Understanding and using the national tariff

November 2020

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1. About this guide

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

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

This guide describes the tariff up to 2020/21. However, the tariff, and the wider payment system, will continue to evolve. The NHS Long Term Plan sets out the intended direction for the payment system. In particular, the Plan commits to moving away from activity-based payments to ensure a majority of funding is population based, and to introduce blended payment for all services. This guide and supporting material will be updated as developments are made.

In addition, as part of the NHS response to Covid-19, providers and commissioners have agreed block payment arrangements for 2020/21, as a departure from national prices and any national blended payment arrangements. For details of the payment arrangements, see: www.england.nhs.uk/coronavirus/finance/

2. What is the national tariff?

Background

The national tariff is the payment system used by commissioners and providers of secondary healthcare. It sets the prices and rules that commissioners use to pay providers (such as acute hospital trusts) for NHS services; in many cases, this is a price paid for each patient a provider sees or treats but the tariff also supports different payment approaches. Payment is made to the organisation, not to individual departments within a hospital. The tariff accounts for around £76 billion of spending each year and an average of 60% of a hospital trust's income. Other funding streams (such as the commissioning for quality improvement scheme (CQUIN) and the Financial Recovery Fund) operate outside of the tariff as does primary care (GP services, for example – see Services outside the tariff's scope below)

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

PbR was introduced to:

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

The House of Commons briefing paper *NHS commissioning before April 2013* offers a good history of how provider payment was managed from formation of the NHS in 1948 to implementation of the 2012 Health and Social Care Act (2012 Act).

What is the national tariff?

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

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

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

National prices are set according to two principles:

- Prices should reflect efficient costs – this means they should:
  - reflect the costs a reasonably efficient provider ought to incur in supplying services of the quality commissioners expect
  - not fully reimburse inefficient providers.
- Prices should provide appropriate signals by:
  - giving commissioners the information needed to make the best use of their budgets and decide the mix of services that will offer most value to the populations they serve
  - giving providers incentives to reduce their unit costs and find ways of working more efficiently
  - encouraging providers to change from one model of delivery to another where commissioners want this, and patient outcomes are the same or better.

The tariff sets currencies (units of healthcare for which payment is made – see Section 4, Currencies), national prices and national variations to those prices. It also allows providers and commissioners to determine prices locally in different ways (see Locally determined prices below). The NHS Standard Contract, that providers and commissioners must use, allows for national prices, national prices adjusted by a local variation or local modification, or local prices. However, the Contract is not itself a part of the tariff.

The national tariff contains the following 'national' elements. Providers and commissioners are obliged to use national elements unless they agree to vary or modify them using the procedures for local variations or modifications (see Locally determined prices below):

- **national prices** – price a commissioner must use as the basis for paying a provider for a service specified in the national tariff
- **national variations** – adjustments to national prices to either:
  - reflect location-specific costs
  - reflect complexity of patient need
  - support transition to new payment approaches.

The national tariff also contains local pricing rules, including those that apply for blended payments (see below). Providers and commissioners must apply these rules when agreeing local pricing arrangements.

As well as these mandatory elements, NHS England and NHS Improvement publish non-mandatory prices alongside the tariff. Non-mandatory prices are set where data is not robust enough to create a national price and are intended as a guide or benchmark to help set local prices (see also Section 5, Scope).

Blended payments

The NHS Long Term Plan made a commitment to move to a blended payment approach. In 2019/20, blended payments were introduced for emergency care and adult mental health services. In 2020/21, arrangements were also introduced for outpatient attendances and maternity services. However, due to Covid-19, providers and commissioners have agreed block payment arrangements for 2020/21, as a departure from national prices and any national blended payment arrangements. As such, the blended payments for outpatient and maternity services have not been implemented in practice. For more details, see Section 5, Blended payments.

Locally determined prices

Where services do not have nationally-set prices, or providers and commissioners want to move away from them, tariff rules allow local payment approaches to be used instead. The tariff specifies that locally determined prices must:

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

There are three types of locally determined pricing:

- **Local variations** – adjustments to national prices and/or currencies agreed between a provider and commissioner.
- **Local modifications** – increases in national prices for specific currencies where providing the service would otherwise be uneconomic. These can be either an agreement (between provider and commissioner) or application (if agreement not possible, providers can apply to NHS Improvement for a modification).
- **Local prices** – agreed between providers and commissioners for services without a national price, following the tariff's local pricing rules. The national tariff also now includes detailed rules governing blended payments for emergency care services, outpatient attendances and maternity services (see Blended payments in Section 5 for more details).

In addition, some non-mandatory prices are published alongside the tariff. Providers and commissioners can use them if they wish but there must be agreement on both sides. Non-mandatory prices are set for various reasons, for example they are in the process of being developed as national prices, or because they are calculated using alternative data sources. They are used where it is thought they might be helpful for providers and commissioners when agreeing how to fund services.

Full details and guidance on locally determined prices can be found in Sections 6 and 7 and Annex G of the 2020/21 National Tariff.

Services outside the tariff's scope

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

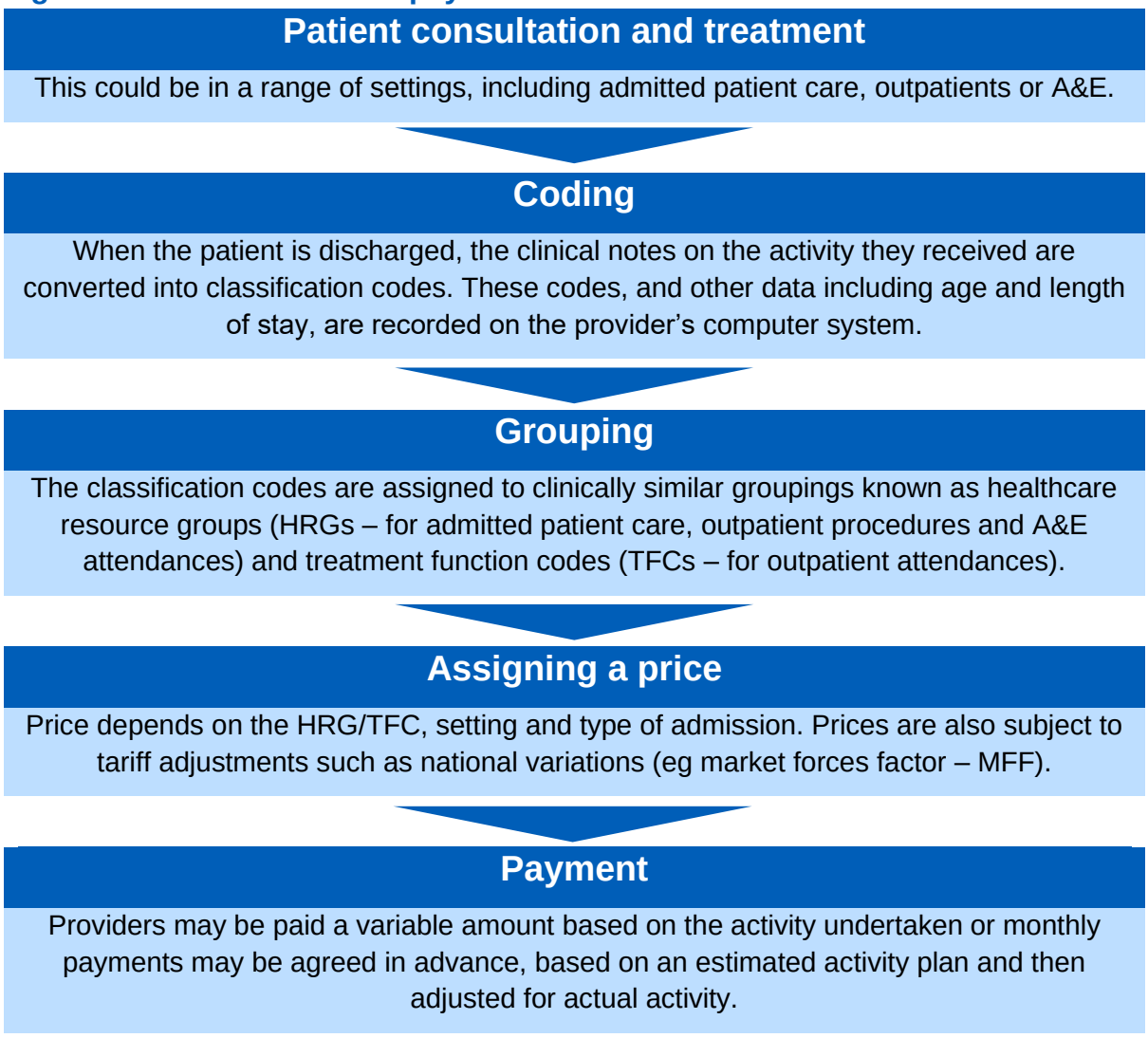
- public health services such as local open access sexual health services, universal health visitor reviews, public health screening programmes, sexual assault services and public health services for people in prisons
- primary care services such as general practice, community pharmacy, dental practice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

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

3. From patient to payment

The national tariff rules and prices can be applied to a range of different payment approaches. This section illustrates one of these approaches – how a national price can be applied to an individual consultation or treatment (summarised in Figure 1). This begins with a patient receiving the consultation or treatment from a healthcare provider. It ends with the commissioner paying the provider.

Figure 1: From treatment to payment



The rest of this section explains each stage in more detail.

Patient consultation and treatment

During a patient's consultation and treatment, clinicians take notes about the care provided and add these to the patient record.

Coding

When a patient is discharged, a clinical coder translates the clinician's notes on the patient record into codes. This allows information about diagnosis (what was wrong) and treatment (what was done) to be documented in a standard format. These codes use two classification systems: ICD-10 for diagnoses and OPCS-4 for procedures (see Section 4, Classification).

The clinical coder enters the codes on the hospital's local information system, often called a patient administration system (PAS). The codes are then stored with other information about the patient such as age and dates of admission and discharge.

Providers submit an extract from their PAS, in a standard format called commissioning datasets (CDS), to a secure national database called the Secondary Uses Service (SUS+) managed by NHS Digital.

Grouping

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

As a result, the national tariff uses healthcare resource groups (HRGs) as the units of healthcare for which payment is made (currencies) for admitted patient care and some outpatient procedures – and for determining the blended payment for A&E attendances. The units used for determining the blended payment for outpatient attendances are treatment function codes (TFCs), which are based on attendance type and clinic type.

HRGs are standard groupings of clinically similar interventions and diagnoses which use comparable levels of healthcare resources. The grouping is done using 'grouper' software, published by NHS Digital. The currencies and software are developed by NHS Digital at the request of NHS England. Section 4 contains more information on currencies and how HRGs are constructed.

HRG4+ is the latest version of the HRG currency design and contains over 2,700 codes. The 2020/21 National Tariff sets prices for over 2,300 HRGs. For the remaining HRGs, it is more useful and appropriate for prices to be set locally.

Assigning a price

National tariff prices are traditionally based on average cost of services reported by NHS providers in the annual reference costs collection. The introduction of best

practice tariffs (BPTs) in 2010/11 signalled the start of some prices being determined by the cost of best clinical practice rather than average cost. Reference costs are being replaced by patient-level cost collections (known as PLICS) and future tariffs will be based on this more detailed, granular cost data.

HRGs provide a currency for payment for the average patient. But some patients' care will vary greatly (for example, an unusually short or long stay in hospital, or because they need more expensive specialised care). Therefore, adjustments are sometimes automatically applied to the tariff, including long stay payments and top-ups for specialised services. Some BPTs also offer additional payments. National variations, such as the market forces factor (MFF), will also change the price a provider receives.

Once the currency has been set, and all applicable tariff policies and local pricing arrangements have been applied, a final price is determined.

Market forces factor – accounting for unavoidable cost differences

Organisations in some parts of the country have higher costs because labour, land and buildings cost more in these areas. The MFF is a national variation to national prices. It is intended to compensate for the unavoidable cost differences of providing healthcare in different parts of the country.

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

The MFF includes both:

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

The national price a provider receives is multiplied by the organisation's MFF value. Provider income under the national tariff can therefore be represented as:

- Provider income = activity x price x MFF

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

Payment

The NHS Standard Contract is published by NHS England. Providers and commissioners must use it when contracting for healthcare services. The contract includes an activity plan stating the expected amount of work, based on a standard currency (eg HRG or TFC) and the price to be paid, based on the national tariff. However, the Contract itself is not part of the national tariff.

Often commissioners and providers will agree an estimated annual contract value, paid in equal twelfths each month, which is adjusted according to actual activity.

4. The building blocks of the national tariff

The national tariff is a data-driven system. To operate effectively, it needs three building blocks, shown in Figure 2.

Figure 2: The building blocks of the national tariff

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

Classification

As mentioned in Section 3 (Coding), when a patient is discharged from hospital, a clinical coder translates the clinician's notes about the patient into codes. This documents the patient's diagnosis and treatment in a standard format. This is necessary for creating clinical data in a format suitable for analysis.

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

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

Grouper software produced by the National Casemix Office at NHS Digital collates diagnosis and intervention codes into HRG codes. See also Coding and Grouping in Section 3.

Currencies

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

The national tariff covers different types of currencies which support different models of service delivery. Currencies can range from block contracts (paying for all activity within a service for a year) to episodic or activity-based payments (where a price is determined for each consultation or treatment). In addition, providers and commissioners can use tariff rules to agree alternative currencies, or variations to national currencies, where needed. New payment models are being developed that are seeking to harness the strengths of various systems and support providers and commissioners in transforming care pathways.

The tariff currently uses HRGs as the currency for admitted patient care and outpatient procedures. HRG prices are also used in the blended payments for emergency care and maternity services. We explain HRGs in more detail below.

The tariff uses treatment function codes (TFCs) to set unit prices that are used in the blended payment for outpatient attendances. TFCs are based on attendance and clinic type or consultant specialty (for example, TFC 130 is for ophthalmology).

How HRG codes are constructed

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

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

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

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

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

Table 1 gives prices for the ED24 root HRG in the 2020/21 National Tariff. This demonstrates how prices differ depending on the split used (reflecting complexity) and whether the care delivered was elective (planned) or non-elective (non-planned).

Table 1: Examples of HRG prices

HRG code	HRG description	Combined day case and elective tariff	Non-elective tariff
ED24A	Complex, Single Heart Valve Replacement or Repair, with CC Score 11+	£14,897	£20,544
ED24B	Complex, Single Heart Valve Replacement or Repair, with CC Score 6-10	£10,755	£16,034
ED24C	Complex, Single Heart Valve Replacement or Repair, with CC Score 0-5	£9,776	£12,688

Cost and activity data

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

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

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

Reference costs also include details of the volume of activity, measured by the number of attendances, bed days, episodes, tests, or other unit of activity appropriate to the service. The national tariff also uses hospital episode statistics (HES) activity data. See Section 6 for details of how tariff prices are calculated.

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

To find out more about patient-level costing, see https://improvement.nhs.uk/resources/transforming-patient-level-costing/

5. Developing the tariff

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

The key aspects of the tariff development cycle are:

- review of current tariff and consideration of aims and objectives for the payment system
- initial price modelling and policy design (using the building blocks described in Section 4)
- draft prices and policy proposals discussed with experts and key stakeholders
- feedback considered and prices and policies refined
- engagement on proposed policies and prices with all interested stakeholders
- further refinement of policies and prices following consideration of feedback
- statutory consultation on proposed tariff policies and prices and assessment of their likely impact
- analysis of feedback before decision to publish final tariff
- publication of tariff, which usually takes effect on 1 April.

Detailed operational guidance is reviewed and updated for each tariff and is a key component of the national tariff package. It describes how national prices should be implemented and the rules for setting prices locally for services that do not have national prices. The current national tariff documents and guidance, including the national tariff workbook (Annex A) which contains the national and emergency care prices, can be found here: https://improvement.nhs.uk/resources/national-tariff/

For each tariff cycle NHS England and NHS Improvement work to review and update the existing tariff to ensure it achieves the intended outcomes. As well as calculating prices (see Section 6), we look at two key aspects – scope and structure:

- Scope means the range of services covered.
- Structure refers to the design of the national tariff to create appropriate incentives and achieve policy goals.

Scope

The national tariff sets national prices for day cases, admitted patient care, some outpatient procedures and some services accessed directly by primary care. The prices are for services carried out for NHS patients by NHS trusts, NHS foundation trusts or independent sector providers.

Prices used to calculate blended payments are not national prices; however, the local pricing rules for blended payments for emergency care and outpatient attendances require that the prices published in Annex A of the national tariff are used to construct the fixed element. In addition, for some other outpatient attendance activity and maternity services, non-mandatory prices are published which can be used in setting the fixed elements in blended payments for these services.

Many services do not have prices published as part of the tariff and providers and commissioners must work together to agree prices for them. The tariff includes rules that apply when a local price is set for services without national prices and for services with a national currency but no national price. As well as local pricing rules for all services, there are specific rules for acute, mental health, community and ambulance services.

Exclusions

Some activity is excluded from national prices and remains subject to local pricing. There are various reasons for this, including:

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

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

Non-mandatory prices

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

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

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

Flexibilities

The national tariff is intended to be a tool, not a straitjacket. It allows providers and commissioners to agree to deviate from tariff prices where the patient and the NHS benefits. See Locally determined prices in Section 2 for more details.

Structure

Elective care

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

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

This means the national price will reward providers achieving higher than average levels of day cases and under-reward providers whose day case rate is lower than

the average. This is because, where clinically appropriate, day cases represent a better experience for the patient and greater value and efficiency to the NHS.

Table 2: Setting a combined day case and elective tariff

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

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

Long stays

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

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

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

Specialised services

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

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

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

Unbundling

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

Unbundled HRGs have been developed for services including chemotherapy, radiotherapy, renal dialysis and critical care. Annex A of the 2020/21 National Tariff contains full details of unbundled HRGs.

Pathway payments

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

- maternity healthcare services (currently non-mandatory)
- healthcare for patients with cystic fibrosis.

Best practice tariffs

Best practice tariffs (BPTs) have been structured and priced to encourage patient care that is both high quality and cost effective. They were introduced in 2010/11 and marked a significant departure from setting national prices based on reference costs. They are intended to reduce unexplained variation in clinical quality and encourage best practice in high volume areas. There are currently 23 BPTs – more information is available in Annex D of the 2020/21 National Tariff.

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

Blended payments

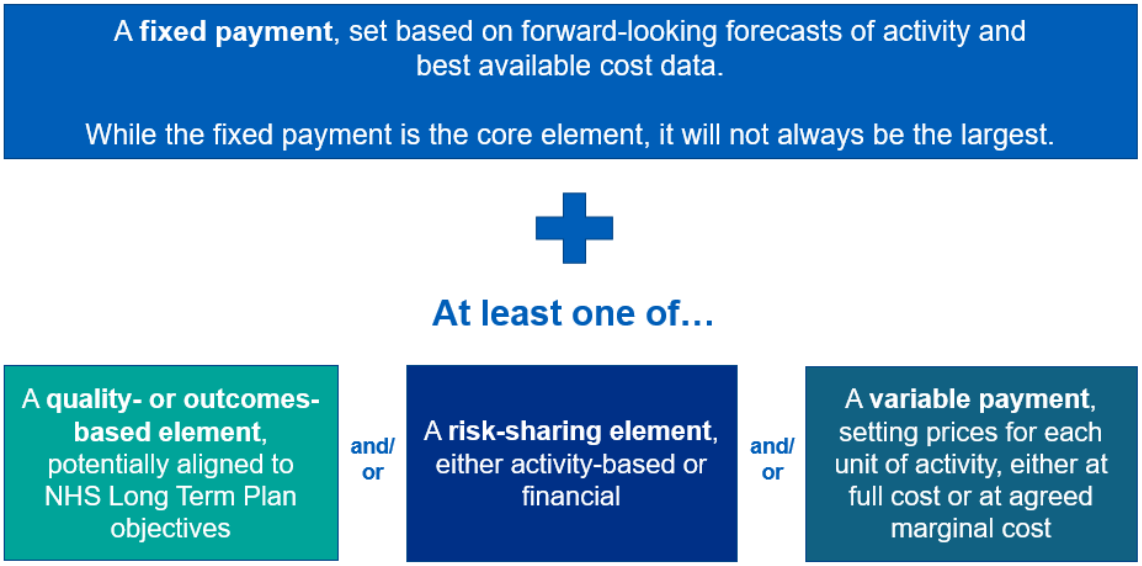
The NHS Long Term Plan commits to introducing blended payments for all services.

Blended payments aim to:

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

Blended payments are made up of a mix of elements, illustrated in Figure 4.

Figure 4: blended payment components



The 2020/21 National Tariff makes blended payment the default payment arrangement for emergency care, adult mental health services, outpatient attendances and most maternity services[1] (although for maternity, local areas can choose to use the maternity pathway payment instead).

For more details on blended payments, and detailed guidance on the specific service areas, *Guidance on blended payments* (a supporting document to the national tariff).

Please note: due to Covid-19, providers and commissioners have agreed block payment arrangements for 2020/21, as a departure from national prices and any national blended payment arrangements. As such, the blended payments have not operated in practice during 2020/21, with blended payments for outpatients and maternity services not implemented at all. Revising the approach to blended payments is being considered for the 2021/22 tariff.

[1] Maternity-related services commissioned by NHS England are not covered by the blended payment.

6. Calculating tariff prices

Since the introduction of PbR in 2003, national tariff prices have been based on reference costs – NHS providers' average unit costs, as collected annually. The logic is that organisations with above average costs will make efficiency savings to reduce their costs in line with the national prices. This, in turn will drive down prices in future years.

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

Figure 5: Development of national tariff prices

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

The price setting process

Calculating prices involves many steps. Full details are available in Section 4 of the 2020/21 National Tariff. The main calculation steps are as follows:

- **Producing draft price relativities**
  We take the latest available reference costs and combine them with the latest available hospital episode statistics (HES) activity data (see Section 4, Cost and activity data) to produce draft price relativities – the relationship between average unit costs for individual currencies. Sources of funding from outside the tariff (eg winter pressures) are removed from the reference costs to ensure they are not reimbursed twice.

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

clinical experts and interested stakeholders. Where illogical prices are reported, these are reviewed and manually adjusted where appropriate.

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

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

Price adjustments: cost uplift and efficiency factors

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

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

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

For the 2020/21 National Tariff, the cost uplift was set at 2.5% and the efficiency factor was 1.1%.

Cost base

The cost base is the level of cost that providers can recover from national prices before adjustments are made for cost uplifts and the efficiency factor. It signifies the total budget allocated to services with national and emergency care prices. The sum of proposed prices and activity should keep within this overall price level.

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

- the existence of different funding sources (such as CQUIN), which mean that trusts can receive clinical income on top of that provided by the national tariff

- the fact that costs will exceed income if providers have not been able to achieve efficiency savings equal to or greater than the efficiency requirement used in the national tariff.

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

Information and factors considered include:

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

7. Find out more

The documents relating to the national tariff currently in effect are available from: https://improvement.nhs.uk/resources/national-tariff/

We regularly provide updates about national tariff and wider payment system developments (https://improvement.nhs.uk/resources/developing-the-national-tariff/).

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

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

8. Glossary of useful terms and abbreviations

The glossary below defines terms relevant to the national tariff.

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

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

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

Blended payment
Blended payment was introduced to move payment away from a purely episodic basis to one that combines both a fixed and a variable component. The aim is to encourage improved partnership working between commissioners and providers.

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

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

CQUIN
CQUIN stands for Commissioning for Quality and Innovation. It is a system that makes a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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