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2023/25 NHS Payment Scheme – a consultation notice

NHS provider payment mechanisms

Guidance on aligned payment and incentive and low volume activity (LVA) block payments

23 December 2022

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1. Introduction

1. The 2023/25 NHS Payment Scheme (NHSPS) contains rules for four payment mechanisms. Two of these – aligned payment and incentive (API) and low volume activity (LVA) block payments – apply to NHS providers only. “NHS providers” refers to NHS trusts and NHS foundation trusts. This document provides additional guidance on API and LVA to support providers and commissioners to implement these rules.

2. We are conscious of the rights of patients enshrined in the NHS Constitution and of our respective responsibilities and duties as set out in the NHS Constitution and related legislation. No API or LVA agreement, or the manner in which participating parties conduct themselves, should infringe or compromise those rights, responsibilities and duties.

3. In addition, the NHSPS states that all payment mechanisms (including API and LVA) should reflect the following payment principles:

   - The payment approach must be in the best interests of patients.
   - The approach must promote transparency and data quality 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 payment approaches.
   - The provider and commissioner(s) should consider how the payment approach could contribute to reducing health inequalities.
   - The provider and commissioner(s) should consider how the payment approach contributes to delivering operational planning guidance objectives.

4. Section 3.1 of the 2023/25 NHSPS document contains more details on these principles.

1.1 Aligned payment and incentive

5. The NHS Long Term Plan committed to moving to blended payment for almost all services. API is a type of blended payment, comprising fixed and variable elements. It was initially introduced in the 2021/22 National Tariff

Payment System (NTPS), although the block payment arrangements introduced as part of the NHS response to Covid-19 meant that it was not used in practice until 2022/23.

6. The main aims of API are to:

   - help systems achieve financial balance
   - not be a barrier to delivering system transformation plans
   - provide a consistent payment model across secondary care services
   - support elective recovery.

7. The two components of API arrangements are:

   - a fixed element, based on funding an agreed level of activity (see Section 3)
   - a variable element, which increases or reduces payment based on the actual activity and quality of care delivered (see Section 4).

8. Both of these components combine to help support the aims set out in paragraph 6. Providers have a portion of their income guaranteed through the fixed element. The variable element then provides further income based on the actual activity undertaken by providers, but can also recoup funding when certain quality-related measures haven't been met, offering fairness to commissioners and the taxpayer (see Section 4).

9. For acute providers, the API approach aims to support the delivery of as much elective activity as is affordable within the NHS settlement. For 2023/25, elective activity[1] will be funded solely through the variable element. This means that activity delivered is funded at 100% of the NHSPS unit price or, where a unit price is not set, a locally agreed price (see Section 4.1). The fixed element therefore does not include elective activity (see Section 3.1).

10. API is designed to support the delivery of system plans and encourage providers and commissioners to collaborate to agree the best way to use the resources available to systems and to remain in financial balance. It provides a consistent approach to paying for both acute and non-acute secondary

[1] 'elective activity' covers elective ordinary and day case, outpatient procedures with an NHSPS unit price, outpatient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery.

healthcare services, helping to address issues associated with a fragmented payment system.

11. Section 4 of the 2023/25 NHSPS sets out the API rules. Sections 2, 3 and 4 of this document provide more details about the API elements.

1.2 Low volume activity (LVA) block payments

12. The LVA block payment was first introduced in 2022/23 as part of the Operational Planning Guidance. It was intended to fund small flows of activity where there was no contractual arrangement between a provider and a commissioner. This means that where the expected annual value of a funding flow was below £500,000, a single fixed value was paid, once, by the ICB to the provider.

13. The fixed value is set by NHS England using a three-year rolling average of SUS activity (for NHS acute trusts) and finance payments data (for NHS non-acute trusts).

14. Implementation of LVA led to a significant reduction in administering these small flows of activity, removing around 500,000 transactions from the system.

15. From 2023, LVA has moved into the NHSPS, with the payment mechanism rules set out in Section 5 of the 2023/25 NHSPS.

16. Section 5 of this document provides more details about LVA arrangements.

2. Aligned payment and incentive – scope

17. API is applicable to almost all services delivered by NHS providers that are within the scope of the NHSPS – that is, secondary care services including acute, maternity, community, mental health and ambulance services.

18. The following table summarises the payment mechanisms within the NHSPS and how they apply:

Table 1 – Payment mechanism categories

Payment mechanism	Applies to
Aligned payment and incentives (API)	Almost all NHS provider relationships with • NHS England for any directly commissioned services; and • with any ICB where the relationship is not covered by LVA arrangements
Low volume activity (LVA) block payments	Almost all NHS provider and ICB relationships for which NHS England has mandated an LVA block payment (this will normally be those with an expected value of annual activity of £0.5m or less, prior to inclusion of any services delegated by NHS England)
Activity-based payment	Services with NHSPS unit prices delivered by non-NHS providers
Local agreement	Activity not covered by another payment mechanism (including non-NHS provider services without NHSPS unit prices and NHS provider activity excluded from API and LVA)

2.1 NHS England commissioned services

19. Almost all NHS England contracts with NHS providers will use API as their primary payment agreement. Certain specialised services are within the scope of API but have their own bespoke payment arrangements. These are:

    - **Radiotherapy** – Fully funded through the API fixed payment arrangements. For 2022/23 we have tried to incorporate radiotherapy into the API variable element to support increases in radiotherapy activity. However, the currencies that are used are still based on the old model of care, pricing each session at a level below what the cost of delivering a new session is.

Therefore, there is no activity-based variable rate for 2023/24, while work is undertaken on the currency model.

- **Chemotherapy** – This will follow the approach for other elective activity, i.e., funded through the variable element. However, as the regimen list has not been updated for a number of years and because new methods are being increasingly used including the expansion of immunotherapy, more activity is defaulting to an HRG[2] which does not have a published unit price. Due to this, an increasing amount of the variable element for chemotherapy activity will need provider and commissioner to locally agree prices which are then paid for each unit of activity delivered for this HRG.
- **Renal transplants, haematopoietic stem cell transplantation (HSCT), Cardiothoracic Transplantation Services, Cardiothoracic Transplantation Services and treatment costs relating to NICE decisions (such as CAR-T)** – where not highly specialised, these services are only delivered by a limited number of centres nationwide. Activity is expected to increase significantly and there are improvements being made to the patient pathway. To support this, these procedures should have locally agreed payment arrangements that have regard to NHS England Specialised Commissioning guidance and detail set out in Annex DpB.
- **Genomic testing** – To support the continued roll out of genomics testing, these services will be funded wholly though the variable element. The provider and commissioner must locally agree a price, which is then paid for each unit of activity delivered.

20. For more details, see Annex DpB and guidance from NHS England Specialised Commissioning.

2.2 Non-NHS providers and the NHS Increasing Capacity Framework

21. Under the NHSPS rules, services with unit prices that are delivered by non-NHS providers would be subject to activity-based payment rather than API. See section 6 of the NHSPS.

22. Therefore, activity contracted under the NHS Increasing Capacity Framework is not covered by API – instead the rules require the use of the unit prices

[2] SB17Z - Deliver Chemotherapy for Regimens not on the National List

published in the NHSPS, subject to any payment rules under the Framework. Where the NHS Increasing Capacity Framework isn't used, the activity-based payment for non-NHS providers applies (see Section 6 of the NHSPS). It is worth noting that the Framework doesn't automatically apply uniformly to specific activity – the same type of activity may be covered by the Framework in one provider but not in another.

23. Similarly, activity which has been subcontracted to another provider also requires the use of the unit and BPT prices published in the NHSPS. For example, when an NHS provider decides, with the agreement of the relevant commissioner, to subcontract some of its elective activity to a non-NHS provider, the commissioner should reimburse the NHS provider using unit prices, rather than API rules.

2.3 CQUIN

24. CQUIN applies to any API arrangement with an expected annual value of £10m or more. The initial API fixed element must assume full achievement of CQUIN metrics and so needs to be increased by 1.25% if CQUIN funding is not already included. Adjustments are made to this through the variable element and based on actual performance against the metrics. Section 4.2 provides more information on CQUIN.

2.4 Best practice tariffs

25. From 2023/24, best practice tariffs (BPTs) will operate differently. There will be two categories of BPT: annual BPTs and elective activity BPTs.

26. For annual BPTs, the level of BPT criteria attainment which the provider is expected to achieve in delivering those services covered by BPTs must be included in the fixed element. Actual achievement of the criteria would then inform the setting of the fixed element in future years, rather than trigger any in-year adjustments.

27. Elective activity BPTs are focussed on elective services. Payment is made based on the actual elective activity undertaken using the BPT unit prices published in Annex DpA. The elective activity BPTs are: endoscopy procedures, pleural effusion, primary hip and knee replacement outcomes,

rapid colorectal diagnostic pathway, and spinal surgery.[3] See Annex DpC for detailed BPT guidance.

2.5 Advice and guidance services

28. Advice and guidance services are a key part of national elective care recovery plans. The fixed element will cover the agreed costs associated with plans for outpatient transformation. This will include the level of advice and guidance activity which should be offered, the appropriate mix of face-to-face and virtual attendances and the shift to patient-initiated follow-up (PIFU) pathways. The variable element also applies to advice and guidance services, with funding increased or reduced based on actual activity undertaken. See Section 4.2 for more details.

2.6 High cost exclusions

29. The costs associated with a range of high cost drugs, devices and listed procedures, and innovative products have historically been removed from unit prices, with exclusion lists published in the NHSPS workbook (Annex DpA, tabs 12a, 12b and 12c). Providers received the funds for these on a 'pass through' or 'cost and volume' basis. The rationale for this is that usage is not necessarily uniform across patients and providers (and so incorporating these costs into prices would likely either under-reimburse or over-reimburse a provider) and that the cost of the excluded item is high compared to the HRG price. This means funding can be volatile with changes in activity.

30. For API agreements, the intention is to get funding directly to providers through the fixed element wherever possible. As such, funding for certain items should be included in the fixed element. These are items where usage is relatively consistent, predictable and less volatile. Other items should be excluded from fixed elements and paid for, according to the local pricing rules, on a cost and volume basis. There is no distinction between commissioners, with the same funding approach applying regardless of whether the item is commissioned by NHS England or an ICB.

31. The list of high cost drugs in Annex DpA, tab 12b, shows items that are excluded from NHSPS prices. Of these items, it also indicates those whose

[3] The spinal surgery BPT operates as an annual BPT for relevant non-elective activity.

funding should be included in the fixed element. Funded high cost drugs which are NICE approved and introduced in-year would be excluded from the fixed element and paid for on a cost and volume basis.

32. For high cost devices, all NHS England commissioned device categories will be excluded from the API fixed element. The reimbursement process, via the High Cost Tariff-Excluded Devices (HCTED) programme, is published under separate guidance. There are then four device categories which are funded by local NHS commissioners and should be excluded from the fixed element. Annex DpA, tab 12a contains the list of excluded high cost devices.

33. The **item costs** for all MedTech Funding Mandate products (Annex DpA, tab 12c) are also excluded from the NHSPS, and funding for these should not be included in the API fixed element. The product should be procured through NHS Supply Chain. Providers and commissioners should be aware of their statutory duties to promote the use of innovative products and services to enhance patient care.

34. The **costs of implementing** the products should be included in the fixed element as this helps ensure savings accrue within the provider. See Appendix 3 for more details.

2.7 Evidence-based interventions

35. The Evidence-Based Interventions (EBI) Programme is a clinical initiative led by the Academy of Medical Royal Colleges (AoMRC). The programme aims to improve the quality of care being offered to patients by reducing unnecessary interventions and preventing avoidable harm. In addition, by only offering interventions on the NHS that are evidence-based and appropriate, the programme frees up resources that can be put to use elsewhere in the NHS.

36. API arrangements should incentivise a reduction in the volume of procedures being undertaken in contravention of the EBI guidance. This should be done by providers and commissioners considering the volume of such procedures being undertaken by the provider and setting the API fixed element at an appropriate, realistic lower level, to reflect an agreed reduction that could reasonably be achieved. This would give the provider an incentive to achieve

a realistic reduction, but without the bureaucracy of individual procedure-level transactions.

37. All up-to-date guidance, resources and programme developments can be found on the AoMRC website.

2.8 Overseas visitors

38. Where an overseas visitor is exempt from charges for NHS hospital treatment, or the NHS hospital service they receive is free, the NHS Who Pays? guidance sets out how the responsible commissioner can be identified.

39. From 2023/24, the risk-share charging rules between trusts and commissioners for non-elective chargeable overseas visitor activity will change. The requirement for trusts to identify chargeable overseas visitors and bill the patient for services used will remain in place and must continue to be a key focus, as per *Guidance on implementing the overseas visitor charging regulations*.

40. The mandatory requirement to collect payment upfront for any chargeable patient that is not in need of urgent or emergency care remains, and overseas visitors should be billed using the NHSPS unit prices (as was previously the case with tariff prices). The rates differ for EEA patients (100% of the relevant unit price) and non-EEA patients (150% of the relevant unit price) – see *Improving Systems for Cost Recovery for Overseas Visitors.*

41. The financial risk of non-payment will continue to be a shared risk between trusts and commissioners**.** In place of the risk-share charging rules for non-elective activity, providers and commissioners must agree annual funding for their shared risk of non-payment as part of setting their API fixed elements. For example, the value could be set based on an historic average rate of non-recovery of patient charges and an agreed rate of income recovery improvement. When agreeing the fixed element, providers and commissioners may wish to consider the element of funding for non-elective chargeable overseas visitor activity which was embedded within previous contract values when these were calculated by NHS England based on 2019/20 payments data during the Covid emergency financial framework.

3. Aligned payment and incentive – fixed element

42. API is comprised of two parts: the fixed and variable elements. The fixed element should be set at a level to include funding for the following items. Please note, this is not an exhaustive list but highlights common categories:

    - an agreed level of acute activity outside the scope of the elective activity variable payment (see section 4.1)
    - maternity, mental health, community and ambulance services
    - expected BPT and CQUIN achievement
    - chargeable overseas visitors
    - CNST contributions
    - homecare services and drugs
    - implementation costs of MedTech Funding Mandate products and models of care.

43. While there is a degree of local freedom in deriving the expected value of the services captured by the fixed element – drawing on clinical expertise, new models of care and up-to-date information – the information provided here aims to guide providers and commissioners to reach an agreed fixed element.

44. The following steps provide a high-level guide for constructing and agreeing the fixed element. The steps calculate a value for a full year. As the NHSPS is set for two years, this final agreed figure for the first year should be rolled forward for the second year, updated to reflect the NHSPS cost uplift and efficiency factors recalculated for 2024/25 using the formula set out in Annex DpD. If an agreement is for provision of services for a period less than 12 months, providers and commissioners should make pro-rata adjustments to reflect the shorter period.

45. Alongside the principles set out at paragraph 3, the fixed element should be:

    - reflective of efficient, expected provider costs – maximising the use of every NHS pound

- used for delivering high-quality services agreed between commissioners and providers – patients receive the best possible care and experience
- adjusted to reflect system planning assumptions – the health of populations is considered and improved.

46. Providers and commissioners should consider using the Core20PLUS5 approach when setting payments to achieve better, more sustainable outcomes and reduce healthcare inequalities.[4] They should consider the climate change and net zero duties set out in Health and Care Act 2022, and their local Green Plan objectives when setting their fixed element. Please see the Net Zero strategy, Delivering a 'Net Zero' National Health Service, for options.

47. We are also developing a series of tools to support setting the fixed element. These include patient-levels cost (PLICS) dashboard that allows ICSs to benchmark and compare costs with their peers, as well as a tool to help develop costed pathways for specific services. These tools will be launched on our FutureNHS workspace and will continue to be updated during the year. Contact pricing@england.nhs.uk for more details.

3.1 Identifying services covered by the fixed element

48. Section 2 describes what should be included within the scope of API agreements and what is to be determined locally.

49. Providers and commissioners must first identify and agree the exact services that the fixed element will cover. This will capture any changes to services based on agreed service transformation plans or in response to COVID-19. For acute providers, elective activity **will not** be funded through the fixed element (see Section 4.1 for details of payments for elective activity). The fixed element will also cover 'business as usual' services, eg running A&E departments, community care home teams, etc, that the provider will carry forward from the previous year.

50. As set out in Sections 2.3, 2.4 and 2.5, funding for BPTs, CQUIN, advice and guidance and certain high cost items are included in fixed payments. CQUIN, elective activity BPTs and advice and guidance are all then subject to the

[4] For more details on ways to address issues around equality and health inequalities, please visit the NHS Equality and Health Inequalities Hub.

variable element, with the provider's overall reimbursement increasing or decreasing based on actual performance (see Section 4).

51. Section 2.7 also describes the Evidence-Based Interventions (EBI) programme, and the expectation that providers and commissioners consider the volume of procedures being undertaken by the provider in contravention of the EBI guidance. They should then set the API fixed element to reflect an agreed reduction in the number of these procedures that could reasonably be achieved.

52. Other activities which are not covered by the fixed element include research grants, private patients or car parking. In addition, Section 2 of the 2023/25 NHSPS sets out the services that are not in scope of the payment scheme.

3.2 Setting the fixed element

53. The API rules state that for any agreement, including the calculation of the fixed element, providers and commissioners should apply the principles for local pricing set out in paragraph 3 (see Section 3.1 of the 2023/25 NHSPS).

54. While there is no prescribed method for setting the fixed element for 2023/24, we encourage providers and commissioners to take a pragmatic approach, such as using fixed element values for 2022/23 and current performance as a starting point and reflecting any other guidance on setting contract values in the 2023/24 Operational Planning Guidance.

55. It is also important that they take into account factors such as:

- inflation
- efficiency
- demand for services
- other funding for specific services
- the expected costs of delivering the elective activity plan
- services changes resulting from system plans
- the overall funding quantum of systems

56. For example, inflation and efficiency adjustments may need to be made to bridge the gap between the source data and the current year.

57. The most recent annual cost adjustments are:

Tariff year	2020/21	2021/22	2022/23	2023/24
Cost uplift factor	2.5%	3.1%	4.7%*	2.9%
Efficiency factor	1.1%	1.1%	1.1%	1.1%

* Cost uplift factor set in November 2022, following adjustments for inflation, pay award and changes to National Insurance contributions.

58. Providers and commissioners should consider whether these national adjustments are appropriate for individual system or organisational circumstances, such as where an organisation's cost base is differently weighted than the NHSPS assumptions. For example, where a provider has a relatively higher proportion of its cost base made up of pay.

59. For acute providers, CNST contributions must also be considered. The cost uplift factor includes unallocated CNST (ie CNST contributions that are not allocated to specific HRG subchapters). However, the fixed element must be uplifted to reflect the CNST HRG subchapter adjustments. Special attention should be given to maternity services to ensure the specific maternity CNST uplift is applied. This is to account for the significant difference between CNST costs relating to maternity services in comparison to non-maternity services. More information on CNST and the HRG sub-chapter figures is available in Section 2.3 of Annex DpD.

60. Providers and commissioners should discuss any changes in MFF values and agree how the effects should be applied to the fixed element value. They should also consider whether other price adjustments, such as specialist top-ups, are already be captured within the data used to calculate the fixed element and if further amendment would be needed.

61. Local plans should highlight any changes to the delivery of services or new models of care, and any anticipated variations in demand from previous years. This should include both national changes (eg changes in funding requirement for services between local NHS commissioners and Specialised Commissioning) and local or system-level plans such as those linked to the Core20PLUS5 approach.

62. The value of the fixed element will also need to give regard to how any additional funding, such as protected funding for mental health services, passes from commissioners to providers.

63. Appendix 1 provides further guidelines on specific items which could be useful when agree the value of the fixed element.

4. Aligned payment and incentive – variable element

64. The variable element is intended to support elective activity, particularly in the context of the elective backlog that has built up during the Covid-19 pandemic, and to reflect the quality of care provided to service users. This section describes how the variable element operates.

4.1 Elective activity

65. The NHSPS can play a key role in supporting elective recovery. The variable element is the sole method for funding elective services. This covers: all elective ordinary and day case, outpatient procedures with an NHSPS unit price, outpatient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery[5]. It does not include outpatient follow up attendances, which are funded through the fixed element.

66. Actual elective activity delivered is paid for at a rate of **100%** of the NHSPS unit price or, where a unit price is not calculated, a locally agreed price. This means that as more elective activity is delivered, the provider receives more funding. There are no payment 'floors', 'ceilings' or marginal rates for this elective activity.

67. The market forces factor (MFF) must be applied to the NHSPS unit price or local price used for the variable element.

4.2 BPTs, CQUIN and advice and guidance

68. The variable element is also used to reflect actual attainment for elective activity BPTs, CQUIN metrics and levels of advice and guidance activity delivered.

69. For BPTs, the variable element only applies to elective activity BPTs (see Section 2.4). Payment is made based on the actual activity undertaken using

[5] To be more specific, "elective activity" means the number of elective spells, first outpatient attendances, outpatient procedures which group to a non-WF HRG with a published HRG price and unbundled diagnostic imaging and nuclear medicine activity.

the BPT unit prices published in Annex DpA. For more information about BPT design and criteria, see Annex DpC.

70. The fixed element must include the 1.25% CQUIN funding to reflect an assumption of full CQUIN attainment.[6] Performance against the CQUIN metrics should then be tracked during the year, with commissioners able to recoup funding where CQUIN metrics are not achieved, for contracts with a value above £10 million. For more information about the CQUIN design and metrics, see CQUIN guidance.

71. Funding for advice and guidance achievement should also be included in the fixed element. The exact level of achievement and the corresponding payment is agreed between the provider and commissioner. Funding should then be paid or deducted for advice and guidance activity that is different to the amount agreed in the fixed element. As this amount is locally agreed, the amount to pay or deduct also needs to be agreed between the provider and commissioner. For more detail about expected levels of advice and guidance services, see the 2023/24 Operational Planning Guidance.

6 Please note: CQUIN funding was transferred into the national tariff in 2021/22, so any tariff or NHSPS prices after this includes CQUIN and no separate adjustment would be required.

5. Low volume activity block payments

72. The 2023/25 NHSPS consultation is proposing that payments for low volume activity (LVA) will form part of the payment scheme from 2023/24. LVA arrangements were first introduced in 2022/23 as part of the Operational Planning Guidance.

73. The approach for 2023/25 largely remains the same as that for 2022/23. The only changes are to update the activity and price data used and, where required, reflect the delegation of certain services from NHSE to ICBs.

5.1 LVA – scope

74. The LVA arrangements cover all clinical services (acute, mental health and community) provided by Trusts, with three exceptions:

- services provided by ambulance trusts, including patient transport services
- non-emergency inpatient out-of-area placements into mental health services where these are directly arranged by commissioners
- elective care commissioned by an ICB where there is no contractual relationship and to allow meaningful choice, including making use of alternative providers if people have been waiting a long time for treatment.

75. Where the LVA arrangements apply, ICBs must pay each trust identified on the LVA payments schedule the calculated amount (see paragraph 78).

76. For those relationships not included on the LVA payments schedule, the NHS Payment Scheme local payment rules apply, and commissioners and providers must agree and sign a written contract. To minimise administrative workload, use of a collaborative contracting approach across ICBs is very strongly recommended; see Contract Technical Guidance for details.

77. LVA arrangements relate solely to ICBs and NHS providers. For all non-NHS providers, commissioners should normally look to agree and sign contracts. However, where there are small volumes of patient activity being delivered by a non-NHS provider which is geographically distant from the commissioner, the parties may choose to operate under existing Non-Contract Activity (NCA) arrangements, as set out in the Contract Technical Guidance. NCA

arrangements may also apply to trust services outside of the scope of LVA as described in paragraph 74 above.

5.2 LVA payment schedule

78. The LVA payments schedule is published in Annex DpA. It identifies those provider/commissioner relationships where, on the basis of historical activity, the annual value of activity for 2023/24 is expected to be below £500,000 (before any delegation of services by NHS England to ICBs). The LVA payments schedule values have been calculated as follows:

    - Acute services – three-year average based on SUS activity from 2018/19, 2019/20 and 2021/22, priced using 2022/23 National Tariff unit prices which have then been uplifted to 2023/24 values. Activity data from 2020/21 has not been used due to the impact of the Covid-19 pandemic.
    - Mental health and community services – as these services are not included fully within SUS, three-year average finance payment data have been used and increased in line with core ICB allocation growth.
    - Where ICBs are taking on delegated NHSE services, the expected value of these service would be added to the initial LVA payment value, covering the services already commissioned by an ICB. However, the LVA threshold would be applied based on the initial LVA payment value only. This could mean that the final LVA value for some provider/commissioner relationships is above the £0.5m threshold (ie LVA for core ICB services + value of delegated services is greater than £0.5m).

79. ICBs should pay the amount included on the LVA payments schedule to the trust in quarter one of 2023/24.

80. Where LVA applies (noting the exceptions at paragraph 74 above), no further payments or amounts should be transacted during 2023/24.

81. The 2023/24 LVA payment schedule values will be updated for each financial year covered by the 2023/25 NHSPS. The values will be updated to reflect the revised cost uplift and efficiency factors calculated by the formula set out in Annex DpD. The revised values will be published as part of an updated NHSPS Annex DpA.

Appendix 1: Further guidance on setting the API fixed element

Table 2 – Guidance on specific items relating to setting the API fixed element

Item	Guidance
Opening baseline	The opening baseline contract value should be rolled forward from 2022/23 (excluding pass-through high cost drugs and devices and SDF), adjusting for any 2023/24 non-recurrent items and full-year effects (eg the employer national insurance contribution rate change). This should include the relevant 2022/23 ERF funding.
Baseline reset	The final baseline contract amendments agreed through the baseline re-set exercise must be applied against the opening baseline such that the funding flows back through the API fixed payment to the trust as intended and in line with the allocation adjustments processed. To assist with this, 2023/24 contract schedules in the planning templates will be pre-populated with the final adjustments. These should not result in any change in activity or performance expectations.
Service changes from 1 April 2023	The cost of service changes from the point of setting the opening baseline should be reflected in amendments to the API fixed payment. The value of such changes should be locally agreed based on a reasonable phasing of expenditure changes.
Additional allocation funding	**COVID:** Funding has changed from a hosted-provider basis to a population basis. All commissioners should reflect this in their API fixed payments with **all trusts**, not just those within their system. To minimise negotiations and expedite the flow of funding to trusts: • ICB inter-system and NHSE England contract arrangements (excluding ambulance trusts) should be uplifted by 0.6% to reflect that COVID-19 funding is now included in allocations on a population basis.

	• ambulance trust contract arrangements should be uplifted by 1.2% to reflect historic COVID-19 funding distribution and that COVID-19 funding is now included in allocations on a population basis. • For intra-system contract arrangements, systems should work collaboratively to understand local service and cost requirements and flow funding appropriately. **Support to underlying capacity recovery:** Commissioner allocations include funding to support the existing acute and ambulance capacity as recovery from COVID continues. All commissioners will need to reflect this in their API fixed payments value with all trusts providing acute and ambulance services, not just those within their system. To minimise negotiations and expedite the flow of funding to trusts: • ICB inter-system and NHS England contract arrangements should be uplifted by 0.9% • For intra-system contract arrangements, systems should work collaboratively to understand local service and cost requirements and flow funding appropriately.
Growth: activity	Commissioner allocations include growth funding for 2023/24. Agreed levels of growth (including ERF growth) should be applied against relevant intra-system, inter-system and NHS England API arrangements. As set out in the NHS Standard Contract, contracts should also consider charge exempt overseas visitor activity, as well as an agreed risk-share for non-payment of chargeable overseas visitor activity. From 2023/24 the nationally mandated episodic charging risk-share terms for chargeable overseas visitors will end. In its place, trusts and commissioners must agree annual funding for their shared risk of non-payment as part of setting their API values in contracts. As an example, the future value could consider the historic rate of non-recovery of patient charges and an agreed rate of income recovery improvement. The API fixed payment change should consider the element of the agreed future funding which is already embedded within the opening baseline.

Growth: inflation net of general efficiency	By default, commissioners and trusts should uplift the fixed payment by the 'Cost uplift factor', 'Efficiency factor' and CNST as set out in the NHS Payment System, unless a locally agreed view of inflationary pressures and efficiency requirements has been established.
Additional efficiency (convergence adjustment)	In addition to the general efficiency factor applied through the NHS payment scheme of 1.1%, additional efficiency ('convergence') has been applied to allocations to bring the quantum back towards affordable recurrent levels. This additional efficiency requirement may be applied as a generic additional efficiency or may be targeted to specific trust API values based on specific efficiency opportunities.
Elective recovery adjustment	The API fixed payment value should be reduced to reflect the 2023/24 elective recovery scheme by removing the value weighted 2023/24 target of (in-scope) elective activity. Further information will be set out in separate elective recovery technical guidance.
Service development funding (SDF)	The API fixed payment should include the agreed level of SDF 2023/24 funding. This should be identified as the full value in the contracts planning tab.
NHS England specialised excluded drugs	The API fixed payment should include the opening 2023/24 baseline value of relevant excluded drugs. This value will be provided through regional commissioning teams. Where actual excluded drug costs exceed the baseline, this will be paid directly from NHS England. The API fixed payment will not include funding for: • Any excluded devices • Certain categories of drug, e.g. CDF, Hep C, innovative medicines fund and treatment costs such as CAR-T

Appendix 2: Maternity services

83. Under the 2023/25 NHSPS, almost all secondary care activity provided by NHS trusts, including maternity services, is covered by API rules. This appendix gives details of how the approach could be applied to maternity services.

84. If a circumstance arises where the API is deemed not suitable, then it is recommend that any activity-based payments for maternity services are based on HRG-level prices, rather than the maternity payment pathway (MPP) prices.

85. Both HRG and MPP prices for maternity services are published in Annex DpA, along with supporting information on factors, definitions and technical information.

Ensuring the fixed element reflects the resource requirements of maternity services

86. The Health and Care Act 2022 sets out planned changes to commissioning arrangements as they are delivered across system footprints by ICSs, which are coterminous with Local Maternity Systems (LMSs). For maternity services, LMSs have been providing place-based planning and leadership across these landscapes for a number of years and are therefore well-placed to support the setting of activity plans and associated payment agreements.

87. For 2023/25, almost all maternity services will be funded through API fixed elements, which is designed to meet the costs of delivering the service plan. Fixed elements can be used to provide certainty, and support planning and forecasting.

88. Fixed elements relating to maternity services should be aligned to Local Maternity System (LMS) plans by supporting the delivery of system objectives, including the training of staff to meet these needs.

89. Section 3 of this document describes in more detail the considerations for agreeing the fixed element. As per paragraph 49**Error! Reference source not found.**, any changes to service models for maternity services between the source data used and what is planned for 2023/24 should be reflected in the

fixed element. This could be changes in the expected level of births, or changes to the configuration of service delivery between providers across a system.

90. The fixed element should also give regard to the Immediate and Essential Actions to Improve Care and Safety in Maternity Services within the Ockenden Report, which includes resourcing Maternal Medicine Networks and Birth-rate Plus. This is also set out in the most recent Priorities and Operational Planning Guidance: Implementation Guidance.

91. Where there is significant uncertainty around expected levels of activity for maternity services and therefore the correct value for payments, a local risk share agreements can be agreed, for example using the model SCFMA.

A note on provider-to-provider maternity payments

92. Under the proposed NHSPS rules for 2023/25, the provider-to-provider payments for maternity services should not be required. Payment approaches should be reflective of the anticipated cost of delivering system plans and should therefore not require intra-provider cross-charging.

Appendix 3: MedTech Funding Mandate and innovation payment policy

MedTech Funding Mandate

93. The MedTech Funding Mandate (MTFM) requires commissioners to fund selected cost saving and clinically effective innovative technologies supported by the policy. The items covered by the MTFM are included in the MedTech Funding Mandate products list in tab 12c of Annex DpA of the NHSPS.[7] These are then excluded from the NHSPS prices as well as from API fixed elements and LVA payments.

94. The item costs of MedTech Funding Mandate products listed in Annex DpA are excluded from fixed payments and reimbursed by local NHS commissioners on a "pass through" or cost and volume approach, from existing allocations. Spectra Optia, which is for the treatment of sickle cell patients, is classed as capital equipment. As such, procuring new devices must be funded by providers, in line with the 2022-25 capital guidance. The MedTech Funding Mandate will instead be used to fund increased activity or service provision. Providers should consult their regional Academic Health Science Network on procuring this technology. All other supported technologies should be funded locally.

95. The products are subject to the NHSPS excluded items pricing rule (see Section 3.4 of the 2023/25 NHSPS), which stipulates that the price the commissioner pays must reflect actual costs, the prices set under any applicable procurement framework or a reference price set by NHS England, whichever is the lowest.

96. To ensure that all costs associated with using the products are reflected in payments, commissioners and providers should consider and agree:

- upfront investment and full cost of implementation
- the profile of cash releasing savings
- the benefits that release capacity
- how benefits to other providers in the same ICS are unlocked.

[7] See also the MedTech Funding Mandate page on FutureNHS

97. When setting fixed payments, providers and commissioners will need to consider the associate implementation costs of the items.

Full implementation costs	Benefit realisation considerations
Set up / upfront investment • business case development • Infrastructure development / adjustment	Are all the benefits accrued to the provider implementing the technologies?
Training	Are all the benefits cash releasing?
Backfill	How will capacity releasing benefits be managed?
Project / data management / reporting	What is the profile of cost savings accrued and how are they evidenced?
Maintenance / calibration of products	How will benefits realisation be managed?
Pathways / estates adjustments	How can services and capacity be best arranged?

98. The fixed element, which will be used to pay for non-product related costs, should be set based on planned activity and best available cost data. This will involve providers and commissioners agreeing all known upfront and implementation costs, ensuring that efficient resource and capacity management are achieved to maximise uptake.

99. Risk sharing agreements or locally designed variable payments could be used to address variations from plans or to incentivise specific areas such as patients' outcomes and data quality, based on local agreement on outcome measures.

Cost effectiveness and expected benefits

100. Commissioners and providers should set out and agree expected cost saving and capacity to be released by planning how services will be delivered by implementing the technology. Providers should monitor the actual outcomes of implementation against these plans.

101. All MTFM supported technologies have NICE guidance which includes tools and resources that can help understand the expected resource impact.

102. Expected benefits from using innovative products may be:

- profiled over a number of years
- a combination of real cash savings and released capacity
- Improved patient outcomes and experience.

Innovation payment policy

103. Innovation payment policy aims to:

- support increased uptake and wider use of approved innovative technologies likely to generate savings on investment
- ensure that a sustainable payment approach is in place and that payments to providers reflect the cost of products and full implementation costs
- support multi-year funding approach as requested by the majority of stakeholders
- ensure that payment rules are efficiently and consistently implemented across healthcare systems, reducing potential inequalities between different areas
- encourage providers and commissioners to work closely together to achieve cultural change and ensure that mandated payment rules are complied with for the benefit of patients.

104. The payment approach for the MedTech Funding Mandate, set out in the previous section, has an important role in delivered these aims.

105. However, for 2023/25, we have also undertaken extensive engagement on how payment policy can best support innovation, in keeping with the NHS Long Term Plan (LTP) commitment to deliver integrated care designed around new models of care, ways of working and digital technology.

106. Innovation payment policy is also being developed to support successful implementation of the innovations listed below. These were chosen following a rigorous selection process against agreed selection criteria.

Innovations	LTP category
Proactive/Anticipatory Care	New model of care/Digital
Hypertension Case Finding	New way of working
Integrated Diabetes model of care	New model of care

Innovations	LTP category
Urgent and Emergency Care system optimisation / Reducing ambulance handover delays	New way of working / best practice
Virtual Consultation (video and telephone hospital appointments)	Digital
Virtual Wards	New model of care/digital

107. Feedback from extensive engagement with relevant NHS England policy leadership and system representatives identified the following key points that should support successful implementation of innovations.

- Commissioners have a legal duty to promote innovation in the provision of health services. They must therefore consider providing appropriate funding for providers wishing to adopt innovation.
- The cost of technologies, software, equipment and devices required to enable innovation should be included in API fixed elements.
- Upfront and full implementation-related costs should be accurately reimbursed through the fixed element. Under API rule 3, providers and commissioner can choose to use a variable element to reflect variation from planned activity or to incentivise uptake above plan levels.
- Providers and commissioner should also consider how best to manage the risk and opportunities associated with innovation, ensuring the financial risk is shared across local partners so that the burden is not on the organisation delivering the service. Whole system focus on collaborative outcomes should be rewarded as financial benefits could be realised in a different part of the system.
- Systems should use the freedom allowed by API to move funding to where it will make the most impact, including in community and primary care settings. This could enable funding a whole pathway, as most innovations include care pathways which extend beyond secondary care services and may involve community, primary care and independent providers
- Funding for innovation should be planned for the long term, where there is enough evidence that specific innovations help achieve better outcomes, enhance service transformation and performance across the system.

108. More details of how payment policy can support these innovations will be available on the Payment System and Costing Support workspace on FutureNHS.

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