other than unbundled diagnostic imaging.

About this proposal

137. The proposed aligned payment and incentive approach set out in Section 6 would involve almost all services being reimbursed via an agreed annual payment, determined in accordance with the applicable rules, rather than national prices. We are therefore proposing to exclude from the scope of national prices, and the currencies for national prices, all services apart from unbundled diagnostic imaging.

138. However, the currencies would continue to be relevant for local pricing arrangements and for services outside the scope of the aligned payment and incentive approach. As described in Section 8.2, we are proposing to calculate national prices and unit prices in the same way, using the HRG4+ phase 3 currency design used for 2016/17 reference costs.

139. Annex DtB contains guidance on some currencies with unit prices and some without either national or unit prices. The currencies would continue to be applicable for local pricing arrangements and activity outside of the scope of the aligned payment and incentive approach. Annex DtB brings together information that was previously in separate annexes, the main tariff document and the maternity pathway payment supporting document. It includes details of currencies for services with unit prices including admitted patient care, outpatient attendances and maternity. As unbundled diagnostic imaging has retained national prices, details of the currencies for these services have been moved into the main tariff document.

Why we think this is the right thing to do

140. The aligned payment and incentive approach would move away from activity-based payments, with an agreed fixed element being used to reimburse the majority of services. Moving away from national prices allows organisations to focus on agreeing their fixed elements based on costs and planned activity.

141. However, we are proposing to calculate both national prices and unit prices for activity outside the scope of aligned payment and incentive agreements. Both

types of price would be set in the same way – by rolling over price relativities from 2020/21. To do this, we need to use largely the same set of currencies for prices as the 2020/21 NTPS (see Section 7.1).

142. We have updated the content of Annex DtB to reflect the proposed move from national prices to unit prices for many services.

7.3 High cost exclusions

Proposal

We propose to:

- add Bimekizumab to the high cost drugs list
- make no additions to or removals from the high cost devices list
- add two items to the innovative products list.

Annex DtA shows the high cost exclusions lists with our proposed changes. It also includes details of which items should have funding included within aligned payment and incentive fixed elements.

About this proposal

143. In previous tariffs, several high cost drugs, devices and listed procedures, and listed innovative products, have not been reimbursed through national prices. Instead, they have been subject to local pricing in accordance with the rules set out in the NTPS.

144. Section 6.5 describes our proposed approach to reimbursing certain high cost drugs and devices within the aligned payment and incentive approach. This would involve funding for items specified in Annex DtA being included in the aligned payment and incentive fixed element. Other items on the high cost exclusion lists would continue to be excluded from tariff payments. All items on the high cost exclusion lists would be excluded from contracts outside the scope of aligned payment and incentive arrangements.

145. Annex DtA shows the high cost exclusions lists with our proposed changes. When considering which items to include in the lists, our guiding principle has been that the item should be high cost and represent a disproportionate cost

compared to the other expected costs of care within the HRG, which would affect fair reimbursement.

146. To establish the contents of the high cost drugs and devices lists, the standard approach for each new tariff is for high cost drugs and devices steering groups to meet and discuss items that could be added or removed. In addition, there is usually a web portal for people to submit nominations for the lists, as well as a horizon scanning exercise to identify new items that might be expected to come onto the list.

147. However, the steering groups for 2021/22 were not able to meet until late in the year and neither the horizon scanning process nor web portal were run. When the steering groups did meet, their view was that – particularly in the context of the rollover of prices and the uncertain impact of COVID-19 – it would not be appropriate to make significant changes to the lists of high cost drugs or devices for 2021/22.

148. During the engagement workshops and in the engagement document, we invited nominations to be sent directly to the pricing team, which we then carefully considered.

149. As a result of this, we are proposing to add Bimekizumab to the high cost drugs list. This is a new drug that is expected to be launched in 2021.

150. We are proposing to update the guidance on the commissioning of high cost devices, including those managed via the Specialised Commissioning High Cost Tariff-Excluded Device (HCTED) programme. See Section 5.5 of the draft 2021/22 NTPS.

151. We are also proposing to add two new items to the innovative products list, which was first introduced in the 2020/21 NTPS. The list intended to support the MedTech Funding Mandate, which was expected to come into effect in April 2020. However, due to COVID-19, the introduction of the Mandate was delayed and is now due to launch in April 2021. We have reviewed potential products against the criteria for the list (that they would be covered by the Mandate and would not otherwise be paid for by the NTPS) and propose to add:

- GammaCore – a non-invasive vagus nerve stimulator used to treat and prevent cluster headaches (www.nice.org.uk/guidance/mtg46)
- Placental growth factor (PIGF)-based tests – used with clinical judgement and other diagnostic tests to help rule out suspected pre-eclampsia (www.nice.org.uk/guidance/dg23)

Why we think this is the right thing to do

152. Some high cost drugs and devices are paid for in addition to the national tariff reimbursement for the related service. This has been a feature of the national tariff for many years and is designed to ensure that providers are appropriately reimbursed for the use of these items.

153. During the October 2020 engagement workshops and in the tariff engagement document, we explained that the lack of clinical availability had meant the steering groups had been unable to run, and that we were therefore considering making no significant changes to the high cost drugs and devices lists. The response from attendees in the sessions, and through the follow-up survey, was broadly supportive. This was also the case in the feedback to the tariff engagement document. However, a number of respondents did feel that the lists should be more regularly reviewed and updated to reflect changes and innovations.

154. During the engagement, stakeholders were invited to submit nominations for potential changes to the lists. We received a small number, which we considered carefully against the guiding principle set out in paragraph 143. As a result, we are proposing to add Bimekizumab to the list.

155. We are working to improve the nominations process for future tariff cycles, setting up a standard template that can be submitted at any time in the year. We would then publish cut-off dates for nominations to be considered for a given tariff.

156. For high cost devices, there were requests for more clarity around where commissioning responsibility rests for high cost devices. We have reviewed the ‘commissioned by’ field in the high cost devices tab in Annex DtA to ensure it is up to date, and that the tab also clarifies where devices should be included in the aligned payment and incentive fixed element.

157. During the engagement, we also received a number of requests for improvements to the process through which devices are considered for addition to the high cost list. We are considering how best to do this as part of the updated nominations process.

158. For the innovative products list, we worked with the NHS England and NHS Improvement innovation team to review products against the criteria for inclusion on the list. The two items proposed were covered by the MedTech Funding Mandate and would not otherwise be paid for by the NTPS so we are proposing to add them to the list.

159. Annex DtA shows our proposed high cost drugs, devices and listed procedures lists. For high cost drugs and devices, this includes details of the proposed reimbursement approach within aligned payment and incentive agreements.

7.4 Best practice tariffs

Proposal

- We propose that ICSs should agree a level of BPT attainment which is funded as part of the fixed element of aligned payment and incentive agreements. Adjustments for actual attainment levels would then be paid as part of the variable element. System would have some flexibility to vary these arrangements.
- We propose that BPTs would apply to all priced activity outside the scope of the aligned payment and incentive approach.
- We propose to retire the day case and outpatient procedure BPTs and to update the guidance for the spinal surgery BPT.

Annex DtC provides detailed guidance on the proposed BPTs for 2020/21.

About this proposal

160. The proposed aligned payment and incentive approach, and the move away from national prices, would require a change in the operation of BPTs. In considering our proposals for BPTs, we have been focused on the balance

between maintaining a focus on clinical quality while ensuring administrative burden is proportionate and avoiding financial instability.

161. We feel that the most effective way to strike this balance is to implement BPTs as part of aligned payment and incentive agreements, involving the following steps:

- Providers and commissioners should agree an anticipated level of BPT attainment which will be delivered within the fixed element.
- Where actual attainment differs from plan, extra BPT payments would be paid or deducted.
- Providers and commissioners would be able to vary the BPT arrangements. This may include reducing the number of BPTs to which the variable rate applies, or the level of payments attached.
- Providers and commissioners can only remove the variable element for all BPTs by applying to NHS England NHS Improvement and gaining approval.

162. This approach would apply to all contracts agreed as part of the aligned payment and incentive approach. For contracts outside the scope of aligned payment and incentive agreements, where providers and commissioners choose to use an activity-based payment approach based on the tariff's unit prices, we propose that BPTs would continue to apply as they have operated in previous tariffs.

163. We would also remove the existing outpatient procedure and day case BPTs and update the Annex DtC guidance for the spinal surgery BPT to clarify the reporting requirements and deadlines.

Why we think this is the right thing to do

164. BPTs have an important role in supporting performance and reporting. Given the proposed changes to the tariff for 2021/22, we do not want to lose the benefits for patients, and the wider healthcare system, that BPTs have delivered. At the same time, we have frequently received feedback about undue levels of administrative burden associated with the operation of BPTs.

165. During our engagement workshops, and in *Developing the payment system for 2021/22*, the approach we described would have involved de-mandating all

BPTs and issuing guidance on how areas could apply these within their fixed elements. There would then be a longer-term project to review financial incentives. We also discussed these proposals with National Clinical Directors, GIRFT and other clinical leads.

166. The feedback we received was relatively mixed – although there was strong support throughout for the longer-term review of incentives. There was support for the potential reduction in administration of the proposed approach, but there was also significant concern about the risks to performance and quality of care.

167. We considered other approaches, including removing BPT activities from the scope of the aligned payment and incentive and continuing to pay on an activity basis, as well as options which allow more local discretion on whether or not to apply BPTs.

168. We feel that our proposed approach strikes an appropriate balance between supporting clinical quality, administrative burden and potential instability. We feel that it is also a pragmatic step forward from the 2020/21 emergency payment arrangements, allowing more focus on supporting clinical quality.

169. For other priced activity, we are proposing that BPTs would continue to be applied to individual units of activity. This would be consistent with the approach used by the NHS Increasing Capacity Framework. It would also ensure a consistent approach to BPTs for priced activity across different commissioner and provider footprints.

170. We would continue to publish full guidance for all BPTs (see Annex DtC), as well as calculating BPT prices (see Section 8.4 and Annex DtA).

171. The proposed aligned payment and incentive approach would incentivise providers to deliver activity in the most cost-effective setting. This would mean the separate financial incentive built into the outpatient procedures and day case BPTs to deliver activity in these settings is now no longer required. We are therefore proposing to retire these BPTs.

172. There had been some confusion between providers and commissioners about the reporting requirements for the spinal surgery BPT. We propose updating the guidance in Annex DtC to address this issue.

8. Proposed method for determining national and unit prices

8.1 Introduction

173. In this section we present our proposals for setting national and unit prices for 2021/22.

174. As set out in Section 6.2, the proposed aligned payment and incentive approach would mean that all services apart from unbundled diagnostic imaging are no longer in the scope of national prices. However, we propose using the same method as for national prices to calculate the unit prices for all services that had national prices in the 2017/19 NTPS (before the introduction of blended payment in 2019/20). The following table compares the different types of prices we are proposing for the 2021/22 NTPS with those that were part of the 2020/21 NTPS:

	2020/21 NTPS	Proposed for 2021/22 NTPS
National prices	Prices covering admitted patient care, outpatient procedures, unbundled services and best practice tariffs.	For unbundled diagnostic imaging services only.
Unit prices to support local payment (blended payment/ aligned payment and incentive agreements)	Prices for emergency care, outpatient attendances and maternity services to be used in the calculation of blended payments.	All prices, other than unbundled diagnostic imaging. To be used for activity outside the scope of aligned payment and incentive agreements, for the variable element and for activity under the NHS Increasing Capacity Framework
Non-mandatory guide and benchmark prices	Prices set where the source data is insufficiently robust for national prices, or where the prices are being tested.	

Our principles

175. We propose to continue using 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 model of delivery to another where it is more efficient and effective.

176. Providers and commissioners should continue to collaborate 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.

8.2 Setting national and unit prices for 2021/22

Proposal

We propose to:

- use largely the same calculation method and currencies as the 2020/21 NTPS
- roll over the price relativities from the 2020/21 NTPS rather than calculate new price relativities.

We propose to set national prices for unbundled diagnostic imaging services only (see Section 6.2). We propose to calculate prices by reference to costs both within and outside the scope of national prices.

About this proposal

177. We propose to set national prices for unbundled diagnostic imaging services only. However, we propose to include 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 costs and related data for those services would be used in the method described in paragraph 181. The resulting prices, while not national prices, would then be used as unit prices which local areas could choose to use for activity outside the scope of aligned payment and incentive arrangements or commissioned under the NHS Increasing Capacity Framework.

178. We propose to set 2021/22 national prices and unit prices by rolling over the price relativities from the 2020/21 NTPS, using the currency design set out in Section 7 of this document, with 2016/17 cost and activity data. This is largely the same method as used for 2019/20 and 2020/21. This closely follows the methodology previously used by the then Department of Health Payment by Results (PbR) team, up to 2013/14, and previous national tariffs.[12]

179. While the PbR method has not been exactly replicated each year, for the 2014/15, 2015/16 and 2016/17 national tariffs, there were minimal changes other than to reflect updates to currencies, cost uplifts, efficiency and manual adjustments. For the 2017/19 NTPS, we made some more substantial changes, including removing calculation steps that did not have any clearly identifiable policy intention (such as adjustments that appeared to be historic manual adjustments).[13]

180. For 2019/20, we implemented the following changes to the method:[14]

- Introduced a cash in/cash out process that increased specificity in how total amounts of money are adjusted for changes in the scope of the tariff.
- Used the updated methodology for calculating MFF values
- Incorporated revisions to the PSS eligibility lists, rules and hierarchy.

[12] For a description of the 2013/14 PbR method, please see Payment by results, step by step guide: calculating the 2013/14 national tariff.
[13] For details of these changes, see paragraphs 186-187 of the 2017/19 NTPS
[14] For details of these changes, see paragraphs 142-144 of the 2019/20 NTPS

- Included a transfer of £1 billion from the Provider Sustainability Fund (PSF) into non-elective and A&E prices.

181. The 2020/21 NTPS used largely the same calculation method and currencies as 2019/20. Rather than calculate new price relativities, the 2020/21 NTPS used 2019/20 NTPS prices as initial relativities.

182. We propose to set prices for 2021/22 by using largely the same method as 2020/21, with the 2020/21 prices as initial relativities. This would mean calculating the prices in the following way.

    - Take the 2020/21 NTPS prices and use them as price relativities for 2021/22.
    - Adjust the price relativities to an appropriate base year. As price relativities are based on 2016/17 reference costs, we need to adjust them to the current year (2020/21) before we can make any forward-looking adjustments. To do this we adjust the draft prices by applying the efficiency, inflation and Clinical Negligence Scheme for Trusts (CNST) adjustment factors for 2017/18, 2018/19, 2019/20 and 2020/21. 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 9.2).
    - Make manual adjustments to modelled prices, based on clinical advice, to reduce the number of instances where price relativities are implausible, illogical or distorted – for 2021/22, we are not proposing to make any manual adjustments as those introduced in 2019/20 and 2020/21 are already reflected in the initial price relativities (see Section 8.5).
    - 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 8.6).
    - 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 the cash in/out approach (see Annex DtE). The changes would be based on the percentage difference between the initial amounts allocated and the desired amounts by point of delivery and/or subchapter,

with the prices changed by the same percentage. We are proposing to continue with the changes made in 2020/21, including:

  - removing £77.8 million from the total amount reimbursed by the tariff to reflect cancer genetic testing not being in the scope of the tariff and instead being funded by Specialised Commissioning
  - transferring £29.1 million from Specialised Commissioning to increase chemotherapy delivery prices (SB11Z to SB15Z) to include chemotherapy supportive drugs.
  - transferring £12.9 million to Specialised Commissioning to fund complex knee revision surgery
  - moving £15.7 million out of all prices, apart from renal dialysis, to increase postnatal maternity prices.

- Apply a cost base adjustment to reflect the proposed transfer of funding from CQUIN (1.25% – see Section 8.6). This would be done at the same time as adjusting prices to proposed 2021/22 levels to reflect cost uplifts (1.3% – see Section 8.7) and an estimate of the minimum level of efficiency that we expect providers to be able to achieve in 2021/22 (1.1% – see Section 8.8).

183. We have continued to use the software package SAS to run the tariff calculation model. We have reviewed and improved the code for the 2021/22 NTPS. However, there have been no changes to the method described above. This SAS code is available in Annex DtE.

Why we think this is the right thing to do

184. This long-established method is based on the national reference costs data provided by the NHS, the most comprehensive cost data currently available which is also quality assured. Using largely the same method as in previous years also maintains price stability, which supports the sector in agreeing contracts locally. We have proposed improvements to the method where we have identified errors, to reflect updated data or to ensure the software infrastructure is as reliable as possible.

185. The proposed rollover of the 2020/21 NTPS price relativities would minimise financial volatility from year-on-year price changes. We did consider recalculating prices using more recent cost and activity data, but felt that this risked introducing uncertainty at a time when stakeholders were likely to be

focusing on responding to the COVID-19 pandemic and the changes to service delivery it has caused. In addition, COVID-19 meant that there was limited availability from clinicians to review any updated prices, meaning it would not be possible to ensure that the prices were a fair reflection of actual activity. In this context, we felt that rolling over the 2020/21 prices was the most sensible approach. We are working on setting prices using latest available patient-level costing data (PLICS), rather than reference costs, for future tariffs.

186. In our engagement, there was strong support for the proposed rollover of price relativities. Respondents welcomed the stability this would provide for the prices, although some were concerned that there would be a significant lag between the 2016/17 cost and activity data used to calculate the prices and current practice.

187. For 2021/22, we propose to use the same modelling process to calculate national prices and unit prices for the following reasons:

    - This would ensure that the unit prices are modelled using the same method and to the same standard as national prices. This would give commissioners and providers confidence that these prices could be used for the purposes of determining local prices, including for activity commissioned under the NHS Increasing Capacity Framework
    - Removing services with unit prices would have an impact on national prices. The current policies to reduce year-on-year volatility and to set the overall cost uplift factor include the costs of all services that had a national price in the 2017/19 NTPS. Removing them from the scope of calculation could increase price volatility.
    - Removing these services from the cost base used to calculate prices would have an undesirable destabilising effect on other prices.

188. As such, we feel that our proposed method is a more appropriate way to calculate national prices for unbundled diagnostic imaging services than developing a method specifically designed for those services alone.

8.3 Managing model inputs for 2021/22

Proposal

- We propose to use the same cost and activity data to model prices for the 2021/22 NTPS that were used for 2020/21.

About this proposal

189. For 2021/22, and in line with the rollover of price relativities, we propose to use the same two main data inputs that we used to generate individual prices for the 2019/20 and 2020/21 NTPS:

    - costs – 2016/17 reference costs
    - activity – 2016/17 hospital episodes statistics (HES) and 2016/17 reference costs.

190. We propose applying the same data cleaning rules that were used in 2020/21 for the reference cost data used for admitted patient care prices. Applying the data cleaning rules would exclude the following records from the raw reference cost dataset:

    - Outliers, detected using a statistical outlier test known as the Grubbs test (also known as the 'maximum normed residual test').
    - Providers that submitted reference 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.
    - Providers that submitted reference costs containing more than 75% duplicate costs across HRGs and departments.

191. As in 2020/21, we propose merging data where:

    - prices would have been based on a very low number of spells (less than 50), unless we have been advised otherwise by the EWGs
    - illogical relativities[15] were found.

[15] An illogical relativity is where the cost of performing a more complex procedure is lower than the cost of performing a less complex procedure (without good reason).

192. We propose to use 2016/17 HES data for activity, grouped by NHS Improvement using the 2016/17 (HRG4+) various groupers and the 2019/20 engagement grouper.

193. Using NHS Improvement grouping is a change from the 2013/14 PbR method, which used HES data grouped by NHS Digital.

Why we think this is the right thing to do

194. Rolling over the price relativities requires the baseline model inputs, relating to cost information, activity data and key policies, to remain consistent with those used for setting the 2020/21 NTPS. Changing the underlying model input information would be inconsistent with the rollover of price relativities proposed in Section 8.2.

195. Cleaning reference cost data would reduce unexplained tariff price volatility. We expect that using cleaned data would, 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 should 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.

196. We propose to use activity data grouped by NHS England and NHS Improvement, rather than NHS Digital because it allows more flexibility in the timing of grouping the data.

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

8.4 Setting prices for best practice tariffs

Proposal
We propose to use the same method for calculating prices for best practice tariffs as we used in the 2020/21 NTPS.

About this proposal

198. Section 7.4 sets out our proposals for changing the way that BPTs operate in 2021/22. However, BPT prices would continue to be required to support these arrangements and for priced activity outside the scope of aligned payment and incentive agreements.

199. We propose to use the same method for setting BPT prices that we have used since the 2017/19 NTPS. This means that, as far as possible, we propose to apply a standard method of pricing BPTs. For 2021/22, this would involve:

- using the proposed rollover of price relativities 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.

Why we think this is the right thing to do

200. Our proposed pricing method for BPTs is consistent with that used for the 2019/20 NTPS and the proposed rollover of price relativities for the 2021/22 NTPS (see Section 8.2).

201. While we received feedback on the operation and implementation of some proposed BPTs (see Section 7.4), stakeholders have not raised concerns about the BPT pricing method.

8.5 Making manual adjustments to prices

Proposal
We propose to make no manual adjustments to the price relativities for 2021/22.

About this proposal

202. In previous years, the prices published as part of this consultation included manual adjustments to the initial price relativities. However, for the 2021/22 NTPS we are proposing not to make any manual adjustments to the initial price relativities. The manual adjustments from 2019/20 and 2020/21 are reflected in these relativities.

Why we think this is the right thing to do

203. Manual adjustments are made to minimise the risk of setting implausible prices (eg prices that have illogical relativities with other prices). Such prices could negatively impact patient care and service viability. Implausible prices may arise due to, for example, variable quality in reference cost data or rapid change in the level of resource required to deliver care in a particular HRG due to changes in clinical practice.

204. The proposed price relativities are the 2020/21 NTPS prices, which were themselves based on the price relativities of the 2019/20 NTPS. As such, the relativities have been through two rounds of clinical and stakeholder review and have been endorsed as a robust reflection of the relative cost of clinical activity. We recognise that this does not reflect changes to services and costs as a result of changing clinical practice – and COVID-19 in particular – which are likely to impact in different ways on different services.

205. Due to COVID-19 the clinical expert working groups (EWGs) did not meet to review the price relativities for 2021/22. This meant that the EWGs did not raise any issues that should be addressed by manual adjustments.

206. During the tariff engagement workshops and in the tariff engagement document and accompanying surveys, we asked for comments on price relativities and received a small number of suggestions which we have considered. However, we are not proposing to make any manual adjustments as a result as the comments repeated issues raised in previous years that the EWGs advised against changing. As it has not been possible to discuss the issues with EWGs again for 2021/22, we are proposing to stick with the previous EWG advice.

8.6 Cost base

Proposal
The cost base for 2021/22 would be affected by the proposed reduction in the number of services covered by national prices.

We propose that the cost base for services retaining national prices would reflect the proposed price setting method, rather than being recalculated. The cost base would be increased by around 1.25% to reflect an equivalent reallocation of CQUIN funding into the tariff.

About this proposal

207. The cost base is the level of cost the tariff will allow providers to recover before making adjustments for cost uplifts and before applying the efficiency factor. After calculating price relativities, we set national prices at a level that will allow providers to recover the cost base. We then adjust those prices to allow for cost uplifts and the efficiency factor.

208. As with many other parts of tariff setting, we use the previous year's tariff as a starting point for the following tariff. As such, we propose using 2020/21 prices and revenue as the starting point for the 2021/22 cost base for both national prices and unit prices.

209. After setting the starting point, we considered new information and several factors to form a view whether an adjustment to the cost base is warranted.

210. Information and factors that we considered include:

- historical efficiency and cost uplift assumptions
- cost data
- additional funding outside the national tariff (including additional funding for COVID-19)
- changes to the scope of the national tariff, including those related to the proposed aligned payment and incentive approach
- any other additional revenue 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.

211. For 2021/22, it is our judgement that it would be appropriate for the cost base to be based on 2020/21 NTPS prices. As described in Section 6.3, we are proposing to integrate CQUIN within the tariff for 2021/22. As such, we propose that the cost base is increased by around 1.25% to reflect the equivalent amount reallocated from CQUIN. We propose to apply this amount to all prices (both for locally priced services and unit and national prices) by making an adjustment in addition to the cost uplift factor in the tariff.[16] The aligned payment and incentive rules also describe how CQUIN would be included in aligned payment and incentive fixed and variable elements (see Sections 6.3 and 6.4).

212. We are proposing to make no adjustments to the tariff relating to arrangements for the NHS Supply Chain for 2021/22. This would mean that the cost base for national prices and unit prices incorporates the adjustment made to the 2019/20 NTPS to reflect arrangements for the NHS Supply Chain, reducing the total amount reimbursed through the national tariff by around £204 million to reflect the costs of Supply Chain Coordination Limited (SCCL) relating to services covered by the NTPS, and not those that are covered by other SCCL income streams (eg rebates from suppliers, customer income from NHS England and income from customers not providing tariff services).

Why we think this is the right thing to do

213. In judging where to set the cost base, we consider the effect of setting the cost base too high or too low. This effect is asymmetric:

- 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 have a greater risk of deficit, service quality could be lower than would otherwise be the case (eg increased emergency waiting times), and some providers might cease providing certain services.

[16] This is an adjustment to the tariff cost base, as funding is moving into national prices and unit prices from outside the NTPS. However, the cost uplift factor is being used to make the adjustment in the tariff. This enables it to be applied to local prices, in line with local pricing rule 2.

- 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.

214. Having considered the factors set out in paragraph 210, we did not find any convincing reason to propose changing the approach to setting the cost base from that used in previous years. As such, we propose to keep the cost base equal to the revenue that would be received under 2020/21 NTPS prices (even though block payment arrangements were used for 2020/21).

215. We believe that it is appropriate to use the same cost base methodology for setting unit prices as it is for national prices. Unit prices are calculated on the same basis and to the same standards and we believe that there is no reason to calculate these prices using a different methodology.

216. We propose to transfer funding from CQUIN to the cost base as we have previously set the cost base recognising that providers receive revenues in addition to tariff revenues. We are proposing to effect this cost base change through an adjustment in addition to the cost uplift factor as this will ensure that the change to CQUIN funding is applied to all prices (both locally determined prices and national and unit prices). We think this approach minimises transactional burdens in the implementation stage when agreeing local prices. This approach would reduce the risk of financial volatility as most of the relevant elements of CQUIN were previously allocated on the basis of contract value.

217. The compensation for services relating to NHS healthcare, performed by SCCL in the public interest, has enabled mark-ups on prices to be removed, lowering procurement prices for trusts and improving transparency of pricing. We believe it is appropriate to make no changes to the 2021/22 NTPS relating to arrangements for the NHS Supply Chain.

218. Feedback from our engagement raised concerns about the lack of evidence of savings achieved by SCCL. There were also concerns from independent sector providers that they are unable to access the benefits of the SCCL reduced prices. We have passed the feedback on to SCCL to make sure that they are aware of these concerns.

8.7 Cost uplifts

Proposal

- We propose to set the inflation cost uplift factor at 1.3% for the purpose of calculating national and unit prices for 2021/22. The proposed cost uplift does not reflect changes in costs as a result of COVID-19.
- We also propose making an adjustment in addition to the cost uplift factor of 1.25% to effect the proposed transfer of funding from CQUIN (see Section 8.6).

About this proposal

219. We propose to use broadly the same methodology for setting cost uplifts that we used in the 2020/21 NTPS.

220. We do not propose to make an adjustment to the cost uplift factor to reflect COVID-19 costs. As part of the November 2020 Spending Review, the Chancellor committed to an extra £3 billion of funding to address additional COVID-19 costs, including the restoration of services, and to funding for further operationally necessary direct COVID-19 costs. This additional funding will be distributed outside of the NTPS – details will be included in guidance on planning for 2021/22.

221. To determine the proposed national prices and unit prices for the 2021/22 NTPS, we have assessed cost pressures and calculated a cost uplift factor, which is used to adjust prices for expected changes to the major components of provider costs. This cost uplift factor is intended to reflect forward-looking cost changes deemed outside the control of providers in prospective national prices. We also propose that the cost uplift factor applies to the calculation of the unit prices to be used for services outside the scope of national prices.

222. To assess the cost pressures, we gathered initial estimates across several 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. Table 2 outlines the cost categories and the source for initial estimates.

Table 2: Costs included in the cost uplift factor

Cost category	Description	Source for initial estimates
Pay	Assumed pay settlement, pay drift and other labour costs.	Internal data Department of Health and Social Care
Drugs	Expected changes in drug costs included in the tariff.	Internal data Office for Budget Responsibility
Capital	Expected changes in the revenue consequences of capital.	Office for Budget Responsibility
CNST	Expected changes in CNST contributions.	NHS Resolution
Other	General inflation for other operating expenses.	Office for Budget Responsibility

223. 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 3 shows the weights applied to each cost category.

224. For the cost weights, we used the 2019/20 and 2020/21 NTPS cost uplift factors to adjust actual costs in the 2018/19 consolidated accounts. Our methodology is reflective of weightings for planned 2020/21 costs, and this is the weighting used to set the cost uplift factor for 2021/22.

Table 3: Elements of inflation in the cost uplift factor

Cost	Estimate	Cost weight	Weighted estimate
Pay	1.0%†	68.47%	0.7%
Drugs*	0.6%	2.56%	0.0%
Capital*	1.9%	7.18%	0.1%
CNST*	0.7%	2.36%	0.0%
Other*	1.9%	19.34%	0.4%
Total		100.0%	1.3%[17]

* The inflation assumptions proposed for these elements are based on an average GDP deflator rate across 2020/21 and 2021/22 – 1.9%

† We are proposing an indicative 0% pay inflation figure, pending agreement of the NHS settlement. However, previously agreed pay uplifts and underestimations in pay assumptions in previous years results in a 1.0% figure.

[17] Note: calculations are done unrounded – only one decimal place displayed

225. We have excluded the following costs from the calculation of the proposed 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, which are not included in the national tariff and are instead funded by Health Education England.
- High-cost drugs, which are not reimbursed through specialised commissioning agreements (see Section 6.5).

226. As the table indicates, total indicative pay cost change is estimated at 1.0% for 2021/22. This includes rate increases for 2021/22 from previously agreed settlements, some catch-up for 2019/20 medical pay and an estimate for pay drift.[18] The additional employer pension costs, arising from the change in the employer contribution rate from 1 April 2019, are not included in the cost uplift factor.

227. As the final NHS settlement for 2021/22 has not yet been agreed, we do not have reliable pay estimates for the remaining pay elements. We are therefore proposing to apply an indicative 0% pay inflation, although the November 2020 Spending Review did commit to increasing NHS pay. If the NHS settlement is agreed before the publication of the 2021/22 NTPS (subject to consultation), these rates will be revised and the cost uplift factor will be updated. However, if the agreement remains outstanding by the time of publication, the relevant cost pressures will be reimbursed in-year, as has been the case in previous years.

228. As described in Section 8.6, we are also proposing to make an adjustment in addition to the cost uplift factor of 1.25% as a result of the proposed transfer of funding from CQUIN.

Why we think this is the right thing to do

229. Every year the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited

[18] This is a weighted estimate of pressures from both Agenda for Change and medical pay awards

control. We therefore make a forward-looking adjustment to the modelled prices to reflect expected cost pressures in future years (the cost uplift factor).

230. We are not proposing to make an adjustment to the cost uplift factor to reflect COVID-19 costs as government funding to address COVID-19 costs, including restoration of services, will be distributed outside of the tariff. While we acknowledge that COVID-19 is likely to have a significant impact on the costs of routine healthcare delivery during 2021/22 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 proposed cost uplift reflects pre-COVID activity. Any adjustments would need to be agreed locally between the provider and commissioner.

231. Any uplifts relating to COVID are likely to need to vary throughout the year and by location. As such, setting a fixed national adjustment factor may not be appropriate. There is expected to be funding for COVID costs included within the NHS settlement, and the November 2020 Spending Review announced £3 billion to cover increased costs and the restoration of services. Details of how this will be distributed will be included in guidance on planning for 2021/22.

232. The uplift assumptions for drugs, CNST, capital and other expenses are reliant on an inflation assumption. Our methodology has traditionally used the latest GDP deflator rate,[19] which is produced quarterly.

233. The latest GDP deflator estimate (-2.79%[20]) was published in November 2021 and anticipates quite substantial deflationary pressures for 2021/22. This is likely due to (among other factors) reduced government spending, along with the economic fallout from COVID-19. We believe that this rate would not be wholly reflective of the bundle of costs that trusts will incur in 2021/22. As such, we are proposing to average the GDP deflator rates across 2020/21 and 2021/22, which gives an inflation rate of 1.9%. This figure would leave inflation consistent with previous years.

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19 GDP is a broad measure of inflation in the economy, calculated by the Office for Budget Responsibility (OBR).

20 Published at www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-november-2020-spending-review. The OBR inflation estimate for 2021/22 is negative due to the expected deflationary pressures as the UK economy contracts due to COVID-19.

234. Total drug cost change is estimated at 0.6% for 2021/22. This is calculated based on an assumption of unit costs for generic drugs changing by the estimated inflation rate outlined in paragraph 233. The unit costs for branded medicines are assumed to be fixed, so the expected change is set at zero. These estimates are weighted based on the proportions of generic and branded medicine for tariff-included drugs, which calculates the final estimate.

235. Total change in the revenue consequences of capital is estimated at 1.9% for 2021/22. This estimate of change would be assumed to apply for depreciation, private finance initiatives (PFI) and public dividend capital (PDC). As with drug costs, this is based on the estimated inflation rate outlined in paragraph 233.

236. Total change in CNST, which is included in the tariff and cannot be allocated to HRG subchapters, is estimated at 0.7% for 2021/22. This is based on the change in contribution rates for unallocated CNST as a proportion of the total CNST collection from NHS providers for 2021/22.

237. Total change in other operating costs is estimated at 1.9% for 2021/22. This is based on the estimated inflation rate outlined in paragraph 233. This estimate of change is assumed to apply to a wide range of costs not covered by the above categories.

238. For the same reasons that we propose to use the national prices calculation method to set unit prices for services outside the scope of national prices (see Section 8.2), we propose to apply the cost uplift factor to those unit prices.

239. The rationale for the proposed CQUIN cost base adjustment is described in Section 8.6.

8.8 Efficiency factor

Proposal

- We propose to set the efficiency factor at 1.1% for the purpose of calculating national and unit prices for 2021/22. The proposed efficiency factor does not reflect changes in costs as a result of COVID-19.

About this proposal

240. National prices are adjusted up by the cost uplift factor, 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 2021/22, we propose that this adjustment also applies to unit prices for services outside the scope of national prices.

241. The efficiency factor reflects the cost reduction we expect providers to achieve by treating patients at lower cost over time, for example by introducing innovative healthcare pathways, technological changes or better use of the labour force.

242. The objective of the efficiency factor is to set a challenging but achievable target to encourage providers to continually improve their use of resources, so that patients receive as much high-quality healthcare as possible. Our estimate of the level of efficiency that is stretching but achievable is based on evidence of the historical efficiency achieved by the sector.

243. Setting the efficiency factor inappropriately can have adverse impacts on providers, commissioners and patients because:

    - setting an efficiency factor too high (prices too low) may challenge the financial position and sustainability of providers. Providers may not be adequately reimbursed for the services they provide, which could affect patients' quality of care.
    - setting an efficiency factor too low (prices too high) may reduce the volume of services that commissioners can purchase with given budgets affecting patients' access to services. Setting prices above efficient costs may reduce the incentive for providers to achieve cost savings.

244. We are proposing to set the efficiency factor for 2021/22 at 1.1% for the purpose of calculating national and unit prices. As with the cost uplift factor, described in Section 8.7, we are not proposing to reflect changes in costs as a result of COVID-19 in setting the efficiency factor. Any COVID uplifts would be distributed outside of the tariff once the NHS settlement has been finalised.

Why we think this is the right thing to do

245. Our recommendation is supported by NHS Improvement analysis of the ten-year efficiency trend in the sector, specifically of NHS acute providers.[21] It is also based on a consideration of other relevant evidence, for example the financial position of the NHS provider sector and external estimates of NHS productivity.[22]

246. The analysis is based on 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 and residual differences between trusts are used to estimate the distribution of efficiency across the sector.[23] This model has been developed further in subsequent tariffs and more recent data has been incorporated each time.[24] The model now includes data from 168 acute trusts for the period between 2008/09 and 2017/18.

247. We estimated two measures of efficiency in this updated model: trend efficiency and variation in efficiency.

    - Trend efficiency is the average sector-wide efficiency gain we observe over time. This could arise from new technologies, improved hospital processes or less efficient trusts catching up with more efficient ones. We estimate trend efficiency as a percentage reduction in costs over time that does not vary by trust. Given the importance of achieving value for money in the NHS, we consider that it is reasonable to set an efficiency ask at least at the level of historical trend efficiency.
    - Variation in efficiency is the range of efficiency performance across trusts. This could arise from differences in use of technologies, or differences in hospital processes. We estimate variation in efficiency as a percentage

[21] It is still not possible to extend the economic model to other sectors, such as ambulance, community and mental health, due to the availability of data. This will continue to be reviewed in future years with further external evidence considered.

[22] Such as published by York, Centre for Health Economics and Office for National Statistics. See, for example: www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity; www.york.ac.uk/che/research/health-policy/efficiency-and-productivity/

[23] For a detailed description of the model, see the Deloitte report, Methodology for efficiency factor estimation.

[24] The report of the efficiency factor for the 2016/17 national tariff can be found here: Evidence on the efficiency factor.

difference in costs from the average trust that does not change over time. We use this to inform our understanding of what reasonable efficiency level, over and above trend efficiency, would enable less efficient trusts to catch up with more efficient trusts.

248. Table 4 displays the results of the core estimate of our model and suggests it may be reasonable for the tariff efficiency factor to be at least 0.9% with a catch-up factor to reduce variations in efficiency.

Table 4: Efficiency estimates

	Estimate
Trend efficiency	0.9%
Variation in efficiency	
Median to 60th centile	1.4%
Median to 70th centile	3.2%
Median to 80th centile	5.2%
Median to 90th centile	8.0%
Notes: The econometric analysis is based on cost data from 168 providers for the period 2008/09-2017/18.	

249. Our modelling suggests 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%. This is 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.

250. However, adjusting the time period of the model highlighted that the delivery of efficiencies has slowed in recent years.

251. Our judgement is that the proposed tariff efficiency factor of 1.1% would be challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure.

252. As with the cost uplift factor, we are not proposing to make 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 2021/22 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 proposed efficiency factor reflects pre-COVID activity. Any adjustments would need to be agreed locally between the provider and commissioner.

253. More detail on reimbursement of COVID-19 related costs and distribution of additional government funding outside the tariff will be included in guidance on planning for 2021/22.

9. National variations

254. National variations refer to variations to national prices specified in the national tariff (s116(4)(a) of the 2012 Act). They relate to circumstances where it is appropriate to make national variations to national prices (as distinct from local variations agreed between commissioners and providers). National variations are intended to reflect certain features of costs that are not fully captured in prices or seek to share risk more appropriately between providers and commissioners. National variations aim to do one of the following:

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

255. For 2021/22, the proposed reduction in the number of national prices would affect the impact of national variations. In order that the policies underlying the variations would continue to operate effectively, we propose:

    - to include guidance on how the MFF, top-ups for specialised services and evidence-based interventions should be considered in aligned payment and incentive agreements (see *Guidance on the aligned payment and incentive approach*)
    - retire the national variation for the primary hip and knee replacement BPT, updating the BPT so the variation becomes part of the guidance and criteria (see Annex DtC).

256. We also propose to move to the third step of the five-step implementation path for the MFF and to keep on hold the transition path for specialist top-up payment, following the move to prescribed specialised services (PSS) designation of specialist services.

9.1 Market forces factor

Proposal
We propose to move to the third step of the five-step market MFF implementation path.

About this proposal

257. The market forces factor (MFF) is a measure of unavoidable cost differences between healthcare providers, and a means of offsetting the financial implications of these cost differences. As well as being part of the NTPS, it is also used in CCG allocations. Each NHS provider is assigned an individual MFF value. This is used to adjust national prices and commissioner allocations.

258. It is important to note that, as the proposed aligned payment and incentive approach set out in Section 6 involves funding the majority of activity through locally agreed payments rather than national prices, the range of activity where the MFF is directly applied would be greatly reduced. However, providers and commissioners should consider changes in MFF value when agreeing the aligned payment and incentive fixed elements (see Section 6.3). MFF adjustments should also be applied to unit prices used in the variable element, and for priced activity outside the scope of aligned payment and incentive arrangements.

259. The MFF was comprehensively reviewed and updated in the 2019/20 NTPS to incorporate more up-to-date data and improve the accuracy of our estimation of unavoidable cost differences between providers.

260. The 2019/20 review led to significant changes to MFF values, largely because much of the data had not been updated for almost ten years. The resulting changes were proposed to be phased in in equal steps over a five-year period to ensure that the impact on revenue and allocations did not cause unacceptable volatility.

261. For 2021/22, we propose moving to the third step of this glidepath (ie the ‘Year 3’ MFF values that were published as part of the 2019/20 NTPS, updated for any mergers). Annex DtA contains the proposed MFF values for

2021/22, as well as the future steps on the glidepath. Each future step will be subject to consultation on subsequent national tariffs, including considerations of whether it would be appropriate to update the data and method used.

262. Moving to the third year of the MFF glidepath would further reduce 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 2021/22 prices, compared to continuing to use the 2020/21 MFF values (ie the second year of the MFF glidepath) is 0.38%.

263. For 2021/22, we considered whether it would be appropriate to further update the data used to calculate MFF values. We also considered reviewing the MFF components to potentially make a change to reflect buildings costs associated with operating leases, facilities management costs and the land index.

264. However, taking into account the need to balance a further update against factors such as providing stability to support planning and reducing administrative burden, we are not proposing to make any changes to the MFF's underlying data and methodology for the 2021/22 NTPS.

Why we think this is the right thing to do

265. Prior to the publication of the 2019/20 NTPS, the data underpinning the MFF model had not been updated for approximately 10 years. As a result of the update the target MFF for a number of providers was reduced to ensure that the allocation of healthcare resources is as fair as possible. However, a five-year transition path was introduced to help mitigate the year-on-year impact on individual providers.

266. We are proposing to move to the next step of the transition path to ensure that MFF values continue to move closer to the target values and thereby more accurately represent the unavoidable costs faced by each provider and commissioner. A more accurate MFF would help to more fairly allocate resources to commissioners and providers across the country, reducing the impact of regional healthcare inequalities.

267. The 2019/20 data and method update reduced the difference in MFF values between London and providers in other parts of the country. Uncontrollable costs, particularly labour costs, continue to be higher in London but the 2019/20 data showed that the gap was narrowing. The COVID-19 pandemic has hit the London labour market particularly hard, suggesting that this gap continues to narrow. This would support the proposed move to the third step of the MFF transition path.

268. During our October engagement workshops, we discussed moving to the third step of the MFF transition path. Attendees were broadly supportive, although it was backed more strongly by commissioners than providers. In the survey sent out after the workshops, and accompanying the tariff engagement document, responses were broadly supportive. However, a number of respondents did raise concerns about:

- individual objections to specific trusts being on a negative transition path
- introducing financial instability by changing the MFF values, particularly during the period of uncertainty relating to Covid-19
- uncertainty around how MFF would operate in the aligned payment and incentive approach.

269. We did not consider that any of the responses identified an error in the data or method of setting the MFF; rather, there were concerns about its impact. We recognise that some providers will be negatively impacted, but considered that this needs to be balanced against the need to distribute scarce healthcare resources in the most appropriate way. Not moving to the next step of the glidepath would result in more resources being allocated on the basis of outdated data.

270. During engagement on the 2020/21 NTPS, we discussed a potential update of the data and method underpinning the MFF. The feedback highlighted the trade-off between the desirability of providers and commissioners having certainty of their MFF values well in advance and the values being based on the most up-to-date and accurate data. For 2021/22, we feel that changing the underlying data or method, and so moving away from the previously published values risks introducing volatility. Moving to the third step of the transition path does involve a change in MFF values. However, these have been available

since the 2019/20 NTPS and so we feel organisations should be able to work with them.

271. In addition, for 2021/22, the impacts of individual MFF values may be diminished as a result of the proposed aligned payment and incentive approach, where provider payments are less reliant on tariff prices. However, change in MFF values is one factor that could be considered in agreeing the fixed element (see *Guidance on the aligned payment and incentive approach*).

9.2 Top-up payments for specialised services

Proposal

We propose to:

- continue to use the University of York model and the baseline of the prescribed specialised services (PSS) flags used in the 2017/19 NTPS
- make no changes the PSS identification rules, hierarchy and provider eligibility lists
- pause the transition for the three services losing top-up funding as a result of the move to PSS and HRG4+, so it remains at 50%, as in the 2019/20 and 2020/21 NTPS
- continue with the payment approach for specialist knee revision services introduced in 2020/21.

About this proposal

272. Specialised services are accessed by comparatively few patients from a small number of providers with the right expertise. They are relatively expensive and account for around 14% of the total NHS budget. Top-up payments for specialised services were introduced in 2005 to reflect the extra costs of complexity.

273. For the 2017/19 NTPS, we considered five methods to manage the change from basing top-ups on the Specialised Services National Definitions Set (SSNDS) to PSS definitions. The method that was chosen involved using the University of York model[25] and updating it for changes in currency design, with

[25] www.york.ac.uk/che/news/2015/che-research-paper-118/

a four-stage transition for the three services losing top-up funding: paediatrics, orthopaedics and spinal cord injury services. There was an additional transition for spinal services, which received SSNDS top-up payments but would not otherwise receive PSS top-up payments. There was also a transition for services gaining funding through top-ups to ensure the overall transition did not change the amount of money that was allocated to top-ups.

274. For 2021/22 we have reviewed the top-up payment rates and propose to make no changes to the PSS identification rules, hierarchy changes and provider eligibility lists.[26]

275. We propose to pause the transition path introduced in the 2017/19 NTPS following the move to PSS designation of specialist services. This means that the top-up payment rates for the three services losing (orthopaedics, paediatrics and spinal surgery services) would be kept at 50% of the difference, as in 2019/20 and 2020/21.

276. We also propose to continue to apply the payment approach for knee revision surgery that was first piloted in 2020/21.

277. 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.

278. As set out in Section 6, the aligned payment and incentive rules would apply to all activity commissioned by NHS England Specialised Commissioning team and means that specialist providers are unlikely to be paid on the basis of national or unit prices. When commissioners and providers are agreeing the fixed element, top-ups previously received should be considered.

Why we think this is the right thing to do

279. Our proposals reflect the definitions of PSS and the HRG4+ currency design introduced in 2020/21.

280. In the October workshops and November tariff engagement document, we outlined the proposal to pause the transition path. The feedback was generally

[26] https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools

supportive, with many respondents accepting that it would be appropriate to make no further changes, particularly while work is completed to understand the reasons for cost variation in specialised and complex care. However, other respondents felt that pausing the transition would unfairly disadvantage some providers of specialised services and that it was unhelpful to move away from a previously stated transition.

281. As well as this sector-wide engagement, we also discussed our proposals with interested stakeholders including NHS Digital National Casemix Office expert working groups (EWGs), the payment system advisory group, HFMA, representatives from providers and Specialised Commissioning colleagues.

282. We continue to believe that moving to the new top-up rates too quickly could destabilise providers. We are also undertaking work to understand how the tariff could more effectively support providers serving patients with more complex care needs. The outcome of this work may have an impact on the specialist top-ups policy in future tariffs. As such, we are proposing to pause the transition rate for 2021/22. This would also be consistent with the proposed rollover of price relativities for 2021/22 (see Section 8.2).

283. While the operation of the top-ups would change, supporting specialist providers to deliver complex care is an important part of the payment system. *Guidance on the aligned payment and incentive approach* makes clear that top-up payments providers have previously received should be considered when agreeing the fixed element.

9.3 Best practice tariff for primary hip and knee replacements

Proposal
We propose to retire the national variation to support the BPT for primary hip and knee replacements.

About this proposal

284. The national variation for the primary hip and knee replacements BPT was introduced in 2014/15. It recognised that in some circumstances (where there

are recent improvements, planned improvements or a particularly complex casemix), providers are unable to demonstrate that they meet all the criteria for the BPT, but it would be inappropriate for them not to receive the full BPT price.

285. Section 7.4 sets out our proposed approach to implementing BPTs for 2021/22. This would involve a move away from the national price-based approach to BPTs used in previous tariffs.

286. Given this change, we are proposing to retire the national variation. We would update the guidance for the primary hip and knee replacements BPT to include the circumstances where it would be appropriate for providers not to be penalised for being unable to demonstrate they have met the BPT criteria. See Annex DtC for the proposed update.

Why we think this is the right thing to do

287. We think that the rationale for the national variation – that there are some circumstances where it would not be appropriate to penalise a provider for not being able to demonstrate the BPT criteria – continues to be valid.

288. We therefore propose updating the guidance for the BPT to include details. Local areas can then agree how to reflect appropriate BPT attainment rates.

10. Locally determined prices

289. Local pricing arrangements have always been a core part of the national tariff. Our proposals for 2021/22 would mean that the tariff includes two types of local pricing rules:

- aligned payment and incentive rules
- general local pricing rules.

290. The general local pricing rules would support commissioners and providers to work together to agree payments for services outside the scope of aligned payment and incentive agreements.

291. The rules for local variations and local modifications of national prices would remain unchanged.

292. In previous tariffs we have supported local price setting by publishing some non-mandatory guide prices and currencies alongside the tariff. We propose to continue publishing these prices, and to introduce new non-mandatory guide prices for paediatric critical care services. See the *Non-mandatory guide prices* workbook for details.

10.1 Local pricing rules

Proposal
We propose to remove local pricing rules 3, 4, 7 and 8a, and replace rules 6, 8b, 9 and 10 with the aligned payment and incentive rules.

About this proposal

293. As set out in Section 7.1, we are proposing to move away from national prices and currencies (other than for unbundled diagnostic imaging). The current local pricing rules 3 and 4 relate to services with a national currency but no national price. While the currencies, and unit prices, would continue to be

published and available for use, they would not be mandated (national) and so we are proposing to remove the rules.

294. The local pricing rule for high cost drugs, devices and listed procedures, and listed innovative products would remain (renumbered to rule 3). However, the reimbursement of certain high cost drugs and devices, specified in Annex DtA, would be covered by the aligned payment and incentive rules – see Section 6.5.

295. In previous tariffs, the payment approach for non-acute services was governed by local pricing arrangements, with specific local pricing rules and guidance for mental health, ambulance and community services. However, the proposed aligned payment and incentive approach would apply to non-acute as well as acute services. As such, we propose that the mental health and ambulance local pricing rules (rules 6-10) are replaced by the aligned payment and incentive rules, which would instead govern the payments for these services. Many aspects of the existing rules would be incorporated into the new rules (eg requirements to submit data to NHS Digital in relation to mental health and IAPT services, and to enable appropriate patient choice for mental health services).

296. The requirements in rules 7 and 8a would be replaced by the aligned payment and incentive fixed and variable rules.

297. See Sections 3 and of the draft 2021/22 NTPS for the proposed aligned payment and incentive and general local pricing rules.

Why we think this is the right thing to do

298. We believe that these proposed changes are necessary to implement the aligned payment and incentive approach. They should also help to simplify the payment system and support increased consistency of payment approach between acute and non-acute services.

Part B: proposed 2021/22 National Tariff Payment System

Contents

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 2021 to 2022 (the 2021/22 NTPS):

   - the local pricing and payment rules, including the rules for the 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 2021/22 NTPS has effect for the period beginning on the date of publication and ending on 31 March 2022, or the day before the next national tariff published under section 116 of the 2012 Act has effect, whichever is the later.[27]

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 2021/22 aligned payment and incentive approach involves many more services being subject to such rules (specifically the aligned payment

[27] If a replacement national tariff was to be introduced before the end of the one-year period, this tariff would cease to have effect when that new tariff takes effect.

and incentive rules in Section 3), rather than national prices.[28] To reflect this change, the order of this tariff document has been revised.

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: 2021/22 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 six annexes, listed in Table 1.

[28] The 2021/22 NTPS contains a significant reduction in the scope of national prices, which apply to unbundled diagnostic imaging services only (see Section 5).

Table 1: 2021/22 NTPS annexes

Annex	Description
DtA	National tariff workbook, including national prices and unit prices
DtB	Guidance on currencies[29]
DtC	Guidance on best practice tariffs
DtD	Technical guidance for mental health clusters
DtE	Models used to calculate national and unit prices
DtF	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 2021/22 NTPS

Title
Non-mandatory guide prices workbook
A guide to the market forces factor
Guidance on the aligned payment and incentive approach

10. All annexes and supporting materials can be downloaded from the NHS England and NHS Improvement website.[30]

11. The national tariff forms part of a set of materials that inform planning and payment of healthcare services. Related materials include the NHS Operational Planning and Contracting Guidance and the NHS Standard Contract.

[29] 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 has been moved to Annex DtB. Details of the maternity payment pathway are also included in Annex DtB.

[30] www.england.nhs.uk/publication/2021-22-tariff-consultation/

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 clinical commissioning groups (CCGs), 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:[31]

- provided or commissioned by local authorities or Public Health England
- commissioned by NHS England under its Section 7A public health functions agreement with the Secretary of State, including national immunisation programmes[32]
- commissioned by NHS England or a CCG 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 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.

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[31] 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).

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

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).[33]

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 2021/22 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 CCGs.

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.

[33] 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 2021/22 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 2021/22 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 2021/22 NTPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act.[34]

23. The following are not in the scope of the 2021/22 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.

26. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain in the scope of the 2021/22 NTPS even if commissioned by a local authority.

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

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 2021/22 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. For 2021/22, nationally set financial sanctions for failure to achieve national quality 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. For 2021/22, CQUIN funding has been transferred into the tariff. This has been given effect for aligned payment and incentive agreements (see rules 2 and 3 in Section 3), and for all prices (both for locally priced services and unit and national prices) by making an adjustment in addition to the cost uplift factor in the tariff method.[35] All providers to which CQUIN applies will be expected to report CQUIN metric data, even if they implemented a local departure away from the aligned payment and incentive rules.

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,

[35] This is an adjustment to the tariff cost base, as funding is moving into national prices and unit prices from outside the NTPS. However, the cost uplift factor is being used to make the adjustment in the tariff. This enables it to be applied to local prices, in line with general local pricing rule 2 (see Section 4.2).

Wales or Northern Ireland is treated in England or vice versa, the 2021/22 NTPS applies in some but not all circumstances.

33. Table 3 summarises how the 2021/22 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 2021/22 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 2021/22 NTPS, including the 2021/22 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 (see Section 8.1). 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.[36]

36. The payment responsibility rules set out in these documents should be applied as well as any applicable provisions of the 2021/22 NTPS. The scope of the 2021/22 NTPS does not cover the payment responsibility 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.

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

3. 2021/22 aligned payment and incentive rules

39. This section sets out the aligned payment and incentive rules for services without national prices for 2021/22. 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.

40. 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 expected annual contract value is less than £10 million and is between providers and CCGs that are members of a different ICS), then the general position is that the local pricing rules in Section 4 apply (but see detailed provisions in rule 4).

41. The aligned payment and incentive approach does not change the requirements to report activity data (see Section 9.2).

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 6 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 £10 million or more,

ii. the commissioner is a CCG, and that CCG and the provider are members of the same ICS,

iii. the commissioner is NHS England for Specialised Commissioning services.

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:

(a) 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 2021/22, calculated by reference to the estimated value of the contract for that year if unit prices were applied or the contract outturn value for the financial year 2019/20, or

(b) 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);

"ICS" means an Integrated Care System as designated by NHS England;[37]

"the payment period" means the period from the date of publication of this 2021/22 NTPS to the end of the financial year 2021/22;[38]

[37] www.england.nhs.uk/integratedcare/integrated-care-systems/

[38] If an aligned payment and incentive agreement is for provision of services for a period less than 12 months, providers and commissioners should make pro-rata adjustments to reflect that, including adjustments to agreed activity levels

"secondary care services" means healthcare services provided for the purposes of the NHS,[39] 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;[40]

"the value of elective activity" is the amount that would be payable for elective services, calculated by reference is the number of elective spells and number of outpatient procedures[41] for the financial year 2021/22, if those services were priced using the unit prices set out in Annex DtA, 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 payment period, calculated in accordance with the following paragraphs.[42]

b) Subject to paragraph (d), the provider and commissioner must agree an initial fixed element representing funding for the provision of secondary care services for the payment period, applying the principles for local pricing specified in Section 4.1, and having regard to guidance published by NHS England and NHS Improvement, the cost uplift and efficiency factors for 2021/22 (as set out in Sections 6.7 and 6.8) and the CQUIN cost adjustment (set out in Section 6.6). This should include an expected value for the provision of high cost drugs,

[39] 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
[40] S.I. 2012/2996, as amended.
[41] Outpatient procedures which group to a non WF HRG with a published HRG price
[42] The supporting document *Guidance on the aligned payment and incentive approach* gives examples of calculation methods that could be used.

devices and listed procedures specified as ‘included in aligned payment and incentive’ in Annex DtA, tabs 14a and 14b.

c) The initial fixed element is increased by 1.25% to reflect assumed full achievement of CQUIN metrics and produce the fixed payment.

d) 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 payment period which is intended to be reflected in the initial fixed element.

e) 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 payment period is greater than the amount planned for and reflected in the initial fixed element, an amount equal to 50% of the difference between the value of 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 payment period is less than the amount planned for and reflected in the initial fixed element, an amount equal to 50% 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 attainment of BPT criteria in relation services delivered is different to that agreed pursuant to paragraph (c) above, the difference between the actual and planned BPT top-up values will be used to adjust the fixed payment.
   iv. If the achievement of CQUIN metrics is below that assumed in paragraph (c) above, an amount is to be deducted as agreed by the commissioner and provider in accordance with guidance issued by NHS England.

Rule 3 (locally agreed adjustments)

a) Where rule 2 applies, the price payable in accordance with rule 2(e) may be adjusted as agreed locally in accordance with following paragraphs.

b) Subject to the paragraph (c), the commissioner and provider may agree:

i. Amounts by which actual elective activity may exceed or be less than planned activity, without any variation of the fixed payment under rule 2(e)(i) or (ii). Where this is the case, the provider must continue to report data as required on elective activity.

ii. Amounts by which actual BPT performance may exceed or be less than the agreed level of attainment, without any variation of the fixed payment under rule 2(e)(iii). Where this is the case, the provider must continue to report data as required on BPT attainment through the relevant clinical audit.

iii. Amounts by which actual CQUIN performance be less than assumed level of achievement, without any variation of the fixed payment under rule 2(e)(iv). Where this is the case, the provider must continue to report data as required in relation CQUIN metrics.

iv. Other changes to the variable element in rule 2(e) (e.g. the use of 75% rather than 50% in paragraph (e)(i) or (ii)).

b) The commissioner and provider may agree to apply no adjustment for actual activity, no adjustment for BPT attainment or no adjustment for failure to achieve CQUIN, only if the agreement is approved by NHS England and NHS Improvement following an application by the commissioner and provider.

c) The commissioner and provider must agree any adjustment to the fixed price under this rule, or any other departure from rule 2, in accordance with rule 6 (other than an agreement subject to approval under paragraph (b)).

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 have an expected annual contract value of less than £10 million and are not members of the same ICS; or

ii. the services are provided pursuant to a contract awarded under the NHS Increasing Capacity Framework.[43]

b) In those cases, the prices payable for the provision of secondary care services for the payment period 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 DtA, subject to the national variations which would have applied if they were national prices; or

ii. in cases falling within paragraph (a)(ii) (whether or not also falling within paragraph (a)(i)), the unit and BPT prices set out in Annex DtA, 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 (see Annex DtD) 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.

[43] For details of the framework, see: www.ardengemcsu.nhs.uk/nhs-england-increasing-capacity-framework/

Rule 6 (local departures)

a) A commissioner and provider may agree to depart from the aligned payment and incentive pricing arrangements for secondary care services specified in rules 2, 3, 4(b)(i)(b) and (ii)[44] and 5. To do so, they must comply with the requirements in 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.

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,[45] 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.

[44] Note that where services are provided pursuant to a contract awarded under the NHS Increasing Capacity Framework, any payment arrangement to be agreed as a departure from rule 4(b)(ii) (requiring use of unit prices) must continue to comply with the rules of Framework, in addition to rule 6.

[45] Template available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

4. General local pricing rules

42. 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.

43. 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).

44. Unbundled diagnostic imaging are the only services subject to national prices in 2021/22. 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.

45. This section is supported by the following annexes and supporting document:[46]

    - Annex DtA: National tariff workbook
    - Annex DtB: Guidance on currencies
    - Guidance on the aligned payment and incentive approach.

[46] 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

46. Subject to paragraph 48, 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.

47. These principles are explained in more detail in Sections 4.1.1 to 4.1.3 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,[47] and NHS Improvement's provider licence.

48. In relation to the 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 6(b)).

49. 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.

4.1.1 Best interest of patients

50. 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:

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

- **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?

51. 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.

52. 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.

53. 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

54. 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

55. 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.

56. 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)?[48]
- **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?

[48] The NHS Standard Contract is used by commissioners of healthcare services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models.

4.2 General local pricing rules

57. For 2021/22, 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 members of different ICSs and have a contract whose value is less than £10 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

58. Rules 1 and 2 apply when providers and commissioners agree local prices for services without national prices, in cases where neither 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
Providers and commissioners must apply the principles in Section 4.1 when agreeing prices for services without a national price.

Rule 2
Commissioners and providers should have regard to the cost uplift and efficiency factors for 2021/22 (as set out in Sections 6.7 and 6.8), and the cost base adjustment for the transfer of CQUIN funding (see Section 6.6), when setting local prices for services without a national price for 2021/22.

59. Where prices are determined locally, it is the responsibility of commissioners to negotiate and agree prices having regard to relevant factors,[49] 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.

[49] '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.

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.

60. The pricing of services under these rules can be supported by the unit prices published in Annex DtA (for example, where providers and commissioners are members of different ICSs and their expected contract value is below £10 million, and they chose to use an activity-based payment approach)

61. 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.

62. 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
- 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 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

63. 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 DtA, tabs 14a to 14c (see also Section 5.5 below). In cases where the product is both used in the course of activity reimbursed by the aligned payment and incentive and listed in tab 14b as ‘included in the aligned payment and incentive’, then the cost of the product is

covered by the aligned payment agreed by the commissioner and provider (see rules (2(b) and (e) in Section 3). In all other cases, the product is reimbursed separately and priced in accordance with rule 3 below. The costs of these excluded items are not included in unit prices (see Section 6).

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 DtA and which:

i. are not listed as "included in the aligned payment and incentive" in tab 14b; or
ii. are so listed, but are used in activity to which an aligned payment and incentive does not apply (see rule 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 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

64. 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.

65. 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

66. 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 2021/22, 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

67. 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 CCG, 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 CCGs 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 CCG 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).[50]

68. 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.

69. 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

70. 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.

[50] These are arrangements made under the NHS Act 2006, section 3 or 3A.

71. 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.

72. Payment for community health services will often be incorporated into 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 members of different ICSs with an expected annual contract value less than £10 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.

73. 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 the supporting document *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

74. 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 aligned payment and incentive fixed payment set out in Section 3), or an individual episode of treatment.

75. 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 2021/22.

76. Under the 2012 Act, the national tariff must specify the NHS healthcare services for which a national price is payable.[51] The healthcare services to be specified must be agreed between NHS England and NHS Improvement.[52] 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 set out in Section 3).

77. 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 2021/22 NTPS uses the version of the currency design that was used for the collection of the 2016/17 reference costs.[53]

78. This section describes the currencies with a national price, while Annex DtB contains details of some currencies with unit prices, such as admitted patient

[51] 2012 Act, section 116(1)(a).
[52] 2012 Act, section 118(7).
[53] Details available at https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/grouper-and-tools-archive/costing-hrg4-2016-17-reference-costs-grouper

care and some with no prices. This section should be read in conjunction with:[54]

- Annex DtA: 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).

5.1 Classification, grouping and currency

79. 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).

80. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2021/22 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 diagnoses[55]
- OPCS Classification of Interventions and Procedures (OPCS-4) for operations, procedures and interventions.[56]

[54] All available from: www.england.nhs.uk/publication/2021-22-tariff-consultation/
[55] The 5th edition update of ICD-10 was published in April 2015.
[56] https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=14270896#14270896

81. ‘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.[57] 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.[58]

82. The 2021/22 NTPS uses spell-based[59] 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.

83. The HRG currency design used for the 2021/22 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 2021/22 NTPS is that used to collect 2016/17 reference costs. This is the same as was used for the 2020/21 NTPS, reflecting the rollover of price relativities (see Section 6.2).

84. 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

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

86. *Annex DtB: Guidance on currencies* includes details of the currencies for the following services, which used to have national prices:

    - Admitted patient care

[57] http://digital.nhs.uk/casemix/payment
[58] 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
[59] A spell is a period from admission to discharge or death. A spell starts on admission of the patient.

- Chemotherapy and radiotherapy
- Nuclear medicine
- Post-discharge rehabilitation
- Direct access
- Cystic fibrosis pathway
- Outpatient attendances
- Looked-after children health assessments

87. 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 DtA.

88. 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 DtA, DtB and DtC) includes the rules for determining which currencies and prices apply where a service is specified in more than one way.

89. 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

90. The services for which there are national prices has changed from the 2020/21 NTPS, with only unbundled diagnostic imaging services retaining national prices. Details of the currencies for these services are included here.

5.2.1 Unbundled diagnostic imaging services

91. 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.

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

93. 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

94. 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 LA08E, 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).

95. 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

96. 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.

97. 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.

98. 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.

99. 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.[60]

100. 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:

101. 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.

102. 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.

103. 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).

104. 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.

105. 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 attendance – we recommend a pragmatic approach. For example, the scan

[60] 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.

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

106. 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), has the potential to improve patient outcomes by reducing complications and readmissions.

107. For 2021/22, there are unit prices in Annex DtA for a pathway-based payment system for patients with cystic fibrosis. See Annex DtB for details of the pathway.

108. A pathway-base system has previously been used for maternity services. For details, see Annex DtA, tabs 7a-7d and Annex DtB. For the 2021/22 NTPS, most maternity activity is likely to be in scope of the aligned payment and incentive rules (see Section 3).

5.4 Best practice tariffs

109. A best practice tariff (BPT) is usually a unit price that is designed to incentivise quality and cost-effective care. In the 2021/22 NTPS, BPTs form part of the aligned payment and incentive arrangements. They also apply for priced activity outside the scope of aligned payment and incentive agreements. See Section 3, Annex DtC and *Guidance on the aligned payment and incentive approach* for details of the operation of BPTs under the aligned payment and incentive rules.

110. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review.[61] The service areas covered by BPTs are all:

[61] *High quality care for all*, presented to Parliament in June 2008.

- 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.

111. 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.

112. 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.

113. 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 DtA, DtB and DtC.

114. 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.

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

116. The 2021/22 NTPS retires two BPTs:

    - Day-case procedures
    - Outpatient procedures

117. 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.

118. Full details of all BPTs and guidance on implementation and eligibility criteria are available in Annex DtC.

5.5 High cost exclusions

119. 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 fixed element (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. The relevant drugs, devices and procedures can be found on the high cost lists in Annex DtA (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 the aligned payment and incentive fixed element. High cost drugs are excluded either individually or as a group exclusion, as indicated in Annex DtA, 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.

120. For the 2021/22 NTPS we have made only very minor updates to the lists for high cost drugs, devices and procedures.

121. Annex DtA (tabs 14a and 14b) gives the details and includes the lists of excluded high cost drugs, devices and listed procedures. Tab 14b also indicates those items whose funding should be included in the aligned payment and incentive fixed element, where that applies.

122. Annex DtA, tab 14c, contains an exclusion list for innovative products to support the MedTech Funding Mandate. These products will be commissioned by CCGs 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.

123. For the 2021/22 NTPS, we have added two items to the list of innovative products:

- GammaCore – a non-invasive nagus nerve stimulator used to treat and prevent cluster headaches (www.nice.org.uk/guidance/mtg46)
- Placental growth factor (PIGF)-based tests – used with clinical judgement and other diagnostic tests to help rule out suspected pre-eclampsia (www.nice.org.uk/guidance/dg23)

6. Method for determining national prices and unit prices

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

125. 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.

126. Providers and commissioners should continue to collaborate 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

127. Compared to previous tariffs, the 2021/22 NTPS reduces the number of national prices to those 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, including activity commissioned under the NHS Increasing Capacity Framework (see rule 4 in Section 3).

128. National prices and unit prices for 2021/22 are modelled from the currency design set out in Section 5 of this document, with 2016/17 cost and activity data. The methodology for the tariff model for 2021/22 prices closely follows the methodology previously used by the then Department of Health Payment by Results (PbR) team, up to 2013/14, and previous national tariffs, including the 2020/21 NTPS.[62]

129. It was not always possible to replicate the PbR method exactly. However, for the 2014/15, 2015/16 and 2016/17 national tariffs, there were minimal changes, other than to reflect updates to currencies, cost uplifts, efficiency and manual adjustments. For the 2017/19 NTPS, we made some further changes, including removing calculation steps that did not have any clearly identifiable policy intention (such as adjustments that appeared to be historic manual adjustments).[63]

130. The 2019/20 NTPS changed the methodology by:[64]

- including a transfer of £1 billion from the Provider Sustainability Fund (PSF) into non-elective and A&E prices (despite them no longer being national prices)
- using the updated methodology for calculating market forces factor (MFF) values
- introducing a cash in/cash out process that increased specificity in how total amounts of money are adjusted for changes in the scope of the tariff.

131. The 2020/21 NTPS used largely the same calculation method and currencies as 2019/20. Rather than calculate new price relativities, the 2020/21 NTPS used 2019/20 NTPS prices as initial relativities.

132. The 2021/22 NTPS again uses largely the same calculation method and currencies, using 2020/21 NTPS prices as initial relativities. Price calculations and related adjustments include all services that had national prices in the

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62 For a description of the 2013/14 PbR method, please see Payment by results, step by step guide: calculating the 2013/14 national tariff.
63 For details of these changes, see paragraphs 186-187 of the 2017/19 NTPS
64 For details of these changes, see paragraphs 142-144 of the 2019/20 NTPS

2017/19 NTPS (ie before the introduction of blended payment in 2019/20), despite all services other than diagnostic imaging no longer being covered by national prices (see Section 5).

133. We have again used the tariff calculation model built using the SAS software package that was used for the 2019/20 NTPS. The SAS code for the model is available in Annex DtE.

134. Section 6.2 explains the method for setting prices and the changes that have been made for 2021/22.

6.2 The method for setting prices

6.2.1 Modelling prices for 2021/22

135. Our modelling approach for 2021/22 involves the following steps:

- Take the 2020/21 NTPS prices and use them as price relativities for 2021/22.
- Adjust the prices relativities to an appropriate base year. As price relativities are based on 2016/17 reference costs, we need to adjust them to the current year (2020/21) before we can make any forward-looking adjustments. To do this we adjust the draft prices by applying the efficiency, inflation and Clinical Negligence Scheme for Trusts (CNST) adjustment factors for 2017/18, 2018/19, 2019/20 and 2020/21. 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 7.2.1).
- Apply manual adjustments to modelled prices, based on clinical advice, to reduce the number of instances where price relativities are implausible, illogical or distorted[65] – for 2021/22 we are not making any manual adjustments as those introduced in 2019/20 and 2020/21 are already reflected in the initial price relativities (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 6.6).

[65] An example of an illogical relativity could be where the price for a more complex treatment is lower than the price for a less complex treatment without good reason.

- Use adjustment factors to increase or decrease the total amounts allocated to specific areas (clinical sub-chapters and/or points of delivery), in line with policy decisions or clinical advice and applied using a cash in/cash out approach (see Annex DtE). The changes are based on the percentage difference between the initial amounts allocated and the desired amounts by point of delivery and/or subchapter, with the prices changed by the same percentage. We are continuing to apply the changes made in 2020/21, including:
  - removing £77.8 million from the total amount reimbursed by the tariff to reflect cancer genetic testing being removed from the scope of the tariff
  - transferring £29.1 million from NHS England Specialised Commissioning to increase chemotherapy delivery prices (SB11Z to SB15Z) to include chemotherapy supportive drugs
  - transferring £12.9 million to NHS England Specialised Commissioning to fund complex knee revision surgery
  - moving £15.7 million out of all prices, apart from renal dialysis, to increase postnatal maternity prices.
- Apply a cost base adjustment to reflect the proposed transfer of funding from CQUIN (1.25% – see Section 6.6). This is done at the same time as adjusting prices to 2021/22 levels to reflect cost uplifts and adjustments (see Section 6.7) and an estimation of the level of efficiency that we expect providers to be able to achieve in 2021/22 (see Section 6.8).

136. This means we have set 2021/22 national prices and unit prices using largely the same method as the 2020/21 NTPS, again rolling over the price relativities rather than calculating them from new cost and activity data.

6.2.2 Setting prices for best practice tariffs for 2021/22

137. For 2021/22, we have used the same method for setting BPTs that was used for 2020/21. 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 DtA, tab 6a. Details of the compliance rates and implementation of BPTs are available in Annex DtC.

6.3 Managing model inputs

6.3.1 Overall approach

140. The two main data inputs used to generate prices for the 2021/22 NTPS are:

- costs – 2016/17 reference costs[66]
- activity – 2016/17 Hospital Episode Statistics (HES)[67] and 2016/17 reference costs.

141. We explain these two datasets in more detail in this section.

142. The reference 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.

143. 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).

66 See 2016/17 reference costs
67 See https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics

Reference cost dataset used

144. We use 2016/17 reference cost data for the prices for the 2021/22 NTPS. We use this reference cost dataset because it is closely aligned with the currency design[68] of the 2021/22 NTPS, reflecting the use of 2020/21 NTPS prices as price relativities.

Reference cost data cleaning

145. One of our main objectives in setting prices is to reduce unexplained tariff price volatility.

146. 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.

147. 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 reference costs more than 50% below the national average for more than 25% of HRGs and at the same time also submitted reference costs 50% higher than the national average for more than 25% of HRGs submitted
- providers that submitted reference costs containing more than 75% duplicate costs across HRGs and departments.

148. 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

[68] We have used the HRG4+ currency system (see Section 3 for further details).

produced by data errors. Small activity numbers increase the likelihood that prices can be distorted by such errors.

149. 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.

150. For the prices in the 2020/21 NTPS, we only cleaned reference cost data for the APC module.

6.3.2 HES data inputs

151. In our modelling of the prices for the 2021/22 NTPS, we used 2016/17 HES data, grouped by NHS Improvement using the 2016/17 (HRG4+) payment grouper and the 2019/20 engagement grouper.

152. Using NHS Improvement grouping is a deviation from the 2013/14 PbR method, which used HES data grouped by NHS Digital. However, we use NHS Improvement grouping because it allows us more flexibility in the timing of grouping the data.

153. 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 Manual adjustments

154. The 2013/14 PbR method involved making some manual adjustments to the modelled prices. This was done to minimise the risk of setting implausible prices (eg prices that have illogical relativities) based on reference cost data of variable quality. For the 2019/20 NTPS we applied manual adjustments where price relativities were likely to be affected by very low activity numbers that could result in less robust reference cost data, and where illogical relativities were identified.[69]

155. For 2020/21 we made further manual adjustments for HRGs AA43* and HT22*.[70]

[69] For full details of the manual adjustments for 2019/20, see Section 4.4 of the 2019/20 NTPS
[70] For full details of the manual adjustments for 2020/21, see Section 4.4 of the 2020/21 NTPS

156. Where the manual adjustments increased the total amount allocated to a particular service, these were offset by reductions elsewhere in the HRG chapter or sub-chapter.

157. For the 2021/22 NTPS, we have not made any further manual adjustments. The adjustments made in 2019/20 and 2020/21 are included in the price relativities used to calculate 2021/22 prices.

6.5 Volatility

158. In the 2017/19 NTPS we introduced an adjustment to reduce the volatility from introducing the HRG4+ phase 3 currency design. This involved adjusting prices in some subchapters such that services recover 75% of the initial estimated loss. Tariff prices outside these subchapters have been top-sliced to pay for this revenue adjustment. We continued this adjustment in 2019/20 but changed the amount recovered to 50% of the initial estimated loss. For 2020/21, we kept the amount recovered at 50%.

159. For 2021/22, we have again kept the amount recovered at 50%. Table 4 displays the adjustment factors.

Table 4: Subchapters and uplift adjustments

Subchapter	Subchapter description	Uplift adjustment
HC	Spinal Procedures and Disorders	3.6%
HD	Musculoskeletal and Rheumatological Disorders	0.5%
HE	Orthopaedic Disorders	3.6%
HN	Orthopaedic Non-Trauma Procedures	3.6%
HT	Orthopaedic Trauma Procedures	3.7%
LD	Renal Dialysis for Chronic Kidney Disease	0.0%
PB	Neonatal Disorders	7.9%
SB	Chemotherapy	2.7%
SC	Radiotherapy	4.0%
	All remaining chapters	-0.6%

6.6 Cost base

160. 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.

161. For 2021/22, 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.

162. 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 2020/21 prices and revenue as our starting point for calculating the cost base for both national prices and unit prices. The reduction in the number of national prices means that the cost base for national prices only includes prices for some diagnostic services.

163. 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.

164. Information and factors that we considered include:

- historical efficiency and cost uplift assumptions
- latest cost data
- additional funding outside the national tariff
- changes to the scope of the national tariff, including those related to the aligned payment and incentive approach
- 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.

165. In judging where to set the cost base, we consider the effect of setting the cost base too high or too low. This effect is asymmetric:

- 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.

166. For 2021/22, it is our judgement that it is appropriate to keep the cost base equal to the revenue that would be received under 2020/21 prices, adjusted for activity and scope changes. This means that the cost adjustments made for 2019/20 (including transferring £1 billion from the Provider Sustainability Fund to A&E and non-elective prices and removing £204 million from the tariff to reflect changes to procurement arrangements), and rolled over to 2020/21, are reflected in the 2021/22 cost base for national prices and unit prices.

167. 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 standards and we believe that there is no reason to calculate these prices using a different methodology.

168. As described in Section 2.5, for 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. We have made an adjustment in addition to the cost uplift factor in the tariff to apply this amount to all prices (both for locally priced services and unit and national prices). The aligned payment and incentive rules also describe how CQUIN should be incorporated in aligned payment and incentive fixed and variable elements (see Section 3).

6.7 Cost uplifts

169. 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 2021/22, 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).

170. The cost uplift factor for 2021/22 is 1.3%. The cost uplift factor does not reflect changes in costs as a result of COVID-19.

171. We have used broadly the same methodology to set the cost uplift factor for 2021/22 as we used for 2020/21. We have not made an adjustment to the cost uplift factor to reflect COVID-19 costs. Additional funding for COVID-19 is distributed outside of the tariff – see guidance on planning for 2021/22 for details.

172. We have also made an adjustment in addition to the cost uplift factor of 1.25% to effect the transfer of funding from CQUIN (see Section 6.6).

6.7.1 Inflation

173. 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 2021/22.

174. 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.

175. 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 5 shows the weights applied to each cost category.

176. For the cost weights, we used the 2019/20 and 2020/21 NTPS cost uplift factors to adjust actual costs in the 2018/19 consolidated accounts. Our methodology is reflective of weightings for planned 2020/21 costs, and this is the weighting used to set the cost uplift factor for 2021/22.

Table 5: Elements of inflation in the cost uplift factor[71]

Cost	Estimate	Cost weight	Weighted estimate
Pay	1.0%†	68.47%	0.7%
Drugs*	0.6%	2.56%	0.0%
Capital*	1.9%	7.18%	0.1%
CNST*	0.7%	2.36%	0.0%
Other*	1.9%	19.34%	0.4%
Total		100.0%	1.3%

* The inflation assumptions for these elements are based on an average GDP deflator rate across 2020/21 and 2021/22 – 1.9%

† The calculations use an indicative 0% pay inflation figure for 2021/22, pending agreement of the NHS settlement. However, previously agreed pay uplifts and underestimations in pay assumptions in previous years results in a 1.0% figure.

177. 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 funded directly by Health Education England (trainee salaries are included within pay costs).
- High-cost drugs, which are not reimbursed through national prices (see Section 5.5).

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

[71] Note: calculations are done unrounded – only one decimal place displayed

Pay

179. As shown in Table 5, 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.

180. 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 – there are no changes made for this in 2021/22. The additional employer pension costs, arising from the change in the employer contribution rate from 1 April 2019, are not included in the cost uplift. We use estimates or assumptions for these components. These are calculated based on the best available information on pay inflation, which uses the latest labour cost data and estimates growth in line with agreed pay awards. We assume pay drift effects of 0.1% in 2021/22.

181. As the final NHS settlement for 2021/22 has not yet been agreed, we do not have reliable pay estimates for the remaining pay elements. We have therefore applied an indicative 0% pay inflation, although the November 2020 Spending Review did commit to increasing NHS pay.[72] If the NHS settlement is agreed before the publication of the 2021/22 NTPS (subject to consultation), these rates will be revised and the cost uplift factor will be updated. However, if the agreement remains outstanding by the time of publication, the relevant cost pressures will be reimbursed in-year, as has been the case in previous years.

182. The combined estimated impact of pay settlements and drift to be included in the cost uplift for 2020/21 is therefore 2.9% for AfC and 2.8% for non-AfC. These figures are weighted by the proportions of each to total pay costs.

[72] Please note: although a 0% pay inflation figure has been applied, previously agreed pay uplifts and underestimations in pay assumptions in previous years results in a 1.0% figure.

183. The projected increase in the pay from previously agreed settlements, some catch-up for 2019/20 medical pay and an estimate for pay drift is 1.0% for 2021/22.

184. 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

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

186. We used an average of the GDP deflator rates[73] across 2020/21 and 2021/22 (1.9%) 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.

187. This results in assumed drugs cost inflation of 0.6% in 2021/22.

Other operating costs

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

189. We again used an average of the GDP deflator rates across 2020/21 and 2021/22 (1.9%) as the basis of the expected increase in costs.

Clinical Negligence Scheme for Trusts

190. 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.[74] NHS Resolution administers the scheme and sets the contribution that each provider must make to ensure the scheme is fully funded each year.

[73] The GDP deflator is a broad measure of general inflation, estimated by the Office for Budget Responsibility (OBR).
[74] CCGs and NHS England are also members of the CNST scheme.

191. 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.[75] In 2021/22, CNST adjustments are applied to national prices and unit prices.

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

Figure 1: Including CNST in the national tariff

193. A provider's CNST contributions are included in its reference costs. For the 2021/22 NTPS, these are 2016/17 reference costs. The cost uplift (including CNST) and efficiency factors for 2017/18, 2018/19, 2019/20 and 2020/21 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 earlier in this section) 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 2020/21 NTPS prices and the total amount of CNST included in 2021/22 prices (national prices and unit prices).

194. Table 6 lists the percentage changes that we have applied to each HRG subchapter to reflect the change in CNST costs.

[75] 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.

195. Most of the changes in CNST costs are allocated at HRG subchapter level, maternity or A&E, but a small residual amount (about £15.2 million in 2021/22) is unallocated at a specific HRG level. This unallocated figure is redistributed as a general adjustment across all prices. We have calculated the adjustment due to this pressure as 0.02% in 2021/22.

Table 6: CNST tariff impact by HRG subchapter

HRG sub chapter	2021/22 uplift (%)	HRG sub chapter	2021/22 uplift (%)	HRG sub chapter	2021/22 uplift (%)
AA	0.36%	JA	0.33%	PP	0.71%
AB	0.22%	JC	0.32%	PQ	0.30%
BZ	0.30%	JD	0.23%	PR	0.54%
CA	0.29%	KA	0.27%	PV	0.56%
CB	0.25%	KB	0.22%	PW	0.67%
CD	0.15%	KC	0.18%	PX	0.58%
DZ	0.16%	LA	0.17%	SA	0.26%
EB	0.24%	LB	0.27%	VA	0.34%
EC	0.11%	MA	0.13%	WH	0.30%
ED	0.15%	MB	0.22%	WJ	0.11%
EY	0.21%	PB	0.69%	YA	0.41%
FD	0.24%	PC	0.60%	YD	0.17%
FE	0.19%	PD	0.66%	YF	0.25%
FF	0.25%	PE	0.39%	YG	0.13%
GA	0.25%	PF	0.57%	YH	0.53%
GB	0.13%	PG	0.41%	YJ	0.26%
GC	0.25%	PH	0.49%	YL	0.12%
HC	0.56%	PJ	0.69%	YQ	0.54%
HD	0.27%	PK	0.43%	YR	0.49%
HE	0.76%	PL	0.38%		
HN	0.41%	PM	0.14%	VB	1.09%
HT	0.43%	PN	0.32%	Maternity	4.52%

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

196. 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.

197. As with pay, drugs costs and other operating costs, we used an average of the GDP deflator rates across 2020/21 and 2021/22 (1.9%) to calculate assumed capital cost inflation in 2021/22.

Service development

198. The service development uplifts reflect expected extra unit costs to providers of major initiatives that are included in the Mandate.[76] However, there are no major initiatives anticipated in the Mandate to be funded through the national tariff in 2021/22, and no uplift is applied.

6.8 Efficiency

199. National prices are adjusted up by the cost uplift factor (see Section 6.7), 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 2021/22, 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).

200. The efficiency factor for 2021/22 is 1.1%. The efficiency factor does not reflect changes in costs as a result of COVID-19.

201. We use evidence-based data to inform the decision on the efficiency factor. An econometric model, first developed by Deloitte to inform the decision on the efficiency factor for the 2015/16 NTPS, analyses 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

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

efficiency. Residual differences between trusts are used to estimate the distribution of efficiency across the sector.

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

203. Our modelling suggests 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.

204. However, adjusting the time period of the model highlighted that the delivery of efficiencies has slowed in recent years.

205. We have set an efficiency factor of 1.1% for 2020/21. We regard this as challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure.

206. 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 2021/22 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 proposed efficiency factor reflects pre-COVID activity. Any adjustments would need to be agreed locally between the provider and commissioner.

207. More detail on reimbursement of COVID-19 related costs, and distribution of additional government funding outside the tariff is included in guidance on planning for 2021/22.

7. National variations to national and unit prices

208. 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.

209. 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’.

210. 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.

211. This section sets out the national variations specified in the 2021/22 NTPS.

212. 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*). Also, when unit prices are being used for payments outside the scope of aligned payment and incentive agreements, the national variations should continue to be applied as in previous years (ie adjusting the prices as if they were national prices).

213. 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)

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

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

215. The 2021/22 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 DtC).

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

216. 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.

217. 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.

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

219. 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.

220. For 2021/22, MFF values for each NHS provider represent the third step of this transition. All MFF values for 2021/22 are available in Annex DtA, tab 13.

221. 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 2021/22 prices, compared to using 2020/21 MFF values, is 0.38%. The aligned payment and incentive rules also require providers and commissioners to consider changes in MFF values since 2019/20 when agreeing the fixed element.

222. 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.

223. 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.

224. Organisations merging or undergoing other organisational restructuring after the publication of the 2021/22 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*.

225. Providers should notify NHS Improvement of any planned changes that might affect their MFF value. Email pricing@improvement.nhs.uk

7.2 Variations to reflect patient complexity

7.2.1 Top-up payments

226. 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.

227. 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.[77]

228. 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.[78]

229. 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.

230. As set out in Section 3, the aligned payment and incentive rules apply to all activity commissioned by NHS England Specialised Commissioning. The default approach to calculating the fixed element (rule 2) involves starting with 2019/20 contract outturn values. This would include the specialist top-ups providers received that year. Where commissioners and providers choose to agree the fixed element using a different approach, the top-ups previously received should be considered.

231. For 2021/22, 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

[77] Estimating the costs of specialised care and Estimating the costs of specialised care: updated analysis using data for 2009/10.

[78] https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools

the top-ups to be paid through prices, as in previous years, Table 7 shows the amount we have calculated different specialist areas would receive. This includes the second 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 inventive approach means that specialist providers are unlikely to be paid on the basis of national or unit prices and so these figures may not be accurate.

Table 7: Top-up impact by specialist area 2021/22

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**

232. We have used the same the top-up rates for 2021/22 as 2020/21, based on 2018/19 HES activity data.

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

Payment approach for complex knee revision surgery

234. In 2021/22, 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).

235. We will assess the impact of the approach for knee revision surgery in 2021/22.

8. Local variations and local modifications to national prices

236. This section is supported by the following annexes:[79]

- Annex DtA: National tariff workbook
- Annex DtB: Guidance on currencies
- Annex DtF: Guidance on local modifications to national prices

237. It is also supported by the following documents:[80]

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

8.1 Local variations

238. 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.[81] 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.

239. 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:

[79] All available to download from: www.england.nhs.uk/publication/2021-22-tariff-consultation/
[80] All available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/
[81] 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.

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

241. 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

242. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.[82]

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.[83] 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.

243. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.[84] They should publish each statement no later

[82] The rules in this section are made under the 2012 Act, section 116(2).
[83] Available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/
[84] 2012 Act, section 116(3).

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.[85] Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.

244. 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.[86] The completed template should be included in the commissioning contract (Schedule 3 of the NHS Standard Contract).

245. 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?

246. 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.

247. 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 (eg an HRG).[87] In practice, several services could be uneconomic as a result of similar cost issues.

248. There are two types of local modification:

[85] 2012 Act, section 116(3)(b).
[86] Available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/
[87] Please note: only unbundled diagnostic imaging services have national prices for 2021/22 (see Section 3). This means that a local modification is not available for any other services.

- 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.[88]
- 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.

249. 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.[89] 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.

250. 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.

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 agreements[90] must be supported by sufficient evidence to enable NHS Improvement to determine whether a local modification is appropriate, based on our method.

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.

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

89 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.

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

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).[91]

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 2020/21; see Annex DtF (Section 2.6) for guidance on how providers should calculate deficits for the purpose of this condition

[91] 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)).

- demonstrate that the services are commissioner-requested services (CRS)[92] 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 commissioners[93] 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 application[94] 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 2021, 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, 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.

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92 See: *Guidance for commissioners on ensuring the continuity of health services; Designating commissioner requested services and location specific services*, 28 March 2013.

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

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

Agreements

262. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate)[95] 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)).

[95] 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).[96]

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.[97]

268. The dates for reporting activity and making the reports available will be published on the NHS Digital website.[98] 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 online[99] about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

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96 2012 Act, section 116(4)(c).
97 https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance
98 https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance
99 See: www.england.nhs.uk/ig/in-val/invoice-validation-faqs/

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