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NHS England

2023/25 NHS Payment Scheme (amended)

NHS provider payment mechanisms

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

27 March 2024

This is a supporting document to the 2023/25 NHS Payment Scheme (NHSPS), amended following consultation on proposed amendments. Amendments to the previous 2023/25 NHSPS (v1.1, published in June 2023) are highlighted in yellow in this PDF.

For a full list of amendments, see the NHS Payment Scheme publication page.

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1. Introduction

1. The 2023/25 NHS Payment Scheme (amended) (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, Section 3.1 of the 2023/25 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.

1.1 Aligned payment and incentive

4. 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.

5. 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.

6. 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).

7. Both of these components combine to help support the aims set out in paragraph 5. 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, but can also recoup funding when certain quality-related measures haven't been met, offering fairness to commissioners and the taxpayer (see Section 4).

8. For acute providers, API 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).

9. 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

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[1] See Appendix 4 for full details of the scope of elective activity

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

10. 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

11. The LVA block payment was first introduced in 2022/23. It funds small flows of activity between a provider and a commissioner where historically there has been no contractual arrangement. Where the expected annual value of a funding flow is below £500,000, a single fixed value is paid, once, by the ICB to the provider.

12. 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).

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

14. The LVA payment mechanism rules are set out in Section 5 of the 2023/25 NHSPS.

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

2. Aligned payment and incentive – scope

16. 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.

17. 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

18. 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** – For 2024/25, we have set unit prices for SABR, SRST and SIRT radiotherapy services to allow them to be paid for on a variable basis. Other radiotherapy services continue to be funded through the API fixed payment arrangements.

- **Chemotherapy** – This will follow the approach for other elective activity (ie 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)** – While 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 B.
- **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.

19. For more details, see Annex B and guidance from NHS England Specialised Commissioning.

2.2 Non-NHS providers and the NHS Increasing Capacity Framework

20. 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.

21. Therefore, activity contracted under the NHS Increasing Capacity Framework is not covered by API – instead the rules require the use of the unit prices published in the NHSPS, subject to any payment rules under the Framework. Where the NHS Increasing Capacity Framework isn't used, the activity-based

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

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.

22. 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

23. Following consultation on amendments to the NHSPS, the nationally mandated CQUIN incentive scheme has been paused for 2024/25. As such, no financial adjustments should be made relating to achievement of CQUIN criteria and fixed payments must include the 1.25% funding previously identified for CQUIN.[3]

2.4 Best practice tariffs

24. From 2023/24, there will be two categories of best practice tariff (BPT): annual BPTs and elective activity BPTs. See Annex C for detailed BPT guidance.

25. For services covered by an annual BPT, the level of BPT criteria attainment which the provider is expected to achieve, and associated funding, must be agreed as part of setting 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.

26. 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 A. The elective activity BPTs are: endoscopy procedures,

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[3] Non-mandatory CQUIN indicators for 2024/25 will be published on the Payment system support FutureNHS workspace. Providers and commissioners can locally agree to use these in a CQUIN-like scheme, as a variation to API arrangements.

pleural effusion, primary hip and knee replacement outcomes, rapid colorectal diagnostic pathway, and spinal surgery.[4]

2.5 Advice and guidance services

27. 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 Excluded items

28. The costs associated with a range of high cost drugs, devices and listed procedures, and innovative products have historically been removed from or not included in unit prices, with exclusion lists published in the NHSPS workbook (Annex A, tabs 12a, 12b and 12c). Providers received the funds for these via local agreement, commonly on a ‘pass through’ or ‘cost and volume’ basis. Homecare services (drugs, devices and their related costs) have also been excluded from prices and core payment mechanisms.

29. For API agreements, this approach continues to apply in most circumstances. As API fixed elements are also locally agreed, it makes practical sense to also agree the funding for excluded items within this where possible. Alternatively, it may be more suitable to fund these items on a cost and volume basis. For excluded items, 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. However, where the commissioner is NHS England Specialised Commissioning, a baseline value of excluded drugs is included in API fixed elements. If the actual costs of excluded drugs exceed this baseline value, this will be paid directly by NHS England.

30. The list of high cost drugs in Annex A, tab 12b, shows items that are excluded from API arrangements and unit prices. In 2022/23, a small cohort of high cost

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4 The spinal surgery BPT operates as an annual BPT for relevant non-elective activity.

drugs on this list were to be included in API fixed elements (Annex A, tab 12b, column C). This exception has been removed for 2023/25 so that there is consistency in the approach between API and price-based arrangements.

31. Funded high cost drugs which are introduced in-year are excluded from the fixed element.

32. As all homecare services (drugs, devices and their related costs) are excluded from unit prices – and unit prices are being used for most elective care – it is much simpler to also apply this approach to API arrangements as a whole. This means that funding for homecare services is determined through local agreement. The commissioner and provider must agree whether to include funding for homecare services in the API fixed element or to pay for the items separately. As API fixed elements are also locally agreed, where appropriate, it makes practical sense to have discussions about these values at the same time.

33. 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 A, tab 12a contains the list of excluded high cost devices.

34. The **item costs** for all MedTech Funding Mandate products (Annex A, 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.

35. 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

36. 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.

37. 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.

38. The EBI programme has split procedures into Category 1 interventions (those which should not be routinely commissioned or performed) and Category 2 interventions (those which should only be routinely commissioned or performed when specific criteria are met).

39. For 2024/25, we have introduced zero prices for four Category 1 interventions, which will apply unless the providers have received prior approval from the commissioners. The four procedures are:

- Intervention for snoring (not obstructive sleep apnea – OSA)
- Dilatation and curettage for heavy menstrual bleeding
- Knee arthroscopy with osteoarthritis
- Injection for nonspecific low back pain without sciatica

40. The four procedures group to multiple HRGs. For each of these HRGs, one of two prices could be payable (see Annex A):

- The HRG unit price, which would apply to:
  - activity outside the scope of the EBI programme which groups to the HRG
  - activity within the scope of the EBI programme where there has been prior approval from the commissioners to deliver the activity.
- A zero price, which would apply to activity within the scope of the EBI programme where there has not been prior approval from the commissioners.

41. The clinical codes for the full algorithm used by SUS+ are found in the "Evidence-based Interventions Clinical coding for all interventions" guidance document on the Academy of Medical Royal Colleges website.[5]

42. SUS+ identifies the procedures listed in paragraph 39 as Category 1 interventions and adds two columns to APC spells and full online extracts (and their "plus" equivalents).[6] The columns are:

- Evidence Based Intervention Category
- Evidence Based Intervention Type:

Code	Intervention type description	AoMRC document page reference[7]
A_snoring	Adult snoring surgery	132
B_menstr_D&C	Dilation and curettage for heavy menstrual bleeding	102
C_knee_arth	Knee arthroscopy with osteoarthritis	92
D_low_back_pain_inj	Injections for nonspecific low back pain without sciatica	21

43. Although payment for Category 1 interventions is dependent on commissioner's prior approval, these approvals do not flow to SUS+ so SUS+ will therefore continue to price this activity.

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

2.8 Overseas visitors

45. 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.

5 https://ebi.aomrc.org.uk/resources/ebi-coding/
6 https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance/sus-pbr-reference-manual/evidence-based-interventions
7 References to guidance document published in December 2023 (https://ebi.aomrc.org.uk/resources/ebi-coding/).

46. 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*.

47. 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). Details of the appropriate charging rates are available in *Improving Systems for Cost Recovery for Overseas Visitors*.

48. 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

49. API is comprised of two parts: fixed and variable elements. The fixed element should be set at a level to include funding for the following items.[8] 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 annual BPT achievement.
    - Chargeable overseas visitors (see Section 2.8).
    - CNST contributions, having regard to the specific subchapter costs including maternity (Section 2.3 of Annex D).
    - Implementation costs of MedTech Funding Mandate products and models of care (see Appendix 3).

50. 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.

51. 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 (see Annex D). 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.

52. Alongside the payment principles (see Section 3.1 of the 2023/25 NHSPS and paragraph 3 of this document), the fixed element should be:

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

[8] The fixed payment must also include the 1.25% funding previously identified for CQUIN.

- 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.

53. Providers and commissioners should consider using the Core20PLUS5 approach when setting payments to achieve better, more sustainable outcomes and reduce healthcare inequalities.[9] 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.

54. We have also developed tools to support setting the fixed element. These include an ICS Cost Benchmarking Dashboard that presents patient-level cost data (PLICS) for a whole system, at ICS level. This allows ICSs to benchmark and compare costs with their peers. There is also a tool to help develop costed pathways for specific services. These tools are available on the 'Payment system support' 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

55. Section 2 describes what should be included within the scope of API agreements.

56. 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.

57. As set out in Sections 2.4 and 2.5, funding for BPTs and advice and guidance are included in fixed payments. Elective activity BPTs and advice and

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

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

58. 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 the expected reduction in the number of these procedures.

59. 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

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

61. While there is no prescribed method for setting the fixed element, we encourage providers and commissioners to take a pragmatic approach, such as using fixed element values for 2024/25 and current performance as a starting point and reflecting any other guidance on setting contract values in the Operational Planning Guidance. Appendix 1 provides guidance on specific items which could be useful when agreeing the value of the fixed element.

62. It is also important that providers and commissioners consider factors such as:

- inflation
- efficiency
- demand for services
- other funding for specific services
- services changes resulting from system plans
- the overall amount of funding available to systems.

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

64. The most recent annual cost adjustments are:

Tariff year	2021/22	2022/23	2023/24	2024/25
Cost uplift factor	3.1%	4.7%*	2.9%	1.7%†
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.

† Figure does not include 2024/25 pay awards.

65. 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.

66. 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). The fixed element must also be uplifted to reflect the CNST HRG subchapter adjustments. Special attention should be given to maternity services to ensure the specific maternity CNST uplift (3.8%) is applied. This is to account for the significant difference between CNST costs relating to maternity services in comparison to non-maternity services. For all other HRG sub-chapters, if it is not possible to apply the specific sub-chapter values, a uniform value of 0.01% should be applied. More information on CNST and the HRG sub-chapter figures is available in Section 2.3 of Annex D.

67. 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 how to take account of eligible provider PSS values and whether any other price adjustments are already captured within the data

used to calculate the fixed element and if further amendment would be needed.

68. 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.

69. 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.

4. Aligned payment and incentive – variable element

70. 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

71. The NHSPS can play a key role in supporting elective recovery. The variable element is the sole method for funding elective services. This covers: most elective ordinary and day case spells, outpatient procedures with an NHSPS unit price, outpatient first attendances, unbundled diagnostic imaging and nuclear medicine, and chemotherapy delivery. It does not include outpatient follow up attendances, which are funded through the fixed element. Full details of in-scope and excluded elective activity is given in Appendix 4.

72. Actual elective activity delivered is paid for at a rate of **100%** of the NHSPS unit price or, in the case of first outpatient attendances 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.

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

4.2 BPTs, CQUIN and advice and guidance

74. The variable element is also used to reflect actual attainment for elective activity BPTs and levels of advice and guidance activity delivered. For 2024/25, the nationally mandated CQUIN scheme has been paused, so there are no adjustments to reflect achievement of CQUIN metrics, although ficed payments should include the 1.25% funding previously identified for CQUIN.[10]

[10] Non-mandatory CQUIN indicators for 2024/25 will be published on the Payment system support FutureNHS workspace. Providers and commissioners can locally agree to use these in a CQUIN-like scheme, as a variation to API arrangements.

75. 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 the BPT unit prices published in Annex A. For more information about BPT design and criteria, see Annex C.

76. 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 Operational Planning Guidance.

5. Low volume activity block payments

77. Payments for low volume activity (LVA) form part of the payment scheme from 2023/24. LVA arrangements were first introduced in 2022/23 as part of the Operational Planning Guidance.

78. 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

79. 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.

80. Where the LVA arrangements apply, ICBs must pay each trust identified on the LVA payments schedule the calculated amount.

81. For those relationships not included on the LVA payments schedule, the NHSPS 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.

82. 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 79 above.

5.2 LVA payment schedule

83. The LVA payments schedule is published in Annex A. 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 2023/24 LVA payments schedule values were calculated as follows. For 2024/25, these values were updated to reflect the cost uplift and efficiency factors.

- 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.

84. The values in the LVA payment schedule for 2024/25 are made up of:

- Core LVA services (ie those that were covered by LVA in 2023/24)
- Secondary dental services
- Delegated specialised services (where applicable).[11]

85. Combining these elements into the LVA value means that almost all LVA relationships increase in value, with some moving above the £500k LVA threshold. However, for 2024/25, LVA eligibility remains based on pre-delegation values for almost all relationships. For a small number of relationships (13), we have judged that the value of the relationship means the risk of not having a contract in place is too great and they will therefore require API agreements for 2024/25. Providers and commissioners can also locally agree to move any LVA relationship to an API one if they wish by following the variations process.

86. ICBs should pay the amount included on the LVA payments schedule to the trust in quarter one of 2024/25.

[11] Please note: In addition to the LVA value that should be used for payment, Annex A includes a breakdown of these values for reference.

87. Where LVA applies (noting the exceptions at paragraph 79 above), no further payments or amounts should be transacted during 2024/25.

88. For 2024/25, the 2023/24 LVA payment schedule values have been updated to reflect the revised cost uplift and efficiency factors.

Appendix 1: Further guidance on setting the API fixed element for 2024/25

The following table is also included in the 2024/25 Revenue finance and contracting guidance. Providers and commissioners are advised to consider the following guidelines in establishing their 2024/25 fixed payment values.

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

Item	Guidance
Opening baseline	The opening baseline should be calculated as: • **2023/24 fixed payment value** – this value should not include the value of services on variable terms as defined in the 2023/25 NHS Payment Scheme (NHSPS). It should be adjusted for any non-recurrent and full-year effect items, as well as the items stated in the baseline adjustments section (for example, IFRS 16) • **2023/24 full variable value** – this value should include the relevant proportion of the 2023/24 ERF allocation, which was incorporated into 2023/24 baselines, plus the 2023/24 planned value of chemotherapy delivery, unbundled diagnostic imaging and nuclear medicine Note that this value should not include high-cost exclusions[12] or the 2023/24 value of SDF.
Baseline reset for public health services	The limited public heath baseline contract amendments agreed through the baseline reset exercise must be applied as an adjustment to the opening baseline, such that the funding flows back through the API fixed payment to the trust on a net neutral basis and in line with the processed commissioner allocation adjustments. These adjustments should not result in any additional performance expectations. These values have been pre-populated in planning templates.
Service changes from 1 April 2024	The cost of service changes from the point of setting the opening 2024/25 baseline should be reflected in amendments to the API fixed payment. The value of such changes should be

[12] High-cost drugs, devices and listed procedures, and MedTech Funding Mandate products as set out in Annex A of the NHSPS. These are reimbursable outside of API arrangements, which means they are not included in the fixed or variable element.

Item	Guidance
	locally agreed based on a reasonable phasing of expenditure changes. For elective service changes, the value of any service change should be agreed and adjusted for in this step but will require a consistent and documented locally agreed elective activity target[13] different from the default value published by NHS England.
Growth: activity	Commissioner allocations include growth funding for 2024/25. Agreed levels of growth, including for elective services, should be applied against the opening 2024/25 baseline for relevant intra-system, inter-system and NHS England API arrangements.
Growth: inflation net of general efficiency	By default, commissioners and trusts should adjust the opening 2024/25 baseline value by the cost uplift factor (CUF), general efficiency factor and CNST, as set out in the NHS Payment Scheme, unless a view of inflationary pressures and efficiency requirements has been locally agreed.
Additional allocation funding	**Continued support to underlying capacity recovery** Commissioner allocations include funding to support the existing acute and ambulance capacity as recovery from the COVID-19 pandemic 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). The uplift should only be applied to the fixed payment value of the relevant services (for example, acute and ambulance) and not to the total value of the fixed payment where this includes other services. To minimise negotiations and expedite the flow of funding to trusts: • ICB inter-system and NHS England contract arrangements should be uplifted by 0.6% (to the value of the relevant services within that contract).

13 While commissioner to provider targets can be locally adjusted, the overall commissioner target must remain as defined by NHS England and any service changes should still enable achievement of this target overall.

Item	Guidance
	• For intra-system contract arrangements, systems should work collaboratively to understand local service and cost requirements and flow funding appropriately. **Ambulance funding** In 2023/24, additional capacity funding of £200m was issued to ambulance trusts through their lead commissioner (ICB). For 2024/25, this funding has been recurrently added to ICB core programme allocations on a population basis. This is determined by each ambulance trust's total funding issued to its commissioning ICBs based on the weighted population of the ICBs. A separate schedule has been issued on FutureNHS setting out the required amendments to contracts to ensure that the allocation change has a neutral impact on ambulance trust income. **Other adjustments** Include other relevant allocation baseline adjustments, as set out in the 2024/25 revenue and finance contracting guidance.
Additional efficiency (convergence adjustment)	In addition to the general efficiency factor, additional efficiency ('convergence') has been applied to allocations to move ICBs towards a fair share distribution of resource at the levels affordable within the settlement. This additional efficiency requirement may be applied as a generic additional efficiency to the opening 2024/25 baseline, or targeted to specific trusts for specific efficiency opportunities. • For significant contracts (for example, with trusts in the system or those outside where the relationship is material to both parties), NHS England would expect convergence to be considered in relation to the relative cost of services and addressing situations where services are costing more than is reasonable or justifiable. • Where the contract is small to both parties and the contract is in excess of reasonable levels for the provision commissioned, both parties could agree a pragmatic solution to apply convergence at the level of the commissioner convergence percentage.

Item	Guidance
Adjustment to remove the variable payment element	The payment value should then be adjusted to remove the 2024/25 value of variable payment elements, comprising: • 2024/25 variable baseline being the value weighted 2024/25 ERF target of elective activity (as published by NHS England) • 2024/25 planned value of delivering chemotherapy, unbundled diagnostic imaging and nuclear medicine Further information is set out in the elective recovery technical guidance.
Service development funding (SDF)	Having removed the 2023/24 value of SDF to form the opening baseline value, the API fixed payment should now be adjusted to include the confirmed level of 2024/25 SDF funding. This should be identified as the full value in the contracts planning tab, split between mental health and non-mental health service expenditure.

Illustrative example

Item	Calculation	Illustrative value
Opening baseline	2023/24 fixed payment = £175m 2023/24 SDF to be removed = £25m 2023/24 target ERF (variable) = £45m 2023/24 planned chemotherapy = £2m 2023/24 planned unbundled diagnostic imaging = £3m = £175m – £25m + £45m + £2m + £3m	+£200.0m
Baseline reset for public health services	The public health baseline exercise identifies an additional £5m of costs to include in the fixed payment.	+£5.0m
Service changes from 1 April 2024	An agreed change to a commissioned pathway results in an agreed reduction to the API fixed payment of £2.5m.	-£2.5m
Growth: activity	A general assumption of 2% is used for the purposes of this worked example.	+£4.1m (2% of adjusted opening baseline of £202.5m)
Growth: inflation net of general efficiency	Cost uplift factor (CUF) of +1.7% General efficiency factor of -1.1% Appropriate growth in CNST between 2023/24 and 2024/25. The change for each individual trust will reflect its relative risk factors.	+£1.7m (0.6% net CUF of £206.6m plus £0.5m CNST)
Additional allocation funding	Action adjustment to reflect the additional allocation funding items described in the baseline adjustments section, and the 0.6% uplift for acute and ambulance capacity support.	+£7.5m
Additional efficiency (convergence adjustment)	An example level of additional efficiency requirement of -1.2%.	-£2.6m (1.2% of £215.8m)
Variable payment adjustment	Target level of ERF performance plus agreed other variable elements £52m.	-£52.0m
Service development funding (SDF)	Add confirmed 2024/25 SDF values to the fixed payment.	+26.0m

Total fixed payment for 2024/25 = £187.2m

Appendix 2: Maternity services

89. 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.

90. 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.

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

Ensuring the fixed element reflects the resource requirements of maternity services

92. 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.

93. 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.

94. 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.

95. Section 3 of this document describes in more detail the considerations for agreeing the fixed element. 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.

96. Paragraph 66 also makes clear that the specific CNST sub-chapter value relating to maternity services must be factored in to fixed elements (3.8%).

97. 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.

98. 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

99. Under the 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

100. 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 A of the NHSPS.[14] These are then excluded from the NHSPS prices as well as from API fixed elements and LVA payments.

101. The item costs of MedTech Funding Mandate products listed in Annex A 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.

102. 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.

103. 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.

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

104. 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?

105. 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.

106. 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

107. 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.

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

109. 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

110. 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.

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

112. 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.

113. 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

114. 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.

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

Appendix 4: API variable payment – elective activity definition

116. In the 2023/35 NHSPS, “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.

117. The following defines the activity which forms part of the API elective variable payment.

Elective spells (day case and ordinary) and outpatient procedures

- HRGs in the 2023/25 NHSPS Annex A with a published day case/ordinary elective or outpatient procedure non-zero unit price, apart from termination of pregnancy services (HRGs MA50Z, MA51Z, MA52A, MA52B, MA53Z, MA54Z, MA55A, MA55B, MA56A, MA56B)

  and

- all such spells and procedures, apart from those with the following Treatment Function Codes: 501, 560, 700, 710, 711, 712, 713, 715, 720, 721, 722, 723, 724, 725, 726, 727, 199, 499.

First outpatient attendances

- All first outpatient attendances – WF01B, WF02B, WF01D, WF02D – which do not group to an HRG with an outpatient procedure unit price published in Annex A of the 2023/25 NHSPS

  and

- all such attendances, apart from those with the following Treatment Function Codes: 501, 560, 700, 710, 711, 712, 713, 715, 720, 721, 722, 723, 724, 725, 726, 727, 199, 499.

118. As described in Section 4.1, the reimbursement for elective activity is on a 100% payment by activity basis. Providers will be paid NHSPS prices (adjusted for MFF and PSS top-ups where relevant) for each unit of elective activity they deliver. There is no floor or baseline level of activity funding guaranteed – payment is entirely dependent on actual elective activity delivered.

119. Activity targets will still be set. The table below sets out which types of elective activity contribute to this target and which don't.

Table 3: Funding different elective activity and contribution to activity targets

NHSPS payment, within scope of activity target	NHSPS payment, outside scope of activity target	Within fixed element
Elective ordinary and day case	Chemotherapy	Outpatient follow-ups
Outpatient procedures	Diagnostic Imaging	Critical Care
First outpatient attendances	Nuclear Medicine	Radiotherapy
	Excluded drugs, devices and procedures	Maternity services
		Other activity

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