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2022/23 National Tariff Payment System – a consultation notice

24 December 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 2022/23 National Tariff Payment System. This is shown as it would appear in final form, if the consultation proposals were implemented. It starts on page 74.

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1. About this document

1. This is the statutory consultation notice for the 2022/23 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 2022/23 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 2021/22 NTPS.
   - Part B – draft tariff. This contains a draft of the proposed 2022/23 NTPS, shown as it would appear in its final form. This includes sections on:
     - the scope of the tariff
     - aligned payment and incentive pricing rules
     - 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.

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

[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:** As with the 2021/22 NTPS, we are proposing national prices to be set for unbundled diagnostic imaging services only. 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.

draft tariff (Dt) annexes form part of the proposed 2022/23 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: Method used to calculate prices
Dt	Annex DtE: 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

[3] All materials are available from: www.england.nhs.uk/pay-syst/national-tariff/consultation-on-2022-23-national-tariff/

2. Context

5. The 2021/22 NTPS came into effect on 1 October 2021. However, the vast majority of activity continued to be funded through the block payment arrangements that were introduced as part of the NHS's response to the COVID-19 pandemic.[4] This means that many of the policies in the 2021/22 NTPS have not been implemented in practice. This includes the blended payment model, known as aligned payment and incentive, that it introduced.

6. The aligned payment and incentive approach covers almost all activity within the scope of the tariff. It involves providers and commissioners agreeing a fixed element, based on the best available data, which is then adjusted by a variable element based on actual performance. As such, aligned payment and incentive represents a shift away from the activity-based payment model the tariff had been used previously. It is also consistent with the commitments to payment system reform made in the NHS Long Term Plan. For 2022/23, we are proposing to continue to use the aligned payment and incentive approach, with some updates to its design. Section 6 of this document discusses this in more detail.

7. While the 2021/22 NTPS policies have not been fully implemented, the overall payment system design continues to be appropriate to the current context. The design allows the 2022/23 NTPS to provide a straightforward transition out of the block payment arrangements, while better supporting providers, commissioners and others to work together as part of integrated care systems (ICSs). It would also move towards the Long Term Plan's goal of moving from activity-based to population-based funding for almost services.

8. If enacted, the Health and Care Bill now before Parliament would make a number of changes impacting the NHS payment system, including abolishing Clinical Commissioning Groups (CCGs) and transferring their responsibilities to Integrated Care Boards (ICBs). Although the current plan is for the CCG and ICB provisions of the Bill to be implemented on 1 April 2022 (when we are proposing the 2022/23 NTPS to take effect – see Section 5), that is subject to the passage of the Bill through Parliament. At the time of this consultation,

[4] See www.england.nhs.uk/coronavirus/finance/ for details of the block payment arrangements.

CCGs remain the statutory commissioner. To address the potential change from CCG to ICB, this consultation notice and draft 2022/23 NTPS refers to local NHS commissioners, rather than specifying CCGs or ICBs.

9. Another change connected with the development of systems and the Bill are the proposals for joint working between NHS England and local commissioners on the commissioning of specialised services,[5] including the use of joint committees. In this document, however, we continue to refer to NHS England Specialised Commissioning which includes any commissioning carried out under such joint arrangements.

10. If implemented, the Health and Care Bill would replace the existing national tariff provisions of the Act with new provisions for "the NHS Payment Scheme". The new scheme would be set out entirely in rules made under the new provisions, which remove the strict separation between national prices on the one hand and (local) prices set in accordance with rules, on the other. There could be some changes to the way the scheme operates as compared with the national tariff, such as allowing prices to be set as a formula and prices to apply differently in different circumstances (for example prices could be national prices for activity outside the scope of the aligned payment and incentive but not for activity within the scope). The provisions would also make changes to the consultation process for pricing proposals. There could also be some changes to the scope of the scheme, for example potentially expanding to cover 'Section 7A' public health services, currently excluded from the NTPS.[6]

11. However, we would expect the implementation of these provisions of the Bill to be separate from and later than the changes relating to ICBs (subject to the Bill successfully passing through Parliament). As such, the proposals we are consulting on here, and the 2022/23 NTPS itself, would operate under the existing legislation (the Health and Social Care Act 2012). The changes arising from Health and Social Care Bill (if enacted) would affect the 2023/24 payment system.

5 www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2021/07/PAR817-NHS-England-and-NHS-Improvements-direct-commissioning-functions.pdf

6 The Secretary of State delegates responsibility of Section 7A services to NHS England. For information see: www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2020-to-2021

12. Looking ahead to 2023/24, place-based partnerships and provider collaboratives may have a larger role to play in the delivery of services. Patient-level cost data (PLICS) has the potential to be used for determining the distribution of resources to place, supporting the reduction of inequalities across systems. Shared governance arrangements may also become much more widespread, with flexible contracting arrangements between members of the collaborative and the commissioner.

13. We will continue to develop the payment system to make sure that it supports the NHS structures in place and forms a key part of the move from competition to collaboration that underpins the goals of the NHS Long Term Plan. Ongoing engagement with stakeholders will be an essential part of this work.

14. The impact assessment that accompanies this notice provides analysis of the impact of the changes in national prices and unit prices compared to 2021/22. It also considers the impact of our proposals in relation to equality and patient choice, and explains how the discharge of our statutory duties would be secured by implementation of the policies presented here.

3. Responding to this consultation

3.1 Statutory consultation on the national tariff and the objection process

15. The proposals for the 2022/23 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 22 January 2022. However, given the launch of the consultation in December, and the bank holidays for Christmas and new year, we will continue to consider objections and feedback submitted until midnight at the end of **28 January 2022**.

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

Objections to the method

17. 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.[7]

18. 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.

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

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

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

20. 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 2022/23 NTPS.

21. Please submit your feedback through the online survey.[8] The deadline for submitting responses is midnight at the end of **28 January 2022**.

22. Please contact pricing@england.nhs.uk if you have any questions on the running of the consultation or the proposals it contains.

[8] Available from: www.engage.england.nhs.uk/pricing-and-costing/2022-23-tariff-consultation

4. How we worked with stakeholders to develop our proposals

23. We have engaged with providers, commissioners, representative bodies and other appropriate stakeholders throughout the development of our proposals for the 2022/23 NTPS. We have learned from the engagement on the 2021/22 NTPS, extending our use of online engagement workshops and webinars.

4.1 Engagement overview

24. Our engagement included:

- regular discussions about policies in development with representative bodies and their members, such as the HFMA, royal colleges and the Social Partnership Forum workforce issues groups
- 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
- continuing with our series of co-design sessions with stakeholders from regions, ICSs, providers, commissioners and think tanks to explore developing policy proposals and longer-term payment system development
- reviewing the initial draft prices with the National Casemix Office expert working groups (EWGS) – clinical experts who reviewed the prices to ensure they reflected clinical reality
- running a series of virtual workshops and webinars, and accompanying online survey, to get feedback on initial policy proposals during September 2021.

25. Annex CnA provides details of the feedback we received from the workshops and survey.

4.2 September 2021 engagement on initial policy proposals

26. During September 2021, we ran a range of external engagement events. This comprised the following:

    - Three webinars in early September to give background to the policies being engaged on. The subjects were:
      - Context for NHS finances and payment for 2022/23
      - Tariff and payment adjustments
      - Setting tariff prices for 2022/23
    - 18 interactive workshops, delivered over Teams and using an online engagement tool (Menti) to gather attendees' views on the policies presented. Three of the workshops were specifically focused on mental health, community and non-acute services.
    - Three webinars at the end of the month to discuss some of the topics discussed at the workshops in more detail. The subjects were:
      - Innovation and the MedTech Funding Mandate
      - Whole system payment – from place to board and for all sectors
      - Products to support fixed payments.

27. We also held separate workshops for representative bodies and NHS England and NHS Improvement regional teams.

28. An online survey ran throughout September to gather additional feedback. The initial draft price relativities were also available from the survey webpage for stakeholders to review the initial outputs from the PLICS-based price calculations. The prices workbook made clear that the final prices would be subject to changes following EWG review and inflation and efficiency adjustments. We did not receive any feedback on these draft prices.

29. All the webinars were recorded and available to watch after the event. The workshops were not recorded, although there were no limits on the number of attendees at each session. Following requests for recordings of the sessions during the engagement period, we recorded presentations of the material not covered in the webinars so it was available to those who were not able to attend.

30. The webinars and workshops proved extremely popular, with the non-acute workshops particularly well attended. More than 1,600 people attended the workshops, while the webinars were viewed more than 2,000 times.

31. An online engagement tool (Menti) was used during the workshops to gather views on specific questions, with 1,180 people using it to provide feedback. Often attendees were asked to show their support or otherwise for a policy by giving a score between 1 (strongly oppose) and 10 (strongly support). The in-meeting 'chat' (via Teams) was also very busy, with more than 1,000 substantive questions and comments from attendees who used it to give more detail of their opinions, as well as asking questions.

32. The engagement tool was also used to ask attendees to indicate the type of organisation they represent. Of those that responded to this question (809), 412 (51%) represented providers and 323 (37%) represented commissioners.

33. The online survey received 54 responses. The majority of these (37 – 69%) were from providers, with seven (13%) commissioners.

34. Annex CnA contains details of the engagement tool results we received during the workshops and the feedback we received from the survey.

4.3 Expert review of draft price relativities

35. For the 2022/23 NTPS, we used the clinical expertise of the National Casemix Office's Expert Working Groups (EWGs). The EWGs are responsible for advising on the design of the casemix classifications known as healthcare resource groups (HRGs). The EWGs consist of clinicians nominated by their professional bodies and royal colleges. Each EWG focuses on a particular body system, known in HRG design as a 'chapter' (for example, Chapter A is the nervous system, while Chapter N is obstetrics).

36. We shared initial draft price relativities with EWGs, who reviewed them during September 2021. The EWGs discussed the prices and identified any illogical price relativities (ie, where a more complex procedure is given a lower price than a less complex one), recommending changes to specific price relativities when needed.

37. We carefully reviewed the feedback received to make manual adjustments to the prices proposed (see Section 8.5)

4.4 Conclusion

38. 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.

39. As we develop the 2023/24 NTPS, we will continue to undertake proactive engagement on our work throughout the development cycle. Please contact pricing@england.nhs.uk if you have any questions about this or would like to register for updates about the payment system.

40. The rest of this document sets out our proposals for the 2022/23 NTPS.

5. Duration of the tariff

5.1 Duration of the tariff

Proposal
We propose to set the tariff for one year – the 2022/23 NTPS.

About this proposal

41. As described in Section 2, the context for 2022/23 continues to be shaped by the COVID-19 pandemic. This has had a significant impact on all aspects of society, as well as the short-term priorities of the NHS, the services delivered and the approaches to giving care.

42. As part of the NHS response to COVD-19, block payment arrangements have been in place for the majority of activity during 2020/21 and 2021/22. The proposed 2022/23 NTPS is intended to form part of the wider financial framework introduced to act as a bridge from the current arrangements to longer-term ways of operating. More details will be included in the 2022/23 Operational Planning Guidance.

43. As this is a transitional period, there are a number of elements of the proposed payment system that may need to be reviewed for 2023/24, 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.

44. In addition, the Health and Care Bill is proceeding through Parliament and, if enacted, its provisions may affect the operation of the payment system in future years.

45. We therefore propose to set the tariff from 1 April 2022 until 31 March 2023 – the 2022/23 NTPS. We would expect a new payment scheme to then come into effect from 1 April 2023.

Why we think this is the right thing to do

46. We are proposing to set the tariff for one year – 2022/23 – for a number of reasons. These include the uncertainty brought about by COVID-19 and the potential changes to legislation arising from the Health and Care Bill. In addition, the planning guidance has been set for a single year and it is appropriate for the tariff to align with that.

47. In our September engagement workshops, we did not ask for specific feedback on the proposal to set the tariff for one year. However, a question was asked in the survey and the views were very positive, with 75% of respondents either supporting (29%) or strongly supporting (46%). In the comments to the survey, respondents felt that the current level of uncertainty and other ongoing changes to the NHS landscape would make a one-year tariff appropriate for 2022/23. A number of respondents did indicate that they would support a longer-term tariff in future years, to support longer-term planning.

6. The aligned payment and incentive approach

48. The aligned payment and incentive approach is a type of blended payment, first introduced in the 2021/22 NTPS. It involves providers and commissioners agreeing a fixed element to deliver an agreed level of activity, which is then adjusted by a variable element to reflect actual elective activity levels and quality of care (based on best practice tariff (BPT) and CQUIN achievement).

49. The 2021/22 NTPS came into effect on 1 October 2021. However, the aligned payment and incentive approach was not implemented in practice as the block payment arrangements, introduced as part of the NHS response to COVID-19, continued in place for the whole of 2021/22. As such, in this section we will set out the aligned payment and incentive approach in detail, highlighting where we are proposing to make changes for 2022/23.

50. We recommend reading the supporting document, *Guidance on the aligned payment and incentive approach*, alongside this section.

6.1 Overview of the proposed payment approach

51. We are proposing the following aligned payment and incentive approach for the 2022/23 NTPS. This is largely the same as the approach introduced in the 2021/22 NTPS. Sections 6.2-6.6 set out changes we are proposing to make for 2022/23.

    - Aligned payment and incentive arrangements would apply to all secondary healthcare services commissioned between NHS trusts, foundation trusts and commissioning bodies who are mapped to the same ICS for financial control purposes. This includes acute, community, mental health and ambulance services.
    - For providers who are not mapped to the same ICS as the commissioner:
        – aligned payment and incentive arrangements would apply to all commissioned activity above an annual contract value threshold (see Section 6.2)

  - payment arrangements for contracts below the annual contract value threshold would be determined by local agreement. If local agreement is not possible, tariff unit prices would be used.
- All NHS England Specialised Commissioning activity would be covered by the aligned payment and incentive approach, with no annual contract value threshold. Other secondary healthcare activity commissioned by NHS England would be subject to the 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.
- As in 2021/22, only unbundled diagnostic imaging services (ie diagnostic imaging not part of an inpatient spell) would have national prices. Diagnostic imaging which forms part of an inpatient spell would be reflected in the fixed element or unit price.
- The payment would comprise the following:
  - **A fixed element**, based on funding an agreed level of activity and reflecting plans for 2022/23 (see Section 6.3).
  - **A variable element** to support elective activity[9] and to reflect achievement of best practice tariff (BPT) and CQUIN criteria and delivery of advice and guidance services (see Section 6.4).
- As in 2021/22, funding for certain high cost drugs and devices would be included in the fixed element. However, for 2022/23, we are proposing to ensure there is parity of funding approach, regardless of the commissioner, and to make clear that all NICE approved, commissioner-funded items introduced within the year are excluded from the fixed element (see Section 6.5). We are proposing that innovative products covered by the MedTech Funding Mandate would be paid for outside of the fixed element, although funding for implementing them should be included within it (see Section 6.6)
- To support local areas to agree how they will work together to manage NHS system finances, a model System Collaboration and Financial Management Agreement (SCFMA) will be published alongside the NHS Standard Contract.

[9] In the variable element, 'elective activity' would include elective ordinary, day case, outpatient procedures and first outpatient attendances. It also covers advice and guidance services.

6.2 Threshold

About the threshold

52. In the aligned payment and incentive rules, a contract value threshold indicates when aligned payment and incentive agreements are required for services commissioned from providers who are mapped to a different ICS to the commissioner.

53. For 2022/23, we propose that the annual contract value threshold should be £30 million. This is higher than the £10 million threshold set for 2021/22. This would mean that any contracted activity with a total value above £30 million would require an aligned payment and incentive agreement.

54. The payment arrangements for activity below the threshold would be for local areas to decide, using the general local pricing rules set out in Section 4 of the 2022/23 NTPS. Local areas are encouraged to consider adopting aligned payment and incentive arrangements where that would not involve excess burden. However, as in 2021/22, the tariff unit prices would be used as a default if agreement is not possible.

55. For smaller arrangements, expected to be valued at below £500,000 per year, NHS providers and commissioners are encouraged to refer to the low volume activity payment arrangements that will be set out in the 2022/23 Operational Planning Guidance. These involve paying a single fixed annual payment based on historic information to maintain the benefits of reduced transactions realised through the COVID-19 block payments arrangements.

Why we think this is the right thing to do

56. For 2021/22, the £10 million threshold was set so 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. Given the planned reduction in the number of commissioning organisations, arising from mergers of clinical commissioning groups as part of the move towards ICSs and the proposed introduction of ICBs, it is likely

the number of contracts would also reduce in 2022/23. As such, we are proposing to increase the threshold to capture an equivalent level of activity.[10]

57. During the September 2021 engagement workshops, we asked for views on whether the threshold should be set at £30 million, stay at £10 million or if another option should be considered. Of these options, £10 million was preferred by 56% of attendees. It was particularly popular among commissioners, with 63% choosing £10 million. £30 million was chosen by 40% of workshop attendees. Alternative options suggested ranged from £3 million to £50 million, while some attendees suggested removing the threshold altogether.

58. The £10 million option was also the most popular among respondents to the online survey, with 47% preferring it, compared to 31% choosing £30 million. There were concerns about the potential burden of agreeing and managing lower value aligned payment and incentive contracts from both those who chose £10 million and those who chose the higher figure. However, respondents in favour of the £30 million threshold felt that it would be of an appropriate scale to keep the number of individual contracts manageable. A number of the comments focused on the relationship between the threshold and out of area activity, particularly as all activity within an ICS would be subject to aligned payment and incentive rules regardless of value.

59. Although the £10 million option was preferred during our engagement, we are proposing to set the threshold at £30 million. This is because, at a national level, the total value of activity captured by aligned payment and incentive agreements would remain broadly the same as in 2021/22. The £30 million threshold for the merged CCG footprints and the proposed ICB footprints is consistent with £10 million for the 2021/22 CCG footprints. This stability would help embed the design of the payment system and also support monitoring of how aligned payment and incentive agreements are being reached between organisations mapped to different ICSs. The threshold level would be considered again for 2023/24.

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

60. During the engagement, there was generally strong support for using unit prices as a default payment approach for activity between providers and commissioners in different ICSs that was below the threshold. This proposal scored an average of 6.9/10 at the workshops and was supported or strongly supported by 60% of respondents to the online survey.

61. In our engagement, we also discussed potential arrangements for low volume activity, below a £500,000 annual value threshold. There was strong support for this, but some questions about the appropriate threshold level and the quality of the data that could be used to set the payment levels. The arrangements are forming part of the planning guidance for 2022/23 and NHS providers and commissioners are encouraged to follow these.

6.3 The fixed element

About the fixed element

62. As in the 2021/22 NTPS, we are proposing that providers and commissioners are required to locally agree their aligned payment and incentive fixed element. The fixed element should fund an agreed level of activity, reflecting changes in service delivery and associated resource requirements. It should be set at a level that is stretching but achievable and aligns with the system plan.

63. While we are not proposing a specific method for setting the fixed element for 2022/23, we encourage providers and commissioners to take a pragmatic approach, such as using the block payments for the second half of 2021/22 as the starting point and reflecting any other guidance on setting contract values included in the 2022/23 Operational Planning Guidance. The supporting document, *Guidance on the aligned payment and incentive approach*, describes the key considerations for setting the fixed element.

64. 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. This would include funding for new ways of delivering services, such as Maternal Medicine Networks for specialist maternity activity, and the costs associated with transforming

outpatient services, including advice and guidance, patient initiated follow up (PIFU) services and virtual outpatient attendances[11]

- the costs of the elective activity plan to tackle the elective backlog that has built up during the Covid-19 pandemic (see section 6.4)
- agreed levels of BPT performance (see Sections 6.4 and 7.4)
- some high cost drugs and devices (see Section 6.5) and other items previously excluded from national prices, such as excess bed day payments
- the cost of implementing products covered by the MedTech Funding Mandate; the products themselves would be paid for separately (see Section 6.6).

65. Providers and commissioners who want to agree alternative arrangements to the fixed element would need to apply to NHS England and NHS Improvement for approval. They would need to provide a justification of how their arrangements will support effective system working, and demonstrate how the arrangements apply the local pricing principles.

66. In the 2021/22 NTPS, CQUIN funding was integrated into the NTPS. To reflect this, the fixed element should include the CQUIN funding of 1.25% of the contract value. If the starting point for setting the fixed element is the emergency payment values for 2021/22, CQUIN funding will already be included. However, if another approach is used, providers and commissioners will need to consider if the 1.25% is included. Either way, the fixed element should be set to assume 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).

67. The cost base for the proposed national prices and unit prices includes the 1.25% increase from CQUIN funding (see Sections 8.2 and 8.7). As such, separate increases to reflect CQUIN funding would not be needed for payment arrangements that rely on these prices.

[11] For details of outpatient transformation and expected advice and guidance activity, see the 2022/23 Operational Planning Guidance.

68. During the September 2021 engagement, we discussed the following tools and products that we are working on to help support providers and commissioners develop their fixed elements:

- Costed pathways supported by GIRFT
- PLICS analysis
- Programme budgeting
- Population group analysis

69. These tools, and supporting materials and guidance on how they can be used, will be published on FutureNHS. We will make them available as soon as possible for local areas to use when it is useful. However, there will be no requirement to use these tools for setting the 2022/23 fixed element.

70. We will continue to work to develop, and seek feedback on, these tools over the coming months. If you would be interested in getting involved, please contact pricing@england.nhs.uk.

Why we think this is the right thing to do

71. During our engagement on potential policies for 2021/22, there was consistent feedback that having a default calculation approach for the fixed element would be helpful (even if there was no overriding consensus on what this default should be). The 2021/22 NTPS did not include a default, but the supporting document did set out some approaches that could be used.

72. However, we know that local areas will be in different positions and no nationally prescribed method would be right for all circumstances. As such, we are proposing that local areas continue to be able to agree an approach to calculating the fixed element that is appropriate for them.

73. The tariff is one part of the overall NHS financial framework. For 2022/23, with the overriding priorities of dealing with the COVID-19 pandemic, addressing the elective backlog that has built up during it and preparing for potential legislative changes in the Health and Care Bill, we are aware that the providers and commissioners are under a great deal of pressure and there may be limited capacity to undertake detailed negotiations about payments. We therefore encourage providers and commissioners to take a pragmatic approach to setting the fixed element for 2022/23.

74. In future years, as blended payment arrangements and ICS structures and culture develop, local areas may be expected to use a wider range of information to develop their fixed elements.

75. Our proposals would mean that the approach to agreeing fixed elements for ambulance, community and mental health providers could involve incremental changes to the approaches they have used to agree payments in previous years. For example, while there is no mandated approach, the best available information for setting mental health fixed payments could include the mental health investment standard (MHIS), Mental Health Services Data Set (MHSDS) and PLICS data.

76. 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.

6.4 The variable element

About the variable element

77. We propose that aligned payment and incentive agreements must include a variable payment for elective activity, advice and guidance activity and for BPT and CQUIN performance. Elective activity would include elective ordinary, day case, outpatient procedures and first outpatient attendances. The variable element would replace the Elective Recovery Fund (ERF) used in 2021.

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

- Activity over the agreed baseline for elective activity would be paid at 75% of national or unit prices after national variations (eg MFF) have been applied.
- Activity below the agreed baseline for elective activity would be deducted at 50% of national or unit prices after national variations (eg MFF) have been applied.
- Advice and guidance activity which is different from the amount agreed in the fixed element would be paid or deducted via local agreement.
- BPT attainment above or below that assumed as part of the fixed element would mean funding is paid or deducted from providers, based on the

difference in value between the expected and actual levels of activity meeting BPT criteria.

- CQUIN indicator attainment less than 100% (assumed as part of the fixed element) would mean payment deducted from providers, in accordance with CQUIN guidance issued by NHS England.

79. Providers and commissioners who want to agree alternative arrangements to the default variable element design would need to apply to NHS England and NHS Improvement for approval. They would need to provide a justification of how their arrangements will deliver the aim of supporting elective recovery and quality of care, and demonstrate how the arrangements apply the local pricing principles.

80. The fixed element would be set at a level to cover the expected costs of delivering the elective activity plan, including the costs associated with transforming outpatient services. The variable element would then be used to adjust the level of overall funding based on elective activity during the year. For more details, see *Guidance on the aligned payment and incentive approach.*

Why we think this is the right thing to do

81. The aligned payment and incentive fixed element is intended to fund delivery of an agreed level of activity consistent with the ICS system plan. It should be set at a level that is stretching but achievable. The variable element would then serve to ensure funding flows to providers in proportion to where elective inpatient and outpatient activity is actually taking place. It would also seek to uphold and drive quality improvements.

82. During our engagement, we discussed continuing with the approach used for the 2021/22 NTPS, where 50% of tariff prices would be paid/recouped for activity above/below the level used to set the fixed element. There were many different views and opinions about the relationship between the variable element, the elective recovery fund and the extent to which the variable element would (or wouldn't) operate as an incentive.

83. At the engagement workshops, the average support for the 50% variable rate was 5.3/10. However, there was less support from providers (who gave an average score of 4.2/10) than commissioners (who scored an average of

5.9/10). There was a range of views in the online survey, with 50% of respondents opposing or strongly opposing and 35% supporting or strongly supporting.

84. Providers were concerned that 50% of tariff prices would not cover the costs of additional activity and so would not help support the activity required to support elective recovery. There were also a number of questions from attendees asking us to more clearly define what the term ‘elective’ refers to.

85. Following the feedback from the engagement, we are proposing to introduce a differential variable rate, with 75% of prices paid for activity above plan and 50% recovered for activity below plan. We are proposing these figures following analysis of elective care, which suggests that approximately:

- 25% of costs are fixed
- 25% of costs are variable
- 50% of costs are staff

86. We feel that removing 50% of prices for activity not delivered represents a scenario where pure variable costs are not incurred, and some element of staffing cost is not incurred. Paying 75% of prices for additional activity assumes that extra staff and variable costs would be required, but fixed costs would not increase (ie extra activity is delivered within existing infrastructure).

87. The variable element is not intended to operate primarily as an incentive. Rather, it is meant to encourage:

- setting of realistic but stretching activity plans with appropriate funding in the fixed element
- sharing financial risk and recognising the provider cost base if those plans differ from activity delivered.

88. The variable element will also support the deployment of elective recovery funding for 2022/23, which would be factored into the fixed payment. This helps address some concerns that were raised for elective recovery funding in 2021/22, namely that there was insufficient certainty around the funding that a provider would receive for additional elective activity delivered

89. For BPTs, CQUIN and advice and guidance, 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. For 2022/23, we are proposing that local systems agree the level of financial adjustment to be made for these, either before the start of the arrangements or during the year. This ensures that the adjustments are consistent with local system plans.

90. In the engagement workshops, there was general support for using the variable element to reflect quality of care, with an average score of 6.1/10. Including BPT achievement was more popular (5.9) than CQUIN (5.3). There were stronger views about CQUIN, with 1 being the most common score. There was a similar pattern in responses to the online survey, with 24% of respondents strongly opposing including CQUIN achievement in the variable rate. Concerns about CQUIN generally related to the administrative burden being disproportionate to its value.

91. The feedback has been carefully considered, however CQUIN continues to have a role in supporting good quality of care. We have used the feedback from the engagement to inform the design of the CQUIN indicators for 2022/23. These focus on relatively simple, yet impactful standardised processes that have an existing expectation of delivery. An independent assessment of burden has been conducted for each indicator that is not assessed using routine data. This is intended to ensure the burden is appropriate, while continuing to incentivise quality of care. Full details of the indicators for 2022/23 and accompanying guidance is available from the CQUIN page on our website.

92. We are not proposing to make any changes to BPTs design and criteria for 2022/23. Annex DtC sets out details of the BPT design and criteria.

93. If providers and commissioners wish to vary away from the default variable element design, they would need to gain approval from NHS England and NHS Improvement. They would need to demonstrate how their alternative approach would address the elective backlog and quality of care. Details of

the approvals process would be published on the locally determined prices web page in advance of the final 2022/23 tariff to support planning returns.[12]

6.5 High cost drugs and devices

About the approach to reimbursing high cost drugs and devices

94. Under the 2021/22 NTPS rules, funding for some high cost drugs and devices is included in the aligned payment and incentive fixed element. This includes all items commissioned by CCGs, while some items commissioned by NHS England Specialised Commissioning are funded on a cost and volume basis.

95. For 2022/23, we are proposing to continue with largely the same approach, with funding for some high cost items included in the fixed element, while others are excluded and funded on a cost and volume basis.[13] As in 2021/22, items included in the fixed element would be those 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.

96. For 2022/23, we are proposing to make the following changes to the approach for high cost drugs. These are:

- to introduce parity of funding approach, so any drug commissioned by NHS England on a cost and volume basis would be funded in this way, whoever the commissioner
- any commissioner-funded item introduced during the financial year, in response to NICE guidelines, should be paid for on a cost and volume basis and therefore excluded from the fixed element.

97. Details of the high cost drugs to be included in the fixed element are included in Annex DtA, tab 14b.

98. For high cost devices, items commissioned by NHS England Specialised Commissioning would continue to be excluded from the fixed element and reimbursed through the High Cost Tariff-Excluded Devices (HCTED)

12 www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

13 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.

programme. For other commissioners, there are four high cost devices which should be excluded from fixed payments. Details of these are included in Annex DtA, tab 14a.

99. Section 7.3 provides more details of our proposals for the high cost exclusion lists.

Why we think this is the right thing to do

100. During the statutory consultation on the 2021/22 NTPS, there was significant feedback from stakeholders saying that the proposed approach to funding high cost drugs was confusing. For the final tariff, we updated the wording and supporting guidance to try to set out the process more clearly. We also removed the table of drugs commissioned by NHS England Specialised Commissioning from Annex A to reduce the risk of confusion.

101. However, in our engagement on the 2022/23 NTPS, it was clear that there remained concerns about the approach to reimbursing high cost drugs and devices. During the engagement workshops, we discussed continuing with the approach used in 2021/22. There were mixed views, with the proposal receiving an average score of 5.3/10. However, commissioners were much more supportive (scoring an average of 6.8/10) than providers (4.6/10). Feedback from providers indicated that there were concerns about the potential financial risk falling on them

102. Having considered the feedback from engagement, and from colleagues in NHS England Specialised Commissioning and the medicines policy team, we are proposing to update the approach to mitigate this potential risk and ensure patients receive the items they require. Ensuring that drugs are paid for in the same way regardless of the commissioner will help minimise confusion, while being clear that new NICE approved drugs introduced in-year are not included in the fixed element will help reduce the risk of unexpected changes to the costs covered by the agreed amount.

103. These updates should make the reimbursement approach more straightforward to implement. It would also mean that providers receive funding in a timely manner, while minimising additional risks from high cost drug and device usage, ensuring that patients receive the treatments they need.

6.6 MedTech Funding Mandate and innovative products

About the approach to reimbursing items covered by the MedTech Funding Mandate

104. The MedTech Funding Mandate was introduced in April 2021 and aims to accelerate the uptake of selected innovative medical devices, diagnostics and digital products. It was initially expected to be introduced in April 2020, but was delayed due to COVID-19. The 2020/21 NTPS introduced into the tariff an innovative products list to support the Mandate. Items were added to this list using the following criteria:

    - that the products would be covered by the Mandate
    - that they would not otherwise be paid for by the NTPS.

105. For the first year, there were two items. The innovative products list was updated for the 2021/22 NTPS and two further items were added. For 2022/23, as the coverage of the Mandate is increasing, we are proposing to add more items to the innovative products list (see Section 7.3).

106. However, during 2021/22 the uptake of MedTech products has not been as significant as expected. Feedback from stakeholders suggested that some of the reason for this was a lack of clarity about who is responsible for paying for the items within the block payment arrangements. Given the proposed move away from block payment to aligned payment and incentive agreements for almost all services, we want to make sure that the payment responsibility is clear.

107. As such, we are proposing that, within aligned payment and incentive arrangements, items on the tariff's innovative products list would be funded by the commissioner on a cost and volume basis through the High Cost Tariff-Excluded Devices (HCTED) programme. Any additional cost of implementation should be factored into the fixed element.

108. Over time, we expect the adoption of approved products to reach a targeted level so they are used as part of standard practice. At this point, the items would be removed from the list and funding would be included in the fixed element.

Why we think this is the right thing to do

109. The MedTech Funding Mandate aims to increase access to innovative products that improve patient experience and reduce costs for the NHS. For the Mandate to have the impact intended, it is important that the funding arrangements are clearly understood and easy to implement.

110. During our September engagement on the 2022/23 NTPS, we asked workshop attendees for their preferred funding approach for items covered by the MedTech Funding Mandate. There were four options given, with 54% of attendees choosing 'Funding excluded from fixed element and pass through payment used instead'. This was the most popular option among both providers and commissioners. It was even more popular among survey respondents, with 68% selecting it. The other options would have involved funding being included in the fixed element, with different approaches to the variable element.

111. Our proposed approach, of excluding funding for innovative products from the fixed element but including funding for implementation within it, would mean that any directly related realisable benefits (cash releasing and capacity creating) would accrue within the provider. This would help improve access to these products, and patient experience as a result.

112. For services outside of aligned payment and incentive arrangements, items on the innovative products list would continue to be subject to the NTPS local pricing rule 3.

7. Currency design and specification

113. 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.

114. The aligned payment and incentive approach introduced in 2021/22 involves a single 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).

115. As in 2021/22, we are proposing that only unbundled diagnostic imaging services would have national prices (see Section 6.1). Healthcare resource groups (HRGs) and treatment function codes (TFCs) would continue to be the basis of unit prices, which could be used for activity outside the scope of aligned payment and incentive agreements.

116. In this section we explain our proposals on the currencies for national and unit prices for the 2022/23 NTPS.

7.1 Currency design

Proposal
The aligned payment and incentive approach uses 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 determine when this is applied and when individual unit currencies apply.

For the individual unit currencies, we propose to use the HRG4+ currency design used for 2018/19 reference costs to set national prices and unit prices.

We propose to:

- remove 60 HRGs
- introduce 122 HRGs
- add an outpatient procedure price for 11 HRGs
- remove outpatient procedure prices for 5 HRGs.

About this proposal

117. The aligned payment and incentive approach, introduced in the 2021/22 NTPS, involves 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 determine when this applies and when individual unit currencies apply.

118. 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 use the HRG4+ currency design used for 2018/19 reference costs to set national prices and unit prices (see Section 7.2 for the scope of currencies).

119. Due to HRG redesign, compared to the 2021/22 NTPS, we are proposing to:

    - remove 60 HRGs
    - add 122 HRGs.

120. See Annex DtA for details of the proposed currencies. Tabs 17a and 17b show details of the HRGs being added or removed.

121. We are not proposing to make any changes to the treatment function code (TFC) currencies used for outpatient attendances.

122. We are proposing to make a small number of changes to currencies for outpatient procedures, following clinical advice on when such procedures are, or are not, appropriate. This would involve adding outpatient procedure prices

for five currencies and removing prices for 11 currencies. Table 2 gives the details of the proposed changes.

Table 2: Proposed changes to outpatient procedure prices

Outpatient procedure price added		Outpatient procedure price removed	
AB11Z AB14Z AB16Z AB18Z AB20Z AB21Z	AB22Z AB25Z AB26Z AB27Z AB28Z	FE46Z JC40Z YC10Z	YR40D YR42D

123. We are also proposing to change the scope of YA13Z to exclude the cost of thrombectomy devices, which are being added to the high cost devices list (see Section 7.3).

124. We are proposing to add new non-mandatory benchmark prices for bilateral cataracts. This follows a request from the National Eye Care Recovery and Transformation Programme.

125. We are also continuing our work on 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. Non-mandatory currencies for frailty and last year of life were published as part of the 2021/22 NTPS, with the aim of testing the currencies.[14] More information about the project is available on the NHS England and NHS Improvement website.

126. Under the aligned payment and incentive rules, the use of mental health clusters is not mandatory. Local areas can decide whether to use them, but providers would only need to collect clustering information if they use it for contracting. As such, we are proposing not to include the Mental health clustering toolkit as an annex to the 2022/23 NTPS.[15]

[14] Guidance on the frailty and last year of life currency is included in a supporting document to the 2021/22 NTPS, available from: www.england.nhs.uk/publication/national-tariff-payment-system-documents-annexes-and-supporting-documents/

[15] The toolkit would remain available as part of previous tariffs, available via: www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

127. The NHS England and NHS Improvement Mental Health Infrastructure Team are working with the National Pricing Team, the National Clinical Director for Mental Health, and system stakeholders to create a new model for mental health currencies. This work is currently in development and will replace clustering in due course. If you would like more information about this programme or would like to be involved in the development and piloting of the new mental health currencies, please contact the Mental Health Infrastructure Team on england.mhinfrastructure@nhs.net.

Why we think this is the right thing to do

128. As we are proposing to calculate prices using PLICS data for the first time (see Section 8.2), we wanted to minimise changes to the currency design. This would allow us to more accurately compare changes in prices to those previously produced using reference costs. As we are proposing to use PLICS data from 2018/19, we therefore propose to use the currency design from 2018/19 as well.

129. The 2018/19 cost collection currency design involved some HRG redesigns compared to 2016/17 to ensure the currencies better reflected the activity being undertaken. This has involved the removal of 60 HRGs and the addition of 122 HRGs. The proposed new currencies have been produced by splitting previous currencies – either by age, complication and comorbidity (cc) score or by narrower groupings of procedures/diagnoses within HRG or HRG split. Details of the proposed currencies are set out in Annex DtA.

130. The proposed changes to outpatient procedure prices follow advice from the clinical EWGS. The proposed changes reflect views on when an outpatient setting for a procedure would be appropriate or inappropriate.

131. We are continuing our work 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.

7.2 Scope of currencies

Proposal
We propose to:

- set national prices reflecting the HRG4+ currency design used for 2018/19 reference costs
- exclude from national prices (and therefore from the currencies for national prices) all services other than unbundled diagnostic imaging.

About this proposal

132. The aligned payment and incentive approach introduced in the 2021/22 NTPS involves 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 continue to exclude from the scope of national prices, and the currencies for national prices, all services apart from unbundled diagnostic imaging.

133. However, individual unit currencies 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 use the same calculation approach for both national prices and unit prices, using the HRG4+ currency design used for 2018/19 reference costs.

134. 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.

Why we think this is the right thing to do

135. The aligned payment and incentive approach involves 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.

136. 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, using 2018/19 PLICS data. As discussed in Section 7.1, this is the first time that PLICS data is being used to set prices and so we want to minimise changes to currency design. As such, we are proposing to use the HRG4+ phase 3 currency design used for 2018/19 reference costs.

7.3 High cost exclusions

Proposal
We propose to:

- add 17 items to the high cost drugs list
- remove 70 items from the high cost drugs list
- add four items and one category (thrombectomy devices) to the high cost devices list
- add seven 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

137. 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.

138. With the introduction of the aligned payment and incentive blended payment in the 2021/22 NTPS, funding for some high cost drugs and devices was included in the fixed element. However, stakeholders reported some confusion and concerns about how this would operate. Section 6.5 sets out our proposals for the funding of high cost drugs, devices and innovative products in the 2022/23 NTPS. This section looks in more detail at the specific changes we are proposing for the high cost exclusion lists.

139. 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.

140. Nominations for changes to the lists could be made by completing a form, downloadable from the NHS England and NHS Improvement website, and submitting it to pricing@england.nhs.uk before 30 September 2021.

141. There were a relatively high number of nominations submitted. For the high cost drugs list, there were nominations for 35 items to be added and six items to be removed. For the high cost devices list, there were nominations for 41 items to be added but no items were nominated for removal. There were also nominations for two device categories.

142. The nominations were shared with members of the NHS England High Cost Drugs Steering Group and High Cost Devices Steering Group. We then held meetings of these groups and Specialised Commissioning to discuss the nominations and make recommendations.

143. Following these meetings, and in line with the advice of the steering groups and Specialised Commissioning, we are proposing to add the items in Tables 3 and 4 to the lists.

Table 3: Items to be added to the high cost drugs list

High cost drugs list	
• Acoramidis • Aducanumab • Bis-choline tetrathiomolybdate • Copper histidine • Deucravacitinib • Efgartigimod • Factor X • Factor XI • Faricimab • Inclisiran	• L’ Arginine • Rozanolixizumab • Setmelanotide • Sodium Benzoate (metabolic disorders only) • Sodium Hydroxybutyrate (metabolic disorders only) • Tofersen sodium • Zilucoplan

Table 4: Items to be added to the high cost devices list

High cost devices list	
• Wireless pacemaker • Mechanical Thrombectomy Stent Retriever	• Endobronchial valve • SpaceOAR Hydrogel • Peripheral Nerve Stimulator

144. In addition, we are proposing to add thrombectomy devices as a new category to the high cost devices list. These devices would be directly funded by NHS England Specialised Commissioning. Cochlear implants were also nominated for addition to the list. The High Cost Devices Steering Group and Specialised Commissioning advised that these items should not be added to the list for 2022/23 while potentially new funding routes are researched. However, cochlear implants will be considered for inclusion on the list for future tariffs.

145. We are also proposing to remove 70 drugs from the list that are no longer in development, unlikely to be in use in 2022/23 or, no longer considered to be high cost.

146. We are also proposing to add seven 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 came into effect 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 items, categorised into two themes:

    - **Benign prostatic hyperplasia (BPH)**, a common condition in older adults with a prostate. It is currently treated with the surgical procedure, transurethral resection of the prostate (TURP) which usually requires the patient to stay in hospital for 1 to 3 days. Four less invasive innovations allow patients with BPH to be treated as day cases:
        - **UroLift:** www.nice.org.uk/guidance/mtg58
        - **GreenLight XPS:** www.nice.org.uk/guidance/mtg29
        - **Rezum:** www.nice.org.uk/guidance/mtg49
        - **PLASMA system:** www.nice.org.uk/guidance/mtg53.

- **Improving the patient experience during procedures technologies** are innovative alternatives to otherwise more invasive and costly procedures. These technologies are:
  - **XprESS multi-sinus dilation system:** www.nice.org.uk/guidance/mtg30
  - **Thopaz+ portable digital system:** www.nice.org.uk/guidance/mtg37
  - **Spectra Optia:** www.nice.org.uk/guidance/mtg28.

Why we think this is the right thing to do

147. 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. As set out above, this process continues for aligned payment and incentive agreements (see also Sections 6.5 and 6.6).

148. During the September 2021 engagement workshops, there was strong support for updating the high cost exclusion lists (average score 8/10). Similarly, in the online survey, 81% of respondents either supported or strongly supported updating the lists. The feedback surrounding the lists related to clarifying the funding of high cost items under the aligned payment and incentive approach (see Section 6.5).

149. Of the nominations for additions to the drugs and devices lists that we are not proposing to make, a number related to items already covered by categories on the lists (for example, chemotherapy drugs). Others were not recommended for inclusion on the list by the steering groups either because they were not felt to be sufficiently high cost, were unlikely to be approved for use within 2022/23 or would be subject to alternative payment routes.

150. The items nominated for removal from the high cost drugs list that we are not proposing to remove were either deemed to be high cost by the steering group or were advanced therapy medicinal products (ATMPs), and so excluded from tariff prices. We are proposing to remove items from the high cost drugs list where they were included on the list as a result of horizon scanning in previous years, but have never been launched and are no longer in development.

151. 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 items proposed are 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.

152. Tabs 14a, 14b and 14c in Annex DtA show our proposed lists of high cost drugs, devices and listed procedures.

7.4 Best practice tariffs

Proposal
We propose to continue with the same approach to BPTs introduced in the 2021/22 NTPS. This would mean that:

- providers and commissioners 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
- BPTs would apply to all priced activity outside the scope of the aligned payment and incentive approach.

Annex DtC provides detailed guidance on the proposed BPTs for 2022/23.

About this proposal

153. The aligned payment and incentive approach, and the move away from national prices, has required a change in the operation of BPTs. However, we want to continue to maintain the focus on clinical quality that BPTs have achieved, while ensuring administrative burden is proportionate and avoiding financial instability.

154. As in 2021/22, 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:

- 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.

155. 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.

Why we think this is the right thing to do

156. BPTs continue to have an important role in supporting performance and reporting. 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.

157. We have considered introducing other approaches to financial incentives, in line with the Long Term Plan goal of a single set of incentives aligned to commitments in the plan.[16] However, for 2022/23, given the other changes and pressures on the healthcare system, it is not the right time to be making significant changes. We will continue to assess how specific financial incentives can function within the NTPS in future years, seeking to balance effectiveness with proportionate administrative burden.

158. Our proposed approach aims to strike an appropriate balance between supporting clinical quality, administrative burden and potential instability.

159. For other priced activity, 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.

160. 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).

16 NHS Long Term Plan, 6.8: www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf#page=101

161. During our September engagement, we asked for views on BPTs continuing to form part of the aligned payment and incentive variable element (see Section 6.4). The proposal was generally supported, with an average score of 6 out of 10 from attendees at the engagement workshops.

8. Proposed method for determining national and unit prices

8.1 Introduction

162. In this section we present our proposals for setting national and unit prices for 2022/23.

163. The aligned payment and incentive approach means 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). This means the 2022/23 NTPS would contain the same types of prices as the 2021/22 NTPS. These are:

- **National prices** – For unbundled diagnostic imaging services only.
- **Unit prices** – Prices calculated in the same way as national prices and 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 or unit prices, or where the prices are being tested.

Our principles

164. 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.

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

8.2 Setting national and unit prices for 2022/23

Proposal

We propose to:

- use largely the same calculation method as used in previous tariffs to set prices based on new cost and activity data
- calculate new price relativities using 2018/19 patient-level cost (PLICS) and hospital episode statistics (HES) data.

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

166. We propose to set national prices for unbundled diagnostic imaging services only. However, we propose to include the scope of 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 168. 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. They would also be used in the aligned payment and incentive variable element (see Section 6.4) and can be a useful reference point for systems, alongside other tools such as Model System, in considering the opportunities to improve efficiency.

167. We propose to set 2022/23 national prices and unit prices, modelled from the currency design set out in Section 7 of this document, with 2018/19 cost and activity data. The proposed methodology for 2022/23 prices closely follows that used in past national tariffs and, up to 2013/14, by the then Department of Health Payment by Results (PbR) team.[17] Annex DtD contains a step-by-step description of the method we are proposing to use, including details of the changes that have been made to the PbR method.

168. We propose to set prices for 2022/23 by using the following process

- Undertake initial processing work on the model inputs to ensure the accuracy of the data used. This includes applying data cleaning rules, converting from episode to spell and linking episode level PLICS costs to HES. See Section 8.3 for more details.
- Determine initial price relativities, using the cost and activity data to calculate average costs for each currency (eg HRG).
- Adjust the price relativities to an appropriate base year. As price relativities are based on 2018/19 cost data, we need to adjust them to the current year (2021/22) before we can make any forward-looking adjustments. To do this we adjust the initial price relativities by applying the efficiency, inflation and Clinical Negligence Scheme for Trusts (CNST) adjustment factors from the 2018/19, 2019/20 and 2020/21 NTPS. At this point we also reduce all admitted patient care prices by the same percentage (a top-slice) to be reallocated for top-up payments for specialised services (see Section 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 2022/23, we initially considered clinical feedback on previous tariff prices, making adjustments where appropriate, before

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

seeking feedback on the updated prices. See Section 8.5 for more details of the manual adjustment process.

- 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 a cash in/cash out approach (see Annex DtD).
- Apply cash in/cash out adjustments to account for changes in high cost drugs and devices lists, and to manage year-on-year volatility of prices (see Annex DtD and Section 8.5).
- Adjust prices to proposed 2022/23 levels to reflect cost uplifts (2.8% – see Section 8.8) and an estimate of the minimum level of efficiency that we expect providers to be able to achieve in 2022/23 (1.1% – see Section 8.8).

169. We have continued to use the software package SAS to run the tariff calculation model. We have reviewed and improved the code for the 2022/23 NTPS. This SAS code is available in Annex DtD.

Why we think this is the right thing to do

170. This long-established method is based on the nationally collected cost data provided by the NHS. This is the most comprehensive cost data currently available which is also quality assured. Using largely the same price calculation 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 or inconsistency, to reflect updated data or to ensure the software infrastructure is as reliable as possible.

171. From the 2018/19 financial year onwards, reference costs ceased to be collected for acute services, with providers mandated to submit PLICS cost data instead. As such, the most recent year reference costs are available for is 2017/18 and we wanted to use more recent data. In addition, we wanted to take advantage of the additional detail available in the patient-level collection.

172. During our engagement, and particularly in the comments received on the ‘Calculating tariff prices’ webinar, there were a number of questions about why we were proposing to use 2018/19 data, rather than 2019/20 or more recent. Stakeholders raised concerns about the quality of 2018/19 PLICS, given that it was the first year that it had been mandatory for all acute providers.

173. We are proposing to use the 2018/19 data as it is the most recent full year that is not affected by COVID-19. Given the move to using PLICS to calculate prices, we felt it was important to have data for the entire year to allow us to directly compare the prices produced.

174. In our engagement workshops, there were relatively few strong views about using 2018/19 PLICS, with an average score of 5.9/10. Of those that gave views, 58% gave a score between 5 and 8, while 13% scored 1 or 2 and 16% scored 9 or 10. There was a similar distribution among respondents to the online survey.

175. We are proposing to use PLICS data for the first time. As such, the processes to manage the model inputs (discussed in Section 8.3) and clinical review of the initial prices (discussed in Section 8.5) have been particularly important to ensure that the prices represent a fair reflection of clinical activity. We are confident that these processes, combined with our impact assessment of the proposed prices (see the Impact assessment document for details) have resulted in a fair and robust set of prices.

176. For 2022/23, 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.

177. As such, 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 2022/23

Proposal
We propose to use 2018/19 cost and activity data to model prices for 2022/23.

About this proposal

178. For 2022/23, we are proposing that the two main data inputs to generate individual prices are:

- costs – 2018/19 PLICS cost data
- activity – 2018/19 hospital episodes statistics (HES) and 2018/19 PLICS.

179. Both reference costs and PLICS are collected at episode[18] level, while prices are set for spells.[19] Reference cost data was aggregated and so in previous tariffs it was necessary to use a complex method to estimate the amount each episode cost contributed to the overall spell cost. As the PLICS data is at record level, we are proposing to create the actual spells in the PLICS data, removing complex estimation steps that had been needed to convert episodes to spells in the method.

180. We propose applying the following data cleaning rules for the cost data. This would involve consolidating and simplifying the cleaning rules used for admitted patient care reference costs in previous years. The proposed cleaning rules would apply consistently for all points of delivery. Applying the

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

19 A spell is the period from patient admission to discharge within a single healthcare provider. A spell may comprise of more than one episode.

data cleaning rules would exclude the following records from the raw 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 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.

181. We propose merging data where:

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

182. In addition, we propose implementing manual adjustments from clinical EWGs received in previous years, embedding these changes in the model inputs.

183. We propose to use 2018/19 HES data for activity, grouped by NHS England and NHS Improvement, and link this with 2018/19 PLICS using the 2018/19 (HRG4+) various groupers and the 2020/21 engagement grouper. Linking PLICS and HES data at record level allows us to independently regroup the PLICS data and to do so consistently with HES. This also allows for faster currency development as costs can be re-grouped to new currency designs when needed.

Why we think this is the right thing to do

184. As discussed in Section 8.2, setting prices using the most recent data required moving from reference costs to PLICS. As with reference cost data in previous years, we are proposing to undertake some initial processing work to ensure the accuracy of the data used.

185. Our proposed approach to cleaning the data would allow the prices to be distributed more closely to costs and significantly reduce the number of illogical costs and, subsequently, illogical prices.[20] We have consolidated and

[20] 'Illogical' costs or prices is where the cost/price of performing a more complex procedure is lower than the cost/price of performing a less complex one (without good reason).

simplified the cleaning rules for 2022/23, ensuring they can be applied consistently to all points of delivery.

186. 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 efficiency of the model and reliability of the tariff. We believe this benefit outweighs the disadvantage of losing some data points as a result of the data cleaning process.

187. Making manual adjustments from previous years in advance of the modelling process should also serve to improve the reliability of the tariff, while also reducing the number of manual adjustments needed for a new tariff. As discussed in Section 8.5, the clinical EWGs continue to have an important role in checking the new price relativities and, where clinical need has changed, adjustments may move individual prices in different directions to previous years.

188. We propose to use activity data grouped by NHS England and NHS Improvement because it allows flexibility in the timing of grouping the data, as well as effective quality assurance of the activity data used to calculate tariff prices.

8.4 Setting prices for best practice tariffs

Proposal
We propose to use the same approach to calculating prices for best practice tariffs as used in the 2021/22 NTPS.

About this proposal

189. Section 6.4 describes how BPTs would operate as part of the aligned payment and incentive variable element. BPT prices would continue to be required to support these arrangements and for priced activity outside the scope of aligned payment and incentive agreements.

190. We propose to use the same approach for setting BPT prices that we have used since the 2019/20 NTPS. This means that, as far as possible, we propose to apply a standard method of pricing BPTs. For 2022/23, this would involve:

- starting with the initial price relativities (described in Section 8.2)
- 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

191. Our proposed pricing approach for BPTs is consistent with that used in previous years, and the proposed method for calculating national and unit prices (see Section 8.2).

192. During our engagement, we received some questions and comments about the operation, implementation and future plans for BPTs. However, there were no specific concerns about the BPT pricing method.

8.5 Making post-modelling adjustments to prices

Proposal
We propose to make adjustments to initial modelled price relativities in the following ways:

- Manual adjustments following clinical feedback on initial draft prices.
- Cash in/cash out adjustments to limit the scale of year-on-year changes for a small number of individual prices.

About this proposal

193. As in previous years, the prices we are proposing as part of this consultation include manual adjustments to the modelled prices.

194. Following discussions with the NHS Digital National Casemix Office, we used the following approach to initial manual adjustments on modelled prices prior to engaging with the clinical expert working groups (EWGs) and the sector.

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

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

196. For an HRG that could involve a high cost device that is excluded from tariff prices (see Section 7.3), we applied manual adjustments based on set values suggested by NHS Digital National Casemix Office. If the modelled price was significantly higher than the suggested value, it was likely to include the device cost and was adjusted downward accordingly. Similarly, where the modelled price was lower than suggested, and the device should be covered by the tariff prices, we applied manual adjustments to set it to the suggested value.

197. We also considered clinical feedback we had received on the draft prices for previous tariffs. Where appropriate, we made adjustments to address the comments before seeking feedback on the updated prices.

198. We subsequently shared the prices with the NHS Digital National Casemix Office and with representatives of medical colleges, associations and societies through their respective EWGs. These initial draft price relativities were also shared with stakeholders during the September 2021 engagement.

199. Sharing the prices in this way allowed us to sense check the initial version of the draft prices. We then manually adjusted the prices based on the feedback received. Adjustments were also made to address illogical relativities across HRGs, and to ensure that prices were reflective of clinical resource requirements.

200. Where manual adjustments increased the total amount allocated to a particular service, these were offset through a reconciliation process that ensures the total amount allocated to each HRG chapter remains consistent (see Annex DtD).

201. However, we have increased the amount of money for the Nuclear Medicine chapter following clinical feedback on the increased cost of importing isotopes.

202. We also used the cash in/cash out process[21] to make adjustments to the initially modelled prices for 52 HRGs and points of delivery. This was done where the initially modelled 2022/23 prices were significantly lower than the 2021/22 NTPS prices and some providers might be disproportionately affected by the changes. The increase in prices was funded by a slight reduction to prices in subchapters with large increases between 2021/22 and the initially modelled 2022/23 prices. For details of the cash in/cash out adjustments, see Annex DtD.

203. The prices we are proposing in this consultation notice include the adjustment processes outlined above. The adjustments also mean that we are not proposing a separate volatility adjustment for 2022/23.

Why we think this is the right thing to do

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

205. Our approach involves making adjustments where the robustness of the cost data may not be certain, such as where there are very low reported activity numbers, or where the reported costs are inconsistent with likely clinical device usage. We then use the clinical expertise of the EWGs to ensure that the prices are a fair reflection of current clinical requirements. This is

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

particularly important to address the lag between the collection of the cost data and the setting of the prices.

206. During September 2021, we published the initial draft price relativities alongside the engagement online survey and sought feedback on them. We received a small number of suggestions and some concerns about the prices for accident and emergency services. We carefully considered the feedback and compared it with the advice of the EWGs. The comments received from stakeholders were consistent with the advice from the EWGs and so were addressed in our response to EWG recommendations.

207. In addition, we increased the total amount of money available for Nuclear Medicine as a result of the significant increase in the cost of importing isotopes required for these services.

208. We made cash in/cash out adjustments for a small number of HRGs, where the prices would otherwise involve a significant change from 2021/22. This is because the impact analysis suggested that changes in the prices could disproportionately affect some providers, and so making adjustments would reduce the volatility of the tariff prices.

209. We have funded the adjustments by slightly reducing the amounts allocated to subchapters that were shown to have had large increases in prices from 2021/22.

210. By making sure that year-on-year price changes do not risk destabilising services, we are able to ensure that care can continue to be delivered efficiently.

8.6 Cost base

Proposal
We propose that the cost base for services retaining national prices would reflect the proposed price setting method, rather than being recalculated.

About this proposal

211. 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.

212. 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 2021/22 prices and revenue as the starting point for the 2022/23 cost base for both national prices and unit prices.

213. 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.

214. 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
- 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.

215. For 2022/23, it is our judgement that it would be appropriate for the cost base to be based on 2021/22 NTPS prices. The proposed cost base would include the 1.25% increase made to 2021/22 prices to reflect the equivalent amount reallocated from CQUIN. Where local prices are agreed that are not based on the 2021/22 cost base, providers and commissioners should have regard to the transfer of CQUIN funding into the tariff (see Section 10.2). 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).

Why we think this is the right thing to do

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

- If we set the cost base too low (ie we set too high an expectation that providers will be able to catch up to past undelivered efficiency), providers would 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.
- 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.

217. Having considered the factors set out in paragraph 216, 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 2021/22 NTPS prices (even though block payment arrangements were used for 2021/22). This does not reflect additional direct costs of COVID-19, which are being funded outside the NTPS. Additional funding to support elective recovery will form part of the aligned payment and incentive variable element (see Section 6.4).

218. 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.

8.7 Cost uplifts

Proposal
We propose to set the inflation cost uplift factor at 2.8% for the purpose of calculating national and unit prices for 2022/23. The proposed cost uplift does not reflect changes in costs as a result of COVID-19.

About this proposal

219. We propose to use broadly the same methodology for setting cost uplifts that was used in the 2021/22 NTPS.

220. We do not propose to make an adjustment to the cost uplift factor to reflect COVID-19 costs. Additional funding to address direct COVID-19 costs will be distributed outside of the NTPS, although funding to support elective recovery will form part of the aligned payment and incentive variable element (see Section 6.4).

221. To determine the proposed national prices and unit prices for the 2022/23 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 5 outlines the cost categories and the source for initial estimates.

Table 5: Costs included in the cost uplift factor

Category	Description	Source for initial estimates
Pay	Assumed pay settlement, pay drift and other labour costs, including the Health and Social Care levy.	Internal data Department of Health and Social Care
Drugs	Expected changes in drug costs included in the tariff.	Internal data Office for Budgetary Responsibility
Capital	Expected changes in the revenue consequences of capital.	Office for Budgetary Responsibility
CNST	Expected changes in CNST contributions.	NHS Resolution
Other	General inflation for other operating expenses.	Office for Budgetary 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 6 shows the weights applied to each cost category.

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

Table 6: Elements of inflation in the cost uplift factor

Cost	Estimate	Cost weight	Weighted estimate
Pay	3.0%	68.9%	2.1%
Drugs	0.9%	2.5%	0.0%
Capital	2.7%	7.1%	0.2%
CNST	-0.1%	2.3%	0.0%
Other	2.7%	19.2%	0.5%
Total			2.8%[22]

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 have instead been funded by Health Education England.
- High cost drugs, which are not reimbursed through specialised commissioning agreements or tariff prices (see Section 6.5).

226. As the Table 6 shows, total indicative pay cost change is estimated at 3.0% for 2022/23. This includes a 2% headline pay award assumption for 2022/23, as well as impacts for previously agreed multi-year pay awards. The pay cost estimate also includes the impact of the Health and Social Care Levy. As presented here, the pay cost estimate does not seek to pre-judge the outcome

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

of the pay review bodies, the outcome of which will not be known until 2022. If further information is available prior to the publication of the final tariff, we will look to update the estimates of the cost uplift factor, where it is practical to do so.

227. As described in Section 8.6, the proposed cost base for 2022/23 reflects the 1.25% increase resulting from the transfer of funding from CQUIN into the 2021/22 NTPS. This means that we are not proposing an additional adjustment in addition to the cost uplift factor for 2022/23. However, any local prices that have not factored in the additional 1.25% from the 2021/22 tariff should consider an adjustment for the transferred CQUIN funding.

Why we think this is the right thing to do

228. 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 pressures in future years (the cost uplift factor).

229. 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 will be distributed outside of the tariff. While we acknowledge that COVID-19 is likely to continue to have a significant impact on the costs of routine healthcare delivery during 2022/23 as a result of the changes to the way many services are delivered, it remains unclear 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.

230. In addition, any uplifts relating to COVID-19 are likely to need to vary throughout the year and by location. As such, setting a fixed national adjustment factor would not be appropriate.

231. The uplift assumptions for drugs, CNST, capital and other expenses are reliant on an inflation assumption. Our methodology uses the latest GDP deflator rate for 2022/23 (2.7%), which was published in October 2021.[23]

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

232. Total drug uplift is estimated at 0.9% for 2022/23. This is calculated based on an assumption of unit costs for generic drugs changing by the inflation rate. 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.

233. Total change in the revenue consequences of capital is estimated at 2.7%, using the inflation rate. This estimate of change would be assumed to apply for depreciation and private finance initiative (PFI).

234. Total change in unallocated CNST, which is included in the tariff but cannot be allocated to HRG subchapters, is estimated at -0.1%. This is based on the change in contribution rates for unallocated CNST as a proportion of the total CNST collection from NHS providers for 2022/23.

235. Total change in other operating costs is estimated at 2.7%, using the inflation rate. This estimate of change is assumed to apply to a wide range of costs not covered by the above categories.

236. 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.

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 2022/23. The proposed efficiency factor does not reflect changes in costs as a result of COVID-19.

About this proposal

237. 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 2022/23, we propose that this adjustment also applies to unit prices for services outside the scope of national prices.

238. The efficiency factor used to calculate prices 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. In 2022/23, there will be additional efficiency requirements on providers as the level of COVID-19 support funding changes compared to that made available at the start of the pandemic. These COVID-19 funding-related effects are considered separately to the setting of the efficiency factor in the NTPS.

239. The objective of the efficiency factor in the NTPS 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.

240. 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.

241. We are proposing to set the efficiency factor for 2022/23 at 1.1% for the purpose of calculating national and unit prices. This is consistent with the efficiency and productivity expectations set out in the NHS Long Term Plan. 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 NTPS efficiency factor.

Why we think this is the right thing to do

242. Our proposal is supported by NHS Improvement analysis of the ten-year efficiency trend in the sector, specifically of NHS acute providers.[24] 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.[25]

243. In previous years, the analysis was 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. Residual differences between trusts are used to estimate the distribution of efficiency across the sector.[26] The model includes data from 168 acute trusts for the period between 2008/09 and 2017/18.

244. For 2022/23, the model was not run as any updated data would be affected by the impact of COVID-19. However, the last run of the model 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.

245. 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.

246. In addition, 1.1% is the efficiency assumption in the original funding settlement within the NHS Long Term Plan Implementation framework.

247. 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.

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24 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.

25 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/

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

While we acknowledge that COVID-19 is likely to have a significant impact on the costs of routine healthcare delivery during 2022/23, due to changes in 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. Additional costs should be treated separately as they should be covered by additional COVID settlements and recovery funding. Any adjustments would need to be agreed locally between the provider and commissioner.

9. National variations

248. 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.

249. The aligned payment and incentive approach, introduced in the 2021/22 NTPS, reduces the number of national prices and consequently the impact of national variations. In order that the policies underlying the variations continue to operate effectively the 2022/23 NTPS would include guidance on how the national variations for the market forces factor (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*).

9.1 Market forces factor

Proposal
We propose to move to the fourth step of the five-step implementation path, introduced after the data and method update in 2019/20.

About this proposal

250. 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 commissioner allocations. Each NHS provider is assigned an individual MFF value. This is used to adjust national prices and commissioner allocations.

251. As the aligned payment and incentive approach involves funding the majority of activity through locally agreed payments rather than national prices, the range of activity where the MFF is directly applied is greatly reduced. However, providers and commissioners should consider changes in MFF values when agreeing the aligned payment and incentive fixed elements as any cost information used may reflect out-of-date MFF figures (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.

252. 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.

253. 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.

254. For 2022/23, we propose moving to the fourth step of this glidepath (ie the ‘Year 4’ MFF values that were published as part of the 2019/20 NTPS, updated for any mergers). Annex DtA contains the proposed MFF values for 2022/23, as well as the fifth and final step on the glidepath. Any 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.

255. Moving to the fourth 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 2022/23 prices, compared to continuing to use the 2021/22 MFF values (ie the third year of the MFF glidepath) is 0.38%.

Why we think this is the right thing to do

256. 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 glidepath was introduced to help mitigate the year-on-year impact on individual providers.

257. We are proposing to move to the next step of the glidepath to ensure that MFF values continue to move closer to the target values set following the 2019/20 data and method update. This would ensure that the values 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.

258. During our September engagement workshops, we discussed three MFF options:

- making no change (ie staying on the third step of the glidepath, as in 2021/22)
- moving to the fourth step of the glidepath
- updating the data used to calculate MFF values, implementing a new glidepath in needed.

259. There was a fairly even split of views in workshop attendees' Menti scores, with updating the data slightly preferred (38%) compared to 30% each for making no change and moving to the fourth step of the glidepath. Providers were more strongly in favour of updating the data than commissioners.

260. Responses to the online survey were also fairly even. Again, continuing to use the glidepath was more popular than not, with making no change the most supported (42%) and moving to the fourth step being supported by 26%. Updating the data was supported by 32% of respondents. Many respondents suggested that it was important to avoid potential volatility from changes to current the MFF values. There were also concerns from individual trusts who were on a negative transition path. However, there were also views that

moving to the fourth step of the glidepath would involve known figures that have been planned for.

261. As with the engagement on the 2020/21 and 2021/22 NTPS, 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.

262. In considering the potential data update, we had concerns that the impacts of the UK leaving the European Union and COVID-19 are not yet fully clear in the available data. As such, making an update based on more recent data might then need to be revised again, causing additional volatility. As such, we are proposing to move to the next step of the 2019/20 glidepath for 2022/23, but then review what data is available before deciding to move to the final step in the next tariff.

263. As in previous years, feedback from the engagement 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 2022/23, changing the underlying data or method, and so moving away from the previously published values, would risk introducing volatility. Moving to the next step of the transition path does involve a change in MFF values. However, these have been available since the 2019/20 NTPS and so organisations should be able to work with them.

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 it has been since the 2019/20 NTPS
- make no changes to the PSS top-up payment rates from the 2021/22 NTPS
- continue with the payment approach for specialist knee revision services introduced in 2020/21.

About this proposal

264. Specialised services are relatively expensive but are accessed by comparatively few patients from a small number of providers with the right expertise. Top-up payments for specialised services were introduced in 2005 to reflect the extra costs of complexity.

265. For the 2017/19 NTPS, there was a change from basing top-ups on the Specialised Services National Definitions Set (SSNDS) to PSS definitions. To manage this change, we adopted a method using the University of York model[27] and updating it for changes in currency design, with 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

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

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.

266. For 2022/23 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.[28]

267. We propose to keep on pause the transition path introduced in the 2017/19 NTPS. 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 it has been since 2019/20.

268. We propose to make no changes to the calculation of the PSS top-ups payment rates set out in the 2021/22 NTPS.

269. We also propose to continue to apply the payment approach for knee revision surgery that was first piloted in 2020/21. This supports a hub-and-spoke model to support orthopaedic providers to deal with complex activity. We are working with GIRFT colleagues to consider how a hub-and-spoke approach might also be applied for elbow surgery.

270. 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.

271. As set out in Section 6, the aligned payment and incentive rules applies to all activity commissioned by NHS England Specialised Commissioning team. This 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

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

273. In the September 2021 engagement, we discussed the proposal to pause the transition path. The feedback was generally supportive (average Menti score

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

6.2/10). In the online survey, the majority of respondents neither supported nor opposed the proposal (49%). There was opposition or strong opposition from 16% of respondents, while 36% either supported or strongly supported making no change. Opposition was from respondents who 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.

274. 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.

275. We continue to believe that moving to the new top-up rates too quickly could destabilise providers. We are using PLICS data and service reviews by NHS England Specialised Commissioning to consider how the payment system 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 2022/23.

276. Supporting specialist providers to deliver complex care is an important part of the payment system, even though the impact of top-ups will be reduced within aligned payment and incentive fixed element. *Guidance on the aligned payment and incentive approach* makes clear that top-up payments providers have previously received should be considered in agreements.

10. Locally determined prices

277. Local pricing arrangements have always been a core part of the national tariff. As in the 2021/22 NTPS, we are proposing that the 2022/23 NTPS contains two types of local pricing rules:

- aligned payment and incentive rules (see Section 6)
- general local pricing rules.

278. 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.

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

280. 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 benchmark prices for bilateral cataract services. See the *Non-mandatory guide prices* workbook for details.

10.1 General local pricing rules – health inequalities

Proposal
We propose to update the local pricing principles to include a requirement to consider how any payment approach could contribute to reducing health inequalities.

About this proposal

281. The local pricing principles must be applied whenever providers and commissioners agree a local payment approach. Aligned payment and incentive rule 2(b) requires the principles to be considered for any

agreements, while rule 3(b) also requires the principles to be applied for any departure from the aligned payment and incentive arrangements.

282. We are proposing to add to the local pricing principles so that the duty to consider health inequalities forms part of all local pricing arrangements.

Why we think this is the right thing to do

283. Addressing health inequalities is a key priority for the NHS, and one of the core aims of ICSs. The NHS Long Term Plan also commits to reviewing our finance framework in relation to health inequalities.

284. Adding health inequalities to the local pricing principles, and providing supporting guidance, will require providers and commissioners to carefully consider how any local pricing approach will ensure equitable access, excellent experience and optimal outcomes for seldom-heard population cohorts. This should be underpinned by analysis of suitably disaggregated data, where available.

285. Consideration of the potential impact on health inequalities of national policies is a key part of our decision-making process. It is important that the same is true for local agreements. The proposed update will support this.

10.2 General local pricing rules – CQUIN adjustments

Proposal
We propose to update local pricing rule 2 to include a requirement for providers and commissioners to have regard to whether local prices need to be uplifted by 1.25% to reflect the transfer of CQUIN funding into the tariff.

About this proposal

286. From 2021/22, CQUIN funding has been transferred into the tariff. For the 2021/22 NTPS, this was given effect in the aligned payment and incentive rules, and by making a 1.25% adjustment in addition to the cost uplift factor in the tariff method. This approach meant that the increase would apply to both locally prices services and unit and national prices.

287. As described in Sections 8.6 and 8.7, for 2022/23, the proposed cost base for tariff prices includes the 1.25% increase and so no adjustment in addition to the cost uplift factor is proposed.

288. We are therefore proposing to update local pricing rule 2 to make sure that providers and commissioners have regard to how the transfer of CQUIN funding into the tariff is reflected in local pricing arrangements.

Why we think this is the right thing to do

289. CQUIN funding is intended to support high quality care. Local prices should be designed to ensure that services can be delivered in the best interests of patients.

290. We are proposing to update local pricing rule 2 to ensure that providers and commissioners have regard to the transfer of CQUIN funding into the tariff when agreeing locally determined payment arrangements. This is particularly important for contracts being re-based if they haven't already been uplifted by 1.25% in 2021/22.

2022/23 National Tariff Payment System – a consultation notice

2022/23 National Tariff Payment System: draft tariff

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 2022/23 National Tariff Payment System. This is shown as it would appear in final form, if the consultation proposals were implemented. It starts on page 74.

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1. Introduction

1. This is the national tariff for the NHS in England. It specifies the following components that make up the National Tariff Payment System for 2022 to 2023 (the 2022/23 NTPS):

   - the local pricing and payment rules, including the rules for the 2022/23 aligned payment and incentive approach
   - currencies
   - national prices and unit prices
   - the method for determining those prices
   - the methods for determining local modifications
   - related guidance.

2. Since 1 April 2016, Monitor and the NHS Trust Development Authority have operated as a single integrated organisation known as NHS Improvement. Since 1 April 2019, NHS England and NHS Improvement have come together to act as a single organisation. This document is published in exercise of functions conferred on Monitor by section 116 of the Health and Social Care Act 2012 (the 2012 Act). The proposals which form the basis of this national tariff were agreed between NHS England and Monitor under section 118 of the 2012 Act. In the rest of this document, 'NHS Improvement' means Monitor, unless the context otherwise requires.

3. This 2022/23 NTPS has effect for the period beginning on 1 April 2022 and ending on 31 March 2023, or the day before the next national tariff published under section 116 of the 2012 Act has effect, whichever is the later.[1]

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

4. The 2012 Act sets out that the national tariff must contain national prices and rules for those services not subject to national prices (known as "local pricing rules"). The 2022/23 aligned payment and incentive approach involves many more services being subject to such rules (specifically the aligned payment and incentive rules in Section 3), rather than national prices.[2]

5. For services without national prices, subject to the rules, we have continued to include in this document what are referred to as 'unit prices' – these are not mandatory national prices, but are produced to assist the pricing of services under the local pricing rules. We have continued to calculate unit prices for all services that had national prices in the 2017/19 NTPS (before the introduction of blended payment in 2019/20), using the same method as for the calculation of national prices. The unit prices are, in particular, available to use for activity outside the scope of the aligned payment and incentive approach, including activity commissioned under the NHS Increasing Capacity Framework, in accordance with the aligned payment and incentive rules (see Section 3).

6. The document is split into the following sections:

   - Section 2: the scope of the tariff
   - Section 3: aligned payment and incentive rules
   - Section 4: general local pricing rules
   - Section 5: currencies with national prices
   - Section 6: the method for determining national and unit prices
   - Section 7: national variations
   - Section 8: local variations and local modifications to national prices
   - Section 9: payment rules.

7. In summary, Sections 3 and 4 set out the rules which apply to services without national prices, while Sections 5 to 8 deal with national and unit prices (and variations/modifications to those prices).

8. There are five annexes, listed in Table 1.

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

Table 1: 2022/23 NTPS annexes

Annex	Description
DtA	National tariff workbook, including national prices and unit prices
DtB	Guidance on currencies[3]
DtC	Guidance on best practice tariffs
DtD	Method used to calculate prices
DtE	Guidance on local modifications to national prices

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

Table 2: Supporting documents to the 2022/23 NTPS

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

10. All annexes and supporting materials can be downloaded from the NHS England and NHS Improvement website.[4]

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

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

[4] www.england.nhs.uk/pay-syst/national-tariff/consultation-on-2022-23-national-tariff/

2. Scope of the national tariff

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

13. Various healthcare services are, however, outside the scope of the national tariff. The rest of this section explains these exclusions.

2.1 Public health services

14. The national tariff does not apply to public health services that are:[6]

- provided or commissioned by local authorities or United Kingdom Health Security Agency (formerly Public Health England)
- commissioned by NHS England under its Section 7A public health functions agreement with the Secretary of State, including national immunisation programmes[7]
- commissioned by NHS England or a local NHS commissioner on behalf of a local authority pursuant to a partnership agreement under section 75 of the National Health Service Act 2006.

15. Public health services commissioned by local authorities include local open access sexual health services and universal health visitor reviews. The services commissioned by NHS England under Section 7A arrangements

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

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

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

include public health screening programmes, sexual assault services and public health services for people in prison.

2.2 Primary care services

16. The national tariff does not apply to primary care services (general practice, community pharmacy, general dental practice and community optometry) where payment for the services is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the National Health Service Act 2006 (the 2006 Act).[8]

17. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act then the 2022/23 NTPS rules on local price setting apply (see Section 4.2.3). For instance, local price-setting rules apply to minor surgical procedures performed by GPs and commissioned by local NHS commissioners.

2.3 Personal health budgets

18. A personal health budget (PHB) is a set amount of money to support the identified health and wellbeing needs of a particular patient, planned and agreed between that patient and their local NHS.

19. There are three types of PHB:

- **Notional budget; no money changes hands:** the patient and their NHS commissioner agree how to spend the money; the NHS will then arrange the agreed care.
- **Real budget held by a third party:** an organisation legally independent of the patient and their NHS commissioner will hold the budget and pay for the care in the agreed care plan.
- **Direct payment for healthcare:** the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.

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

20. If an NHS commissioner uses a notional budget to pay providers of NHS services, this is in the scope of the 2022/23 NTPS. Payment will be governed by the national prices or rules applicable to the services in question.

21. A notional budget may also be used to buy integrated health and social care services to facilitate more personalised care planning. Where these services and products are not NHS services, the 2022/23 NTPS does not apply.

22. If a PHB takes the form of a direct payment to the patient or budget held by a third party, the payments for health and care services agreed in the care plan and funded from the PHB are not in the scope of the 2022/23 NTPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act.[9]

23. The following are not in the scope of the 2022/23 NTPS, as they do not involve paying for provision of NHS healthcare services:

    - Payment for assessing an individual's needs to determine a PHB.
    - Payment for advocacy (advice to individuals and their carers about how to use their PHB).
    - Payment for the use of a third party to manage an individual's PHB on their behalf.

24. More information about PHBs can be found on the NHS Personal Health Budgets page.

2.4 Integrated health and social care

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

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

26. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain in the scope of the 2022/23 NTPS even if commissioned by a local authority.[10]

27. Payment to providers of NHS services that are jointly commissioned are governed by the national prices and rules applicable to those services, as set out in this document.

28. Local authority social care or public health services commissioned under joint commissioning arrangements are outside the scope of the 2022/23 NTPS.

2.5 Contractual incentives and sanctions

29. In previous years, commissioners' application of CQUIN payments and contractual sanctions were based on provider performance, after a provider's income has been determined in accordance with the NTPS.

30. Nationally set financial sanctions for failure to achieve national standards have been removed from the NHS Standard Contract. However, the Contract continues to include certain provisions under which commissioners may withhold payment from providers. Where these contractual provisions are used and change the amount paid for the provision of an NHS service, this is permitted under the rules relating to the making of payments to providers (see Section 9).

31. As with 2021/22, CQUIN funding is included in the tariff. This has been given effect for aligned payment and incentive agreements (see rules 2 and 3 in Section 3). The cost base for 2022/23 unit and national prices includes the 1.25% increase made in 2021/22. Where local prices are agreed that are not based on the 2021/22 cost base, an additional 1.25% increase would be required (see general local pricing rule 2 in Section 4.2). All providers to which CQUIN applies will be expected to report CQUIN metric data, even if they implemented a local departure from the aligned payment and incentive rules.

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

2.6 Devolved administrations

32. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, the 2022/23 NTPS applies in some but not all circumstances.

33. Table 3 summarises how the 2022/23 NTPS applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

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

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

34. In the final scenario above, the commissioner in England must follow the prices and rules in the 2022/23 NTPS, including the aligned payment and incentive rules in Section 3. However, there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally in the country in question, or use a different currency from that mandated by the national tariff. In such cases, the commissioner must follow the general rules for local pricing (see Section 4.2). If there is a national price for the service, a local variation would be required to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the commissioner should follow the rules for local pricing.

35. Providers and commissioners should also be aware of guidance relating to cross-border payment responsibility. The England/Wales cross border healthcare services: statement of values and principles sets out the values and principles agreed between the NHS in Wales and the NHS in England to ensure smooth and efficient interaction between NHS organisations for patients along the England-Wales border. NHS England also provides comprehensive guidelines on payment responsibility in England.[11]

36. The payment responsibility rules set out in these documents should be applied as well as any applicable provisions of the 2022/23 NTPS. The scope of the 2022/23 NTPS does not cover these rules.

2.7 Overseas visitors

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

38. For more details, please see the overseas visitors charging rules.

39. It is important to be aware of exemptions from charges. This may be services (for example accident and emergency or family planning services) or

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

individuals (including vulnerable people such as refugees or asylum seekers). Please see Chapter 1 of the Guidance on implementing the overseas visitor charging regulations for details of exempt services and individuals.

3. Aligned payment and incentive rules

40. This section sets out the aligned payment and incentive rules for services without national prices for 2022/23. There are national prices for unbundled diagnostic imaging services only (see Section 5). This means that all secondary care services apart from diagnostic imaging are not in the scope of national prices.

41. Providers and commissioners must apply the rules set out here to agree the amounts payable for the specified services, subject to certain exceptions. In cases where the exceptions apply (eg where the contract is between a provider and a local NHS commissioner that are mapped to different ICSs for financial control purposes, and the expected annual contract value is less than £30 million), then the general position is that the general local pricing rules in Section 4 apply (but see detailed provisions in rule 4).

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

43. The aligned payment and incentive approach is a type of blended payment, based on the model introduced in the 2019/20 tariff. In line with the commitments in the NHS Long Term Plan, a blended payment approach remains the direction of travel for the NHS payment system.

Rule 1 (general rule)

a) Commissioners and providers must determine the prices payable for the provision of secondary care services in accordance with this rule, and rules 2 to 5 below, and having regard to guidance published by NHS England and NHS Improvement in relation to the pricing of those services.

b) The local pricing rules specified in Section 4.2 (general local pricing rules) do not apply to those cases where the aligned payment and incentive specified in rule 2 applies.

c) Subject to rule 4 (exceptions), rule 2 and the aligned payment and incentive specified in that rule applies to all secondary care services where one or more of the following conditions applies:

i. the commissioner and provider have an expected annual contract value of £30 million or more,[12]

ii. the commissioner is a local NHS commissioner, and that both provider and commissioner are mapped to the same ICS for financial control purposes,

iii. the commissioner is NHS England for Specialised Commissioning services.[13]

d) In these rules:

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

"expected annual contract value" means:

i. the amount agreed by the commissioner and provider as the expected value of the contract between them for the provision of secondary care services for the financial year 2022/23, or

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

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

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

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

"ICS" means an integrated care system;[14]

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

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

"the value of elective activity" is, in relation to any period during the financial year 2022/23, the amount that would be payable for elective activity, calculated by reference to the number of elective spells, first outpatient attendances and outpatient procedures which group to a non-WF HRG with a published HRG price for that year, if that activity was priced using the unit prices set out in Annex 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 financial year, calculated in accordance with the following paragraphs.[17]

b) The provider and commissioner must agree an initial fixed element representing funding for the provision of secondary care services for the financial year, applying the principles for local pricing specified in Section 4.1, and having regard to guidance published by NHS England and NHS Improvement,[18] the

14 www.england.nhs.uk/integratedcare/integrated-care-systems/
15 This includes hospital, community, mental health and ambulance services, but excludes services provided pursuant to the public health functions of local authorities or the Secretary of State
16 S.I. 2012/2996, as amended.
17 The supporting document *Guidance on the aligned payment and incentive approach* provides more detail on calculating this payment.
18 Including the 2022/23 Operational Planning Guidance.

cost uplift and efficiency factors for 2022/23 (as set out in Sections 6.6 and 6.7). This should include an expected value for the provision of high cost drugs, devices and listed procedures unless they are identified as not included in aligned payment and incentive fixed elements in Annex DtA (tabs 14a, 14b and 14c), and the implementation costs of the listed innovation products in tab 14c.

c) The high cost drugs, devices and listed procedures, and innovative products that are not identified as included in aligned payment and incentive fixed elements in Annex DtA (tabs 14a, 14b and 14c) will be reimbursed in accordance with local pricing rule 3 (see Section 4.2.2) and, for devices commissioned by NHS England Specialised Commissioning, the HCTED (high cost tariff-excluded devices) programme.

d) The initial fixed element must reflect assumed full achievement of CQUIN metrics and so needs to be increased by 1.25% if CQUIN funding is not already included. This produces the fixed payment.

e) The provider and commissioner must also agree:

   i. the expected level of BPT criteria attainment which the provider will achieve in delivering those services,
   ii. the expected level of elective activity for the financial year which is intended to be reflected in the initial fixed element,
   iii. the expected level of advice and guidance activity for the financial year which is intended to be reflected in the initial fixed element.

f) Subject to rule 3, the price payable shall be the fixed payment, varied as set out below:

   i. If the value of elective activity undertaken during the financial year is greater than the amount planned for and reflected in the initial fixed element, an amount equal to 75% of the difference between the value of actual elective activity and the value of planned elective activity must be added to the fixed payment.
   ii. If the value of elective activity undertaken during the financial year is less than the amount planned for and reflected in the initial fixed element, an amount equal to 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 level of advice and guidance activity is different to that agreed pursuant to paragraph (e) above, the fixed payment should be increased or decreased as agreed by the commissioner and provider in accordance with guidance issued by NHS England.

iv. If the attainment of BPT criteria in relation to services delivered is different to that agreed pursuant to paragraph (e) above, the fixed payment should be increased or decreased by the difference in value between the expected and actual levels of activity meeting BPT criteria, calculated using the BPT and unit prices published in Annex DtA.

v. If the provider does not achieve required performance against the CQUIN metrics, the fixed payment should be decreased as agreed by the commissioner and provider in accordance with guidance issued by NHS England.

Rule 3 (locally agreed adjustments)

a) The commissioner and provider may agree an adjustment to the price payable under rule 2, including a change as to how the fixed payment is calculated or a variation to the fixed payment other than as provided for in rule 2(f), provided that:

   i. they comply with paragraphs (b) to (f), which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in Section 8.1; and

   ii. the agreement is approved by NHS England and NHS Improvement following an application by the commissioner and provider.

b) The commissioner and provider must apply the local pricing principles in Section 4.1.

c) The agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers the services in question.

d) The commissioner must maintain and publish a written statement of the agreement, using the template provided by NHS Improvement,[19] within 30 days

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

of the relevant contract being signed, or in the case of an agreement during the term of an existing contract, the date of the agreement.

e) The commissioner must have regard to the guidance in Section 8.1 when preparing and updating the written statement.

f) The commissioner must submit the written statement to NHS Improvement.

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

a) Rules 2 and 3 do not apply where:

   i. a commissioner and provider of secondary care services (other than Specialised Commissioning Services) have an expected annual contract value of less than £30 million and are not mapped to the same ICS for financial control purposes; or
   ii. the services are provided pursuant to a contract awarded under the NHS Increasing Capacity Framework.[20]

b) In those cases, the prices payable for the provision of secondary care services for the financial year must be determined as follows:

   i. in cases falling within paragraph (a)(i):
      a. the prices agreed between the commissioner and provider in accordance with the general local pricing rules in Section 4.2, or
      b. where no agreement can be reached between provider and commissioner, the unit and BPT prices set out in Annex DtA (to the extent those prices apply to the services), 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 (to the extent those prices apply to the services), subject to the national variations which would have applied if they were national prices, and any payment rules applicable under the Framework.

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

Rule 5 (additional requirements)

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

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

4. General local pricing rules

44. National prices can sometimes be adjusted through local variations or, where they do not adequately reimburse efficient costs because of certain issues, through local modifications. Provisions relating to local variations and local modifications to national prices can be found in Section 8. Where there are no national prices, commissioners and providers must determine local prices in accordance with any rules specified in the national tariff.

45. Section 3 has set out the rules which apply in most cases to secondary care services without national prices. This section sets out:

- the principles that apply to locally determined prices (Section 4.1)
- the general local pricing rules which apply to cases where the aligned payment and incentive rules in Section 3 do not apply (Section 4.2).

46. Unbundled diagnostic imaging are the only services subject to national prices in 2022/23. The local prices for all other services are, however, to be determined in accordance with the detailed aligned payment and incentive rules in Section 3 and the general local pricing rules in Section 4.2.

47. This section is supported by the following annexes and supporting document:[21]

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

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

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

48. Subject to paragraph 50, commissioners and providers must apply the following three principles when agreeing a local payment approach:

- The approach must be in the best interests of patients.
- The approach must promote transparency to improve accountability and encourage the sharing of best practice.
- The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches
- The approach should consider how the payment approach could contribute to reducing health inequalities.

49. These principles are explained in more detail in Sections 4.1.1 to 4.1.4 and are additional to other legal obligations on commissioners and providers. These obligations include other rules set out in the national tariff, and the requirements of competition law, procurement law, regulations under section 75 of the 2012 Act,[22] and NHS Improvement's provider licence.

50. In relation to the 2022/23 aligned payment and incentive approach set out in Section 3, commissioners and providers must apply the principles when setting the fixed element of the payment (see rule 2(b)) or when agreeing local departures from the approach (rule 3(b)).

51. Providers and commissioners should maintain a record of how local payment approaches comply with the principles. The content and level of detail of this record will vary depending on the circumstances. For example, more information is likely to be required for high value contracts than for lower value contracts.

4.1.1 Best interest of patients

52. Local variations, modifications and prices must be in the best interests of patients today and in the future. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

[22] 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?

53. The extent to which, and way in which, these factors need to be considered will differ according to the characteristics of the services and the circumstances of the agreement.

54. To have considered a relevant factor properly, we would expect providers and commissioners to have:

- obtained sufficient information
- used appropriately qualified/experienced individuals to assess the information
- followed an appropriate process to arrive at a conclusion.

55. It is up to providers and commissioners to determine how to consider the factors set out above based on the matter in hand.

4.1.2 Transparency

56. Local variations, modifications and prices must be transparent. Increased transparency will make commissioners and providers more accountable to each other, patients, the general public and other interested stakeholders. Transparent agreements also mean that best practice examples and innovation in service delivery models or payment approaches can be shared more widely. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

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

4.1.3 Constructive engagement

57. Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that delivers the best value for patients in their local area. This process should involve clinicians, patient groups and other relevant stakeholders where possible. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time. Constructive engagement is intended to support better and more informed decision making in both the short and long term.

58. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

- **Framework for negotiations**: Have the parties agreed a framework for negotiating local variations, modifications and prices that is consistent with the existing guidelines in the NHS Standard Contract and procurement law (if applicable)?
- **Information sharing**: Are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?
- **Involvement of relevant clinicians and other stakeholders**: Are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
- **Short- and long-term objectives**: Are clearly defined short- and long-term strategic objectives for service improvement and development agreed before starting price negotiations?

4.1.4 Health inequalities

59. Addressing health inequalities is a key priority for the NHS. When agreeing a locally determined price, commissioners and providers must ask how the

agreement facilitates equitable access, excellent experience and optimal outcomes for seldom heard population cohorts. This should be underpinned by analysis of suitably disaggregated data, where available.

60. The agreement must not adversely affect other national and local initiatives which seek to tackle health inequalities. Where all or part of the agreement is specifically tailored to enhance equality of healthcare provision, commissioners and providers must jointly recognise both the expected cost of this and the anticipated benefit. This should be reflected in the locally determined price.

61. In agreeing a locally determined price, it is recommended commissioners and providers visit the NHS Equality and Health Inequalities Hub[23] to consider their legal duties with regard to health inequalities and to learn more on how the NHS aims to reduce health inequalities. Providers and commissioners should also consider using the Core20PLUS5 approach to achieve better, more sustainable outcomes and reduce healthcare inequalities.

4.2 General local pricing rules

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

4.2.1 General rules for all services without a national price

63. Rules 1 and 2 apply when providers and commissioners agree local prices (whether a single annual price for a bundle of services or unit prices for single items of treatment) for services without national prices, in cases where neither the aligned payment and incentive approach nor the NHS Increasing Capacity Framework apply (see rule 4 in Section 3).

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

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

Rule 1

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

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

Rule 2

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

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

65. The pricing of services under these rules can be supported by the unit prices published in Annex DtA (for example, where providers and commissioners are mapped to different ICSs and their expected contract value is below £30 million, and they chose to use an activity-based payment approach).

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

66. Rule 2 requires commissioners and providers to have regard to national price adjustments. In effect they should be used as a benchmark to inform local negotiations. However, these are not the only factors that should be considered. Other relevant factors may include, but are not restricted to:

- commissioners agreeing to fund service development improvements
- additional costs incurred as part of any agreed service transformation
- funding of initiatives to address health inequalities
- taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
- comparative information (eg benchmarking) about provider costs and opportunities for local efficiency gains
- differences in costs incurred by different types of provider – for example, differences in indemnity arrangements (such as contributions to the Clinical Negligence Scheme for Trusts – CNST) or other provider specific costs (such as the effects of changes to pensions and changes to the minimum wage).

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

67. A number of high cost drugs, devices and listed procedures and listed innovative products are subject to special reimbursement arrangements. These items are listed in Annex DtA, tabs 14a, 14b and14c (see also Section 5.5 below). The costs of all these items are not included in unit prices (see Section 6). For activity reimbursed by the aligned payment and incentive, the costs of the majority of these items are not included in fixed payment. For some listed high cost drugs, the cost of the product is covered by the aligned payment and incentive fixed element agreed by the commissioner and provider (see rule 2(b) and (e) in Section 3). These items are listed in tab 14b as ‘Included in aligned payment and incentive fixed element’. For the listed innovation products in tab 14c, the implementation costs are also covered by the fixed element. In all other cases, the product is reimbursed separately and priced in accordance with rule 3 below.

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

Rule 3

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

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

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

(c) The price agreed should reflect:

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

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

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

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

4.2.3 Primary care services

68. Primary care is a core component of NHS care provision. It enables local populations to access advice, diagnosis and treatment. Primary care services cover a range of activities, including:

- providing co-ordinated care and support for general health problems
- helping people maintain good health
- referring patients on to more specialist services where necessary.

69. Primary care is also a key part of the provision of community-based health services, interacting with a number of other community-based health teams, such as community nurses, community mental health teams and local authority services.

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

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

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

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

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

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

72. The price paid to providers of NHS services in a primary care setting in most of these instances will be locally agreed, and providers and commissioners of these services must therefore adhere to the general rules set out in Section 4.2.1.

73. The payment for these services could also be part of an aligned payment and incentive agreement, were a provider delivering a bundle of services including such primary care services.

4.2.4 Community services

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

75. Community providers often work closely with other NHS and social care providers, such as GPs and local authority services, and are a key contributor to developing more integrated health and social care and new care models.

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

76. Payment for community health services will often use an aligned payment and incentive agreement, in accordance with the rules in Section 3. However, in cases falling outside those rules (eg provider and commissioner that are mapped to different ICSs with an expected annual contract value less than £30 million), payment must adhere to the general rules set out in Section 4.2.1. This allows continued discretion at a local level to determine payment approaches that support high quality care for patients on a sustainable basis.

77. NHS England and NHS Improvement and NHS Digital are testing new currency models for community healthcare, which could be used to support future funding for these services. These models focus on five currency areas: children and young people with disabilities; single episodes of care; long-term conditions; frailty; last year of life. We have published details of the first two of these currencies as non-mandatory models. See Community services currency guidance: frailty and last year of life. More details on the project are available on the NHS England and NHS Improvement website.

5. Currencies

78. A ‘currency’ is a unit of healthcare for which a payment is made. A currency can take many different forms; for example, it could involve a bundle of services for a group of patients or a particular population (eg the services covered by the fixed payment set out in Section 3), or an individual episode of treatment.

79. Currencies are one of the ‘building blocks’ that support the NTPS. They include the clinical grouping classification systems for which there are national prices and unit prices in 2022/23.

80. Under the 2012 Act, the national tariff must specify the NHS healthcare services for which a national price is payable.[26] The healthcare services to be specified must be agreed between NHS England and NHS Improvement.[27] The service specifications are referred to as currencies. The 2012 Act also provides that the national tariff may include rules for determining which currency applies where there is more than one currency and price for the same service. In addition to currencies for national prices, we also use currencies as the basis for the unit prices in the national tariff, which are used to facilitate local pricing (specifically the aligned payment and incentive approach in Section 3).

81. We are using healthcare resource group HRG4+ phase 3 currency design as the basis for setting national prices and unit prices for many services, including admitted patient care and outpatient procedures. The 2022/23 NTPS uses the version of the currency design that was used for 2018/19 reference costs.[28]

82. This section describes the currencies with a national price, while Annex DtB contains details of some currencies with unit prices. It should be read in conjunction with the following:[29]

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26 2012 Act, section 116(1)(a).
27 2012 Act, section 118(7).
28 Details available at https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/costing---hrg4-2018-19-reference-costs-grouper
29 All available from: www.england.nhs.uk/pay-syst/national-tariff/consultation-on-2022-23-national-tariff/

- 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).
- Annex DtC: Guidance on best practice tariffs.

5.1 Classification, grouping and currency

83. The national tariff relies on data. To operate effectively, the payment system needs:

- **a way of capturing and classifying clinical activity**: this enables information about patient diagnoses and healthcare interventions to be captured in a standard format
- **a currency**: the large number of codes for admitted patient activity in the primary classification system makes it impractical as a basis for payment; instead casemix groupings (healthcare resource groups – HRGs) are used as the currency for admitted patients, outpatient procedures and A&E. For outpatient attendances, the currency (treatment function codes – TFCs) is based on groupings that relate to clinical specialty and attendance type (eg first or follow-up attendance).

84. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2022/23 NTPS relies largely on two standard classifications to record clinical data for admitted patients. These are:

- the World Health Organization International Classification of Diseases, 10th revision (ICD-10) for diagnoses[30]
- OPCS Classification of Interventions and Procedures (OPCS-4) for operations, procedures and interventions.[31]

85. 'Grouping' is the process of using clinical information such as diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E

30 The 5th edition update of ICD-10 was published in April 2015.
31 https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=14270896#14270896

only) to classify patients to casemix groups structured around healthcare resource groups (HRGs). HRGs are groupings of clinically similar conditions or treatments that use similar levels of healthcare resources. The grouping is done using grouper software produced by NHS Digital.[32] NHS Digital also publishes comprehensive documentation giving the logic and process behind the software's derivation of HRGs as well as other materials that explain and support the development of the currencies that underpin the national tariff.[33]

86. The 2022/23 NTPS uses spell-based[34] HRGs as the currencies for the diagnostic imaging services with national prices. HRGs are also used for most admitted patient care, outpatient attendances and maternity services, for which unit prices or non-mandatory guide prices are set.

87. The HRG currency design used for the 2022/23 NTPS national prices and unit price is HRG4+ phase 3. HRG4+ is arranged into chapters, each covering a group of similar conditions or treatments. Some chapters are divided into subchapters. The specific design for the 2022/23 NTPS is that used to collect 2018/19 reference costs.

88. The currencies for outpatient attendances are counted based on coding to identify clinical specialty and attendance type, defined by TFC.

5.2 Currencies with national prices

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

90. Annex DtB includes details of the currencies for the following services, which used to have national prices:

- Admitted patient care
- Chemotherapy and radiotherapy
- Nuclear medicine
- Post-discharge rehabilitation
- Direct access

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

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

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

- Cystic fibrosis pathway
- Outpatient attendances
- Looked-after children health assessments

91. The method we use to determine national prices and unit prices is set out in Section 6. The list of national prices, unit prices and related currencies is in Annex DtA.

92. In particular circumstances we specify services in different ways, and attach different prices – for example, setting best practice tariffs (BPTs) to incentivise improved outcomes for particular cohorts of patients. As well as specifying the currencies with national prices and unit prices, this section (in combination with Annexes DtA, DtB and DtC) includes the rules for determining which currencies and prices apply where a service is specified in more than one way.

93. Section 3 sets out the aligned payment and incentive rules. The general local pricing rules are set out in Section 4.2.

Changes to the scope of services with national prices

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

5.2.1 Unbundled diagnostic imaging services

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

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

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

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

Where diagnostic imaging costs remain included in national prices

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

- where the patient data groups to a procedure-driven HRG that would be covered by an aligned payment and incentive agreement (that is, not from HRG4+ subchapter WF)
- where the national price is zero (eg 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).

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

Processing diagnostic imaging data

100. It is expected that providers will use Secondary Uses Service (SUS) submissions as the basis for payment. Where there is no existing link between the radiology system and the patient administration system (PAS), the diagnostic imaging record must be matched to any relevant outpatient attendance activity – for example, using the NHS number or other unique identifier and scan request date. This will enable identification of which radiology activity must and must not be charged for separately. Where the

scan relates to outpatient activity that generates a procedure-driven HRG with a national price, the scan must be excluded from charging.

101. The Terminology Reference-data Update Distribution Service (TRUD) provides a mapping between National Interim Clinical Imaging Procedure (NICIP) codes and OPCS-4 codes. NHS Digital publishes grouper documentation that sets out how these OPCS-4 codes map to HRGs.

102. Note that when using the 'code-to-group' documentation these diagnostic imaging data are subject to 'preprocessing'. This means that some of the OPCS-4 codes relating to scans do not appear on the code-to-group sheet and need to be preprocessed according to the code-to-group documentation. This process will be carried out automatically by the grouper and SUS Payment by Results (PbR). It is necessary to map the NICIP codes to OPCS-4 codes, using the TRUD mapping. In some systems it may be necessary to map local diagnostic imaging codes to the NICIP codes before mapping to OPCS-4.

103. National clinical coding guidance, both for the OPCS-4 codes and their sequencing, must be followed. More than one HRG for diagnostic imaging will be generated where more than one scan has been done, and each HRG will attract a separate price. However, where a patient has a scan of multiple body areas under the same modality, this should be recorded using OPCS-4 codes to indicate the number of body areas and will result in one HRG that reflects the number of body areas involved. This means you would not generally expect more than one HRG for any one given modality (eg MRI) on the same day.[35]

104. A scan will not necessarily take place on the same day as an outpatient attendance. If there is more than one outpatient attendance on the day the scan was requested, and if local systems do not allow identification of which attendance the scan was requested from, follow these steps:

105. If the diagnostic imaging occurs on the same day as the outpatient activity, and there is more than one outpatient attendance, the scan should be

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

assumed to be related to the activity it follows, using time to establish the order of events. If the scan occurs before any outpatient activity on that day, it should be assumed to be related to the first outpatient attendance that day.

106. If the diagnostic imaging occurs on a different day from the outpatient activity, the scan can be assumed to be related to the first attendance on the day the scan was requested.

107. The diagnostic imaging record should be submitted to SUS PbR as part of the outpatient attendance record, and it will generate an unbundled HRG in subchapter RD. SUS PbR will not generate a price for this unbundled HRG if the core HRG is a procedure-driven HRG covered by an aligned payment and incentive agreement (that is, not from HRG4+ subchapter WF).

108. If the diagnostic imaging is not related to any other outpatient attendance activity – for example, a direct access scan or a scan post-discharge – it must be submitted to SUS PbR against a dummy outpatient attendance of TFC 812 Diagnostic Imaging. As outpatient attendances recorded against TFC 812 are zero priced, this will ensure that no price is generated for the record apart from that for the diagnostic imaging activity.

109. If there is a practical reason why it is difficult to submit the diagnostic imaging record as part of an outpatient attendance record – for example, because the scan happens after the flex-and-freeze date for SUS relevant to the outpatient attendance – we recommend a pragmatic approach. For example, the scan could be submitted as for a direct access scan, using a dummy outpatient attendance of TFC 812 Diagnostic Imaging to ensure that no double payment is made for the outpatient attendance.

5.3 Pathway payments

110. Pathway payments are single payments that cover a bundle of services which may be provided by several providers for an entire episode or whole pathway of care for a patient. They are designed to encourage better organisation and co-ordination of care across a pathway and among different healthcare providers. Improving the co-ordination of care, including across different care settings (eg primary, secondary, community services and social care), can improve patient outcomes by reducing complications and readmissions.

111. For 2022/23, there are unit prices in Annex DtA for a pathway-based payment for patients with cystic fibrosis. See Annex DtB for details of the pathway.

112. A pathway-base system has previously been used for maternity services. For details of the pathway, see Annex DtB. For the 2022/23 NTPS, most maternity activity is likely to be in scope of the aligned payment and incentive rules (see Section 3). The document *Guidance on the aligned payment and incentive approach* includes an appendix specifically focussed on payment for maternity services. Unit prices for maternity services are also available in Annex DtA, while non-mandatory guide prices, which can support areas to agree aligned payment and incentive fixed elements, are available in the *Non-mandatory guide prices* workbook.

5.4 Best practice tariffs

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

114. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review.[36] The service areas covered by BPTs are all:

- high impact (that is, high volumes, significant variation in practice, or significant impact on patient outcomes)
- supported by a strong evidence base and clinical consensus on what constitutes best practice.

115. The aim of BPTs is to reduce unwarranted variation in clinical quality and spread best practice. BPTs may introduce an alternative currency, including a description of activities that are associated with good patient outcomes.

116. BPTs provide an incentive to move from usual care to best practice by creating a price differential between agreed best practice and usual care. See Section 6.2.2 for more detail on the method for setting BPT prices.

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

117. Where a BPT introduces an alternative currency for services with national or unit prices, that currency should be used in the cases described below and as set out in Annexes DtA, DtB and DtC.

118. Each BPT is different, tailored to the characteristics of clinical best practice for a patient condition and to the availability and quality of data. However, many BPTs share similar objectives, such as:

- avoiding unnecessary admissions
- delivering care in appropriate settings
- promoting provider quality accreditation
- improving quality of care.

119. Some BPTs relate to specific HRGs (HRG-level), while others are more detailed and relate to a subset of activity in an HRG (sub-HRG). The BPTs that are set at a more detailed level are identified by 'BPT flags'. For sub-HRG level BPTs, there will be other activity covered by the HRG that does not relate to the BPT activity and so a 'conventional' price is also published for 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.

120. Top-up payments for specialised services and long-stay payments apply to all relevant BPTs. The short stay emergency adjustment (SSEM) may apply to BPTs that are in part or in whole related to emergency care.

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

5.5 High cost exclusions

122. Several high cost drugs, devices and listed procedures are subject to special reimbursement arrangements. Their costs are not included in either national prices or unit prices. For some items, their cost may be included in the aligned payment and incentive (see rule 2 in Section 3). For other items, or where an item is used in activity outside the aligned payment and incentive, local prices must be agreed by the commissioner and provider in accordance with rule 3 in Section 4.2.2.

123. The relevant drugs, devices and procedures can be found on the high cost lists in Annex 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 under the aligned payment and incentive.

124. 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.

125. For the 2022/23 NTPS we have updated the lists of high cost drugs, devices and procedures.

126. 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 lists those items whose costs are covered by the aligned payment and incentive fixed element, where that applies.

127. Annex DtA, tab 14c, contains an exclusion list for innovative products to support the MedTech Funding Mandate. These products will be commissioned by local NHS commissioners and reimbursed under local pricing arrangements – provided for in local pricing rule 3 (see Section 4.2.2). As part of these arrangements, NHS England and NHS Improvement Innovation team may publish ‘reference prices’ to be used for some of these listed products.

128. For the 2022/23 NTPS, we have added seven items to the list of innovative products.

6. Method for determining national prices and unit prices

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

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

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

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

6.1 Overall approach

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

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

133. National prices and unit prices for 2021/22 are modelled from the currency design set out in Section 5 of this document, with 2018/19 cost and activity data. The methodology for 2022/23 prices closely follows that used in past national tariffs and, up to 2013/14, by the then Department of Health Payment by Results (PbR) team.[37] Annex DtD contains a step-by-step description of the method we are proposing to use, including details of the changes that have been made to the PbR method.

134. We have continued to use the software package SAS to run the tariff calculation model. We have reviewed and improved the code for the 2022/23 NTPS. This SAS code is available in Annex DtD.

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

6.2 The method for setting prices

6.2.1 Modelling prices for 2022/23

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

- Undertake initial processing work on the model inputs to ensure the accuracy of the data used. This includes applying data cleaning rules, converting from episode to spell and linking episode level PLICS costs to HES (see Section 6.3).
- Determine initial price relativities, using the cost and activity data to calculate average costs for each currency (eg HRG).
- Adjust the price relativities to an appropriate base year. As price relativities are based on 2018/19 cost data, we need to adjust them to the current year

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

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

(2021/22) before we can make any forward-looking adjustments. To do this we adjust the initial price relativities by applying the efficiency, inflation and CNST adjustment factors from the 2018/19, 2019/20 and 2020/21 NTPS. At this point we also reduce all admitted patient care prices by the same percentage (a top-slice) to be reallocated for top-up payments for specialised services (see Section 7.2).

- Make manual adjustments to modelled prices, based on clinical advice, to reduce the number of instances where price relativities are implausible, illogical or distorted (see Section 6.4)
- Apply the first element of the cost base adjustment factors to prices to ensure prices reimburse a total amount of cost equal to the previous tariff (see Section 6.5).
- Use adjustment factors to increase or decrease the total amounts allocated to specific areas (clinical sub-chapters and/or points of delivery), where appropriate, in line with agreed policy decisions or clinical advice and applied using a cash in/cash out approach (see Annex DtD).
- Apply cash in/cash out adjustments to account for changes in high cost drugs and devices lists, and to manage year-on-year volatility of prices (see Annex DtD and Section 6.4).
- Adjust prices to proposed 2022/23 levels to reflect cost uplifts (2.8% – see Section 6.6) and an estimate of the minimum level of efficiency that we expect providers to be able to achieve in 2022/23 (1.1% – see Section 6.7).

6.2.2 Setting prices for best practice tariffs for 2022/23

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

- using the modelled price, without adjustments, as the starting point
- setting a fixed differential between the BPT and non-BPT price (either a percentage or absolute value)
- setting an expected compliance rate that would be used to determine final prices
- calculating the BPT and non-BPT price so that the BPT would not add to or reduce the total amount paid to providers at an aggregate level.

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

139. All BPT prices are included in Annex 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 – 2018/19 PLICS cost data
- activity – 2018/19 Hospital Episode Statistics (HES)[39] and 2018/19 PLICS.

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

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

Cost dataset used

143. We use 2018/19 PLICS cost data for the prices for the 2022/23 NTPS. We use this cost dataset because it is closely aligned with the currency design[40] of the 2022/23 NTPS.

Cost data cleaning

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

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

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

145. We consider that using cleaned data (ie raw reference cost data with some implausible records removed) will, over time, reduce the number of illogical cost inputs (for example, fewer very low-cost recordings for a particular service and fewer illogical relativities). This, in turn, should reduce the number of modelled prices that require manual adjustment and therefore increase the reliability of the tariff. We believe this benefit outweighs the disadvantage of losing some data points as a result of the data cleaning process.

146. The data cleaning rules exclude:

- outliers from the raw reference cost dataset, detected using a statistical outlier test known as the Grubbs test (also known as the 'maximum normed residual test')
- providers that submitted costs more than 50% below the national average for more than 25% of HRGs as well as 50% higher than the national average for more than 25% of HRGs submitted.

147. We merged data where prices would have been based on very small activity numbers (fewer than 50) unless we were advised otherwise by the EWGs. This was done to maintain stability of prices over time. A review of orthopaedic services found that most trusts have small numbers of cases with anomalous costs for the HRG to which they are allocated, and that these costs are often produced by data errors. Small activity numbers increase the likelihood that prices can be distorted by such errors.

148. We also merged data where illogical relativities were found – for example, where a more complex HRG had a lower cost than a less complex HRG.

6.3.2 HES data inputs

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

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

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

6.4 Making post-modelling adjustments to prices

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

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

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

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

155. We also considered clinical feedback we had received on the draft prices for previous tariffs. Where appropriate, we made adjustments to address the comments before seeking feedback on the updated prices.

156. We subsequently shared the prices with the NHS Digital National Casemix Office and with representatives of medical colleges, associations and societies through their respective EWGs.

157. We then manually adjusted the prices based on the feedback received. Adjustments were also made to address illogical relativities across HRGs, and to ensure that prices were reflective of clinical resource requirements.

158. Where manual adjustments increased the total amount allocated to a particular service, these were offset through a reconciliation process that ensures the total amount allocated to each HRG chapter remains consistent (see Annex DtD).

159. However, we have increased the amount of money in the Nuclear Medicine chapter following feedback on the increased cost of importing isotopes.

160. We also used the cash in/cash out process[41] to make adjustments to the initially modelled prices for 52 HRGs and points of delivery. This was done where the initially modelled 2022/23 prices were significantly lower than the 2021/22 NTPS prices and some providers might be disproportionately affected by the changes. The increase in prices was funded by a slight reduction to prices in subchapters with large increases between 2021/22 and the initially modelled 2022/23 prices. For details of the cash in/cash out adjustments, see Annex DtD.

161. These adjustments mean that there is no separate volatility adjustment for 2022/23.

6.5 Cost base

162. The cost base is the level of cost that the tariff will allow providers to recover, before adjustments are made for cost uplifts and the efficiency factor is applied.

163. For 2022/23, we have maintained our historic method for setting the tariff cost base. This equalises the cost base to that which was set in the previous tariff, adjusted for activity and scope changes.

164. As with many other parts of tariff setting, the previous year's tariff is a starting point for the following tariff. As such, we used 2021/22 prices and revenue as

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

our starting point for calculating the cost base for both national prices and unit prices. The cost base for national prices only includes prices for unbundled diagnostic services.

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

166. Information and factors that we considered include:

- historical efficiency and cost uplift assumptions
- latest cost data
- additional funding outside the national tariff (including additional funding for direct COVID-19 costs)
- changes to the scope of the national tariff
- any other additional revenue that providers use to pay for tariff services
- our pricing principles and the factors that legislation requires us to consider, including matters such as the importance of setting cost-reflective prices and the need to consider the duties of commissioners in the context of the budget available for the NHS.

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

- If we set the cost base too low (ie we set too high an expectation that providers will be able to catch up to past undelivered efficiency), providers would be at greater risk of deficit, service quality could decrease below the level that would otherwise apply (eg increased emergency waiting times), and some providers might cease providing certain services.
- However, if we set the cost base too high, commissioners, who have an obligation to stay within their budgets, are likely to restrict the volumes of commissioned services and could cease commissioning certain services entirely. This would reduce access to healthcare services.

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

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

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

6.6 Cost uplifts

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

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

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

6.6.1 Inflation

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

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

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

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

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

Table 4: Elements of inflation in the cost uplift factor

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

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

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

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

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

Pay

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

181. Pay-related inflation has three elements:

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

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

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

Drugs costs

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

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

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

Other operating costs

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

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

Clinical Negligence Scheme for Trusts

189. The CNST is an indemnity scheme for clinical negligence claims. Providers contribute to the scheme to cover the legal and compensatory costs of clinical negligence.[44] NHS Resolution administers the scheme and sets the contribution that each provider must make to ensure the scheme is fully funded each year.

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

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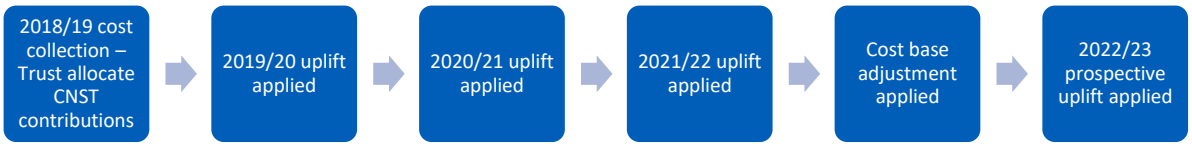
43 The GDP deflator is a broad measure of general inflation, estimated by the Office for Budget Responsibility (OBR). Published at www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2021-budget-and-spending-review

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

45 For example, maternity services have been a major driver of CNST costs in recent years. For this reason, a provider delivering maternity services as a large proportion of its overall service mix would

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

Figure 1: Including CNST in the national tariff



291.

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

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

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

Table 5: CNST tariff impact by HRG subchapter

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.

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

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

195. Providers' costs typically include depreciation charges and private finance initiative (PFI) payments. As with increases in operating costs, providers should have an opportunity to recover an increase in these capital costs.

196. As with pay, drugs costs and other operating costs, we used the 2022/23 GDP deflator rate published in October 2021 (2.7%) to calculate assumed capital cost inflation.

Service development

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

6.7 Efficiency

198. National prices are adjusted up by the cost uplift factor (see Section 6.6), reflecting our estimate of inflation, and down by the efficiency factor, reflecting our estimate of the average efficiency providers can be expected to achieve year-on-year. This approach is consistent with other sectors where prices are regulated centrally. For 2022/23, the efficiency factor applies to national prices and unit prices. It should also be considered as part of aligned payment and incentive agreements (see Section 3) and other local pricing arrangements (see Section 4).

199. The efficiency factor for 2022/23 is 1.1%. The efficiency factor does not reflect changes in costs as a result of COVID-19.

200. In previous years, the decision on the efficiency factor was informed by an econometric model of cost variations between providers over time explained by i) the outputs they produce and ii) factors outside their control. The remaining trend over time is interpreted as trend efficiency. Residual differences between trusts are used to estimate the distribution of efficiency across the sector. The model includes data from 168 acute trusts for the period between 2008/09 and 2017/18.

201. For 2022/23, the model was not run as any updated data would be affected by the impact of COVID-19. Instead, we have used the previous run of the model.

202. This modelling suggested that trusts have become 0.9% more efficient each year on average. Around this trend, we estimate that there is substantial variation in efficiency that could justify an efficiency factor greater than 0.9% (ie if poorer performers, with greater efficiency opportunities, improved their efficiency at a greater rate). For instance, if the average performer catches up

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

to the 60th centile we estimate that this would release 1.4% efficiency in addition to trend efficiency.

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

204. We have set an efficiency factor of 1.1% for 2022/23. We regard this as challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure.

205. As with the cost uplift factor, we have not made an adjustment to the efficiency factor to reflect changes in costs as a result of COVID-19. While we acknowledge that COVID-19 is likely to have a significant impact on the costs of routine healthcare delivery during 2022/23 as a result of the changes to the way many services are delivered, it is not clear to what extent those changes would increase or decrease costs. The efficiency factor reflects pre-COVID activity. Any adjustments would need to be agreed locally between the provider and commissioner.

206. More detail on reimbursement of COVID-19 related costs, and distribution of additional government funding outside the tariff will be included in the 2022/23 Operational Planning Guidance.

7. National variations to national and unit prices

207. In some circumstances, it is appropriate to make national adjustments to national prices. For example, adjustments may reflect local differences in costs that the formulation of national prices has not taken account of, or they may share risk more appropriately among parties.

208. We refer to these nationally determined adjustments as ‘national variations’ to national prices. We refer to the price, after application of national variations, as the ‘nationally determined price’.

209. Specifically, national variations aim to either:

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

210. This section sets out the national variations specified in the 2022/23 NTPS.

211. While national variations apply to services with national prices, they should be considered as part of aligned payment and incentive agreements (see Section 3 and *Guidance on the aligned payment and incentive approach*). When unit prices are being used as part of the variable element or for payments outside the scope of aligned payment and incentive agreements, national variations should continue to be applied to adjust the prices as if they were national prices.

212. For national prices, national variations sit alongside local variations and local modifications. Providers and commissioners should note:

- if a commissioner and a provider choose to bundle services that have a mix of national prices and locally determined prices, national variations can in

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

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

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

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

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

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

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

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

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

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

219. For 2022/23, MFF values for each NHS provider represent the fourth step of this transition. All MFF values for 2022/23 are available in Annex DtA, tab 13.

220. Moving to the third step of the transition further reduces the total amount of money that would have been paid through the MFF if all activity was reimbursed using national prices and unit prices, with compensating increases in the prices. The resulting increase in 2022/23 prices, compared to using 2021/22 MFF values, is 0.38%. Providers and commissioners can consider how to take account of changes in provider MFF values when agreeing their aligned payment and incentive fixed element.

221. The MFF value for independent sector providers should be the MFF value of the NHS trust or foundation trust nearest to the location where the services are being provided.

222. Where NHS providers outsource the delivery of entire services to other providers, consideration needs to be given to the MFF that is applied. For example, if provider A seeks to outsource the delivery of a service to provider B in such a way that the patient is recorded as provider B's activity (ie provider B will bill the commissioner for the activity) but the activity is still delivered at the provider A site, then the relative MFFs of the two providers must be considered:

    - If provider B has a higher MFF than provider A, discussion with the commissioner is needed to agree an appropriate price in the light of the lower unavoidable costs they will incur.
    - Conversely, if provider B has a lower MFF than provider A, discussion with the commissioner is needed to ensure the provider is adequately compensated for the delivery of the service.

223. Organisations merging or undergoing other organisational restructuring after the publication of the 2022/23 NTPS will not have a new MFF set during the period covered by this tariff. For further guidance in these circumstances see the supporting document, *A guide to the market forces factor*.

224. Providers should notify NHS England and NHS Improvement of any planned changes that might affect their MFF value. Contact pricing@england.nhs.uk.

7.2 Variations to reflect patient complexity

7.2.1 Top-up payments

225. National prices and unit prices in this national tariff are calculated on the basis of average costs. This means they do not take account of cost differences between providers because some providers serve patients with more complex needs. The purpose of top-up payments for some specialised services has been to recognise these cost differences and to improve the extent to which prices paid reflect the actual costs of providing healthcare when this is not sufficiently differentiated in the HRG design.

226. Specialised service top-ups have been part of the payment system since 2005/06. The current list of qualifying specialised services, and the design and calculation of specialised top-ups for these services, are informed by research undertaken in 2011 by the Centre for Health Economics at the University of York.[47]

227. Only a few providers are commissioned to deliver such specialised care. The list of eligible providers is contained within the prescribed specialised services (PSS) operational tool.[48]

228. Top-ups are funded through an adjustment (a top-slice) to remove money from the total amount allocated to national prices and unit prices. This money is then able to be reallocated to providers of specialised services.

229. As set out in Section 3, the aligned payment and incentive rules apply to all activity commissioned by NHS England Specialised Commissioning. When agreeing the fixed element, commissioners and providers should consider the top-ups previously received.

230. For 2022/23, the national prices and unit prices have been adjusted by the top-slice, reducing the total amount allocated to prices by £485.9 million. Were the top-ups to be paid through prices, Table 6 shows the amount we have calculated different specialist areas would receive. This includes the second step in the transition of the difference in income for some services as a result

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

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

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 the amounts providers receive may vary.

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

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

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

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

Payment approach for complex knee revision surgery

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

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

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

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

8. Local variations and local modifications to national prices

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

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

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

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

8.1 Local variations

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

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

49 All available from: www.england.nhs.uk/pay-syst/national-tariff/consultation-on-2022-23-national-tariff/
50 All available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/
51 Local variations are covered by sections 116(2) and (3) and 118(4) of the 2012 Act.

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

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

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

8.1.1 Rules for local variations

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

Rules for local variations

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

242. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.[54] They should publish each statement no later

52 The rules in this section are made under the 2012 Act, section 116(2).
53 Available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/
54 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.[55] Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.

243. Commissioners are required to make a written statement of each local variation and submit these to NHS Improvement. Commissioners should use the template provided by NHS Improvement to prepare the written statement.[56] The completed template should be included in the commissioning contract (Schedule 3 of the NHS Standard Contract).

244. NHS Improvement will publish the information submitted in the templates on its Locally determined prices web page so that all agreed local variations are accessible to the public from a single location. Where NHS Improvement publishes the information, it will do so on behalf of the commissioner for the purposes of section 116(3) of the 2012 Act (the commissioner's duty to publish a written statement). Commissioners may take other additional steps to publish the details of the local variations (eg making the written statement available on their own website).

8.2 Local modifications

8.2.1 What are local modifications?

245. Local modifications apply to a single service with a national price. Only unbundled diagnostic imaging services have national prices in the 2022/23 NTPS (see Section 5), meaning that local modifications are not available for any other services.

246. Under the 2012 Act, NHS Improvement is required to publish in the national tariff its methods for deciding whether to approve local modification agreements or grant local modification applications.

247. Local modifications are intended to ensure that healthcare services can be delivered where they are required by commissioners for patients, even if the nationally determined price for the services would otherwise be uneconomic.

55 2012 Act, section 116(3)(b).
56 Available from: www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices/

248. Local modifications can only be used to increase the price for an existing currency or set of currencies. Each local modification applies to a single service with a national price. In practice, several services could be uneconomic as a result of similar cost issues.

249. There are two types of local modification:

- Agreements: where a provider and one or more commissioners agree a proposed increase to a nationally determined price for a specific service. For local modification agreements, NHS Improvement requires commissioners and providers to prepare joint submissions.[57]
- Applications: where a provider is unable to agree an increase to a nationally determined price with one or more commissioners and instead applies to NHS Improvement to increase that price.

250. Local modifications are subject to approval (in the case of local modification agreements) or grant (in the case of local modification applications) by NHS Improvement.[58] To be approved or granted, NHS Improvement must be satisfied that providing a service at the nationally determined price would be uneconomic without the local modification.

8.2.2 Overview of our method for determining local modifications

251. NHS Improvement's method is intended to identify cases where a local modification is appropriate for a provider with costs of providing a service (or services) that are higher than the nationally determined price(s) for that service (or services). Applications and agreements[59] 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

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

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

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

- comply with our conditions for local modification agreements and applications set out in Sections 8.2.4 to 8.2.6.

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

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

8.2.3 Determining whether services are uneconomic

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

- The provider's average cost of providing each service is higher than the nationally determined price.
- The provider's average costs are higher than the nationally determined prices as a result of issue(s) that are:
  - **specific**: the higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable; for example, we would not normally consider an issue to be specific if a large number of providers have costs that are similarly higher than the national price
  - **identifiable**: the provider must be able to identify how the issue(s) it faces affect(s) the cost of the services
  - **non-controllable**: the higher costs should be beyond the direct control of the provider, either currently or in the past. Previous investment decisions that continue to contribute to high costs for particular services may reflect management choices that could have been avoided (for example private finance initiatives – PFI). Similarly, antiquated estate may reflect a lack of investment rather than an inherent feature of the local healthcare economy. In both such cases,

we will not normally consider the additional costs to be non-controllable. This means that higher costs as a result of previous investment decisions or antiquated estate are unlikely to be grounds for a local modification. Any differences between a provider's costs and those of a reasonably efficient provider when measured against an appropriately defined group of comparable providers would also be considered to be controllable. NHS Improvement also considers CNST costs to be controllable and therefore unlikely to be the grounds for a local modification

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

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

8.2.4 Additional condition for local modification agreements

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

8.2.5 Additional conditions for local modification applications

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

- demonstrate it has a deficit equal to or greater than 4% of revenues at an organisational level in 2021/22; see Annex DtF (Section 2.6) for guidance on how providers should calculate deficits for the purpose of this condition

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

- demonstrate that the services are commissioner-requested services (CRS)[61] or, in the case of NHS trusts or other providers that are not licensed, that the provider cannot reasonably cease to provide the services
- demonstrate it has first engaged constructively with its commissioners[62] 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[63] to NHS Improvement
- specify the services affected by the proposed local modification, the circumstances or locations in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the current financial year
- submit the application to NHS Improvement by 30 September 2022, unless there are exceptional circumstances (for example, where there is a clear and immediate risk to patients).

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

8.2.6 Dates

Applications

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

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

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

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

Agreements

262. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate)[64] once they are agreed between the provider and commissioner. If the terms of a local modification agreement are included in the commissioning contract before NHS Improvement approves the local modification, the contract may provide for payment of the modified price pending a decision by NHS Improvement. But if NHS Improvement subsequently decides not to approve the modification, the modification would not have effect and the national price would apply. The provider and commissioner must then agree a variation to the commissioning contract to stop the modification and they may agree a mechanism for adjustment and reconciliation in relation to the period before the refusal, or possibly a local variation to the national price.

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

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

9. Payment rules

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

9.1 Billing and payment

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

9.2 Activity reporting

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

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

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

269. NHS England has approval from the Secretary of State to allow CCGs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online[68] about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

65 2012 Act, section 116(4)(c).
66 https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance
67 https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance
68 See: www.england.nhs.uk/ig/in-val/invoice-validation-faqs/

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