NHS England

Proposed amendments to the 2023/25 NHS Payment Scheme

Consultation notice

Publication reference:

Contents

About this document

This is the statutory consultation notice for proposed amendments to the 2023/25 NHS Payment Scheme.

The 2023/25 NHS Payment Scheme (NHSPS) came into effect on 1 April 2023 and applies for two years – 2023/24 and 2024/25. However, we are proposing some amendments to the NHSPS for 2024/25. These amendments would be made under Section 114E of the Health and Social Care Act 2012 (the 2012 Act). We have considered the likely impact of the amendments and our assessment is that they are not so significant as to require publication of a new edition of the NHSPS (see 'Expected impact of the proposed amendments' below).

The originally published 2023/25 NHSPS continues to apply. The only changes we are proposing for 2024/25 are the amendments set out in this consultation. Please note:

- Prices and low volume activity (LVA) values for 2024/25 will be calculated using the approach set out in Annex D of the 2023/25 NHSPS and are not subject to further consultation. A prices workbook is not part of this consultation and will be issued separately.
- We are not proposing any changes to the general payment approach used to support elective recovery. As such, commissioners would be allocated their fair share of elective recovery fund (ERF) funding and have an elective activity target set for 2024/25. Providers would be paid for 100% of NHSPS unit prices for all elective activity delivered. However, baselines and targets may be reviewed for 2024/25.

There continue to be two types of NHSPS price:

- **Unit prices**: used for all services within scope of an activity-based payment mechanism and for the aligned payment and incentive (API) elective variable element.
- **Guide prices**: can be used to support local payment arrangements and as a source of benchmarking data.

In addition to the amendments consulted on here, we will also review supporting guidance for 2024/25. We will also use the Payment system support FutureNHS workspace to share helpful resources.

Responding to this consultation

The proposed amendments to the 2023/25 NHSPS are subject to a statutory consultation process as required by the 2012 Act. The statutory consultation period is 28 days, ending on 20 January 2024. However, given the bank holidays for Christmas and New Year, we will continue to consider feedback submitted until midnight at the end of **26 January 2024**. Please submit your feedback through the online survey.

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

Summary of proposals

We are proposing to make the following amendments to the NHSPS for 2024/25. Many of these changes are intended to support delegation of specialised services to ICBs.

The rest of this document describes these proposals in more detail, including the expected impact of the changes. The Consultation Annex workbook contains details of proposed amendments that would be implemented in a spreadsheet.

Amendments to support delegation of specialised services

- Guarantee each specialist provider a minimum level of top-up payment.
- Introduce new unit prices for specialist radiotherapy.
- Convert renal transplant guide prices into unit prices.
- Introduce guide prices for haematopoietic stem cell transplantation (HSCT).

Other amendments

- Reduce the unit prices for two cataract HRGs.
- Pause the nationally mandated CQUIN incentive scheme.
- Ensure payment for some activity covered by the Evidence-Based Interventions programme requires an approved individual funding request (IFR).
- Update the high cost and MedTech Funding Mandate exclusion lists.
- Create a market forces factor (MFF) value for a merged trust.
- Update low volume activity (LVA) values to include delegated services, with LVA eligibility based on pre-delegation values.
- Change the weighting of the pay element of the cost uplift factor to align with the methodology used for education and training tariffs.
- Update the payment principles to ensure providers do not lose income as a result of implementing GIRFT Right Procedure Right Place (RPRP) programme guidance.
- Update the Fragility hip and femur fracture best practice tariff (BPT) criteria to include use of the 4AT screening tool before and after surgery.

Expected impact of the proposed amendments

We have assessed the potential impact of the proposed amendments against the criteria set out in the 2012 Act, for the purposes of determining whether a new edition of the NHSPS would be required. This involved considering the proportion of ICBs and relevant providers affected by the amendments, the likely impact, whether any organisation would be disproportionately affected and if there would be any increase or decrease to prices.

While almost all ICBs and providers would be affected by at least some of the amendments, our assessment is that the impact of the proposed changes would be relatively minor for individual organisations, and no organisations are disproportionately affected relative to the services which are affected by the amendments proposed. The changes to existing prices are considered small within the context of the overall number of prices set. We therefore consider it to be appropriate to amend the NHSPS as the proposed changes are not so significant as to require publication of a new edition.

Proposed amendments to support delegation of specialised services

Guarantee each specialist provider a minimum level of top-up payment

Proposal

We propose that each provider of specialised services is guaranteed a minimum level of elective top-up funding, irrespective of the amount of top-up-eligible activity delivered.

Why we are proposing this amendment

We want to ensure that specialist providers have a baseline level of funding protected. This would help them plan effectively and support changes in service delivery.

Detail

NHSPS prices are calculated on the basis of average costs. This means they do not take account of cost differences between providers, even though some providers serve patients with more complex needs. Only a few providers are commissioned to deliver such care, based on the prescribed specialised services (PSS) definitions provided by NHS England Specialised Commissioning.

The purpose of PSS top-up payments is to recognise these cost differences and to improve the extent to which payments reflect the actual costs of providing specialised healthcare when this is not sufficiently differentiated in the HRG design.

When calculating prices, we make an adjustment (a top-slice) to the total amount of money allocated to unit prices and reallocate this money to eligible providers of specialised services via top-up payments.

In the 2023/25 NHSPS, top-up payments are applied whenever prices are used for relevant elective activity. Providers and commissioners should also consider how to take account of eligible provider PSS values when agreeing their API fixed element relating to non-elective services.

For 2024/25, we are proposing that each specialist provider is guaranteed a level of income from top-up payments for elective activity (a ‘floor value’), as well as earning additional top-up funding where more elective activity is delivered. This would ensure that all providers have a baseline level of funding protected, which will support changes in service delivery. For example, where hub and spoke models are being rolled out, the hub would retain sufficient funding to continue to invest in service transformation activities.

Payment of the top-ups would remain the responsibility of NHS England. Where specialised activity in 2024/25 is paid for by an ICB as a result of delegation, NHS England will pay the corresponding eligible top-up on this activity. A new tab would be added to the 2024/25 Annex A, setting out the floor elective top-up payment amounts for each provider (see Consultation Annex). The values included in the Consultation Annex show the amounts

calculated using 2019/20 activity data and the 2023/24 PSS Tool at 2023/24 price levels. These will be updated for 2024/25, using the latest prices and PSS tool. No provider would lose funding, compared to continuing with the 2023/24 top-up payment approach.

How this amendment would be implemented

A new tab would be added to the 2024/25 Annex A, which would include details of the floor value of elective top-up payments that each specialist provider would receive. See the Consultation Annex.

The API rules would be amended to make clear that the payment of specialist top-ups remain the responsibility of NHS England, even when the core activity has moved to an ICB as a result of delegation. See the revised wording in the table below (Section 8.3).

The published 2023/25 NHSPS would also be amended as follows:

- Section 4, API Rule 2f)i) and Section 8, paragraph 92 – remove references to PSS top-ups being applied when prices are used.
- Section 8.3 – the following paragraph added after paragraph 110:
  - Each eligible provider will receive a specialist top-up payment from NHS England relating to the specialised services they deliver. The top-up payment received will be the maximum of the value of the top-up as earned against eligible elective activity and the floor values as set out in Annex A. The payment of top-ups remain the responsibility of NHS England, even if the specialised activity has been delegated to ICBs.

Create new unit prices for radiotherapy

Proposal

We propose to introduce unit prices for four types of specialist radiotherapy.

Why we are proposing this amendment

We want specialist radiotherapy services to be in scope of API, paid for as part of the elective variable element. This would help ensure the services are appropriately funded following delegation to ICBs.

Detail

Radiotherapy services are currently funded on a variable basis. To support delegation of these services to ICBs, we are proposing to introduce unit prices for four types of specialist radiotherapy.

Type of radiotherapy	Current situation	Proposal
Stereotactic radiosurgery/ radiotherapy (SRS/T)	SRS/T has been contracted on a standalone basis, with contracts ending in March 2024	• Introduce four new local codes for radiotherapy. • Set unit prices based on current cost data.
Stereotactic Ablative Therapy (SABR)	SABR is currently funded on standardised local prices.	• Introduce new local codes for radiotherapy. • Convert the current local prices into unit prices.
Selective Internal Radiation Therapy (SIRT)	SIRT radiotherapy involves four payment parts: • the work up procedure (groups to HRGs with unit prices - YR54A/B/C) • the procedure itself (groups to HRG with unit price – YR57Z) • the cost of microspheres (funded via the specialised services device programme – SSDP) • unbundled radiotherapy, which has a standardised local price (SC28Z).	• Convert the current local price for unbundled radiotherapy (SC28Z) to a unit price.
Brachytherapy	Brachytherapy procedures group to HRGs with unit prices. There is also an unbundled radiotherapy element, which has a standardised local price (SC28Z)	• Convert the current local price for unbundled radiotherapy (SC28Z) to a unit price.

These proposed amendments would be mean these services are in scope of API for all NHS providers, allowing them to be paid for using the unit prices.

How this amendment would be implemented

Tab 4 (Other unit prices) of the 2024/25 Annex A would include unit prices for the following local codes:

- SABR1, SABR HCC
  SABR2, SABR Lung
  SABR3, SABR Oligomets

SABR4, SABR Pancreas
SABR5, SABR Re-irradiation

- SRST1, SRS/T Tier 1
  SRST2, SRS/T Tier 2
  SRST3, SRS/T Tier 3
  SRST4, SRS/T Tier 4
  SRST5, SRS/T Paediatrics
- SIRT1, Selective Internal Radiation Therapy
- BRACH, Brachytherapy High Dose Rate (HDR)
  BRACL, Brachytherapy Low Dose Rate (LDR)

NHS England Specialised Commissioning will publish guidance to accompany the use of the new local codes and prices.

Convert guide prices for renal transplant services to unit prices

Proposal

We propose to convert renal transplant guide prices to unit prices.

Why we are proposing this amendment

We want renal transplant services to be in scope of API, paid for as part of the elective variable element. This would help ensure the services are appropriately funded following delegation to ICBs.

Detail

Renal transplantation is a high-cost surgical service, delivered in a limited number of specialist centres. Activity is expected to increase significantly over the next few years. Renal transplants are currently commissioned by NHS England Specialised Commissioning but are expected to be delegated to ICBs in 2025/26.

Adult renal transplantation is currently covered by a mandated set of HRG codes and guide prices. We are proposing to convert these guide prices into unit prices for 2024/25. We will also create unit prices for paediatric renal transplantation. Following clinical advice, the paediatric price would be 25% increase on the equivalent adult price to reflect additional complexity.

Setting unit prices for these services would bring them into the scope of the API variable element, ensuring there are system incentives to build capacity, support mutual aid and patient choice. In addition, it would ensure that providers are funded for additional activity.

How this amendment would be implemented

Tabs 1, 1a and 1b (APC & OPROC) of the 2024/25 Annex A would include unit prices for the following HRGs:

- Renal transplantation: LA01A, LA01B, LA02A, LA20B, LA03A, LA03B and LB46Z

The guide prices for these HRGs would be removed from tab 8 (Other guide prices).

The phrase 'Renal transplants' would be removed from aligned payment and incentive Rule 4a)i) in the 2023/25 NHSPS.

Section 15 (Renal transplant) of Annex B would be moved to the 'currencies with unit prices' part of the Annex.

Create guide prices for haematopoietic stem cell transplantation

Proposal

We propose to create guide prices for haematopoietic stem cell transplantation (HSCT).

Why we are proposing this amendment

We want to support local areas to agree variable payments for HSCT services. This may be the most appropriate way of paying for these services in the context of delegation and increasing levels of activity.

Detail

As with renal transplantation, HSCT is a high-cost surgical service delivered in a limited number of specialist centres – and activity is expected to increase. HSCT is currently commissioned by NHS England Specialised Commissioning and is expected to be delegated to ICBs in 2025/26.

No prices are currently set for HSCT, which has been reimbursed using local prices. However, HSCT activity can be grouped to 20 specific HRGs which cover the inpatient episode. For 2024/25, we propose to set a guide price for the inpatient spell. This could then become a unit price in 2025/26, with reimbursement of the costs of the stem cell moving to a passthrough basis.

Introducing guide prices would support local areas who chose to reimburse HSCT services on a variable basis.

How this amendment would be implemented

Tab 8 (Other guide prices) of the 2024/25 Annex A would include guide prices for the following HRGs:

- SA19A, SA19B, SA20A, SA20B, SA21A, SA21B, SA22A, SA22B, SA23A, SA23B, SA26A, SA26B, SA27A, SA27B, SA34Z, SA38A, SA38B, SA39A, SA39B, SA40Z

The following footnote would be added to NHSPS, Section 4 (API rules), Rule 4 a)i):

- Guide prices for HSCT services are included in Annex A. These can be used to help local areas pay for these services on a variable basis, as an agreed variation to the API rules.

Other proposed amendments

Reduce the unit prices for two cataract HRGs

Proposal

We propose changing the unit prices for two cataract HRGs (BZ34A and BZ34B) to reflect recent cost data.

Why we are proposing this amendment

We want to ensure that the prices paid for cataract activity accurately reflect the complexity involved.

Detail

The 2023/24 prices for cataract activity are calculated based on 2018/19 NHS cost data. As set out in the consultation on the 2023/25 NHSPS, the cataract prices were manually adjusted to reflect clinical feedback that the cost differential between the more complex and least complex HRG did not accurately reflect the difference in resources required to treat the most complex patients.

We have since reviewed more recent data, including 2021/22 NHS cost data and 2023/24 activity data as reported in SUS. This makes clear that not all of the activity grouping to the more complex HRGs would require additional resource to deliver a cataract procedure. We are therefore proposing to lower the unit prices of BZ34A and BZ34B to reflect the cost differential implied in the 2021/22 cost data.

The 2023/24 unit prices for the three cataract HRGs are:

- BZ34C (Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 0-1) – £860
- BZ34B (Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 2-3) – £1,021
- BZ34A (Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 4+) – £1,021

For 2024/25 we propose reducing the price of BZ34A and BZ34B from £1,021 to £890. BZ34C would remain priced at £860. These would then be adjusted for inflation and efficiency, in the same way as all other prices, for the final 2024/25 prices.

The difference between £890 and £860 (3.4%) is equal to the relative difference between NHS reported costs for these HRGs in 2021/22.

How this amendment would be implemented

The prices for BZ34B and BZ34A would be changed in the 2024/25 Annex A.

Pause the nationally mandated CQUIN incentive scheme

Proposal

We propose pausing the nationally mandated CQUIN scheme for 2024/25.

Why we are proposing this amendment

We want to ensure that incentive schemes are proportionate and effective. We propose pausing the nationally mandated CQUIN scheme while a wider review of incentives for quality is undertaken.

Detail

The CQUIN incentive scheme is intended to support improvements in the quality of services and the creation of new, improved patterns of care. In the 2023/25 NHSPS, the API rules mean that CQUIN funding is part of the variable element. Providers and commissioners agree a fixed element that assumes full achievement of CQUIN criteria, with funding then paid back by providers if they achieve less than this.

We are proposing to pause the nationally mandated CQUIN incentive scheme in 2024/25. This would mean that providers' income associated with CQUIN achievement is not at risk and there is no obligation to repay any amounts if they do not fully achieve CQUIN criteria. CQUIN funding would continue to be included in prices.

We would continue to publish CQUIN indicators as a non-mandatory list that providers and commissioners may choose to use locally. This list would comprise the 2023/24 indicators, along with those that were shortlisted but not used in 2023/24. Providers and commissioners who jointly agree to use these indicators to transact a financial arrangement should follow the API variations process to allow this.

No CQUIN performance data will be collected centrally by NHS England in 2024/25. Where a CQUIN-like scheme has been locally agreed, performance reporting/assessment procedures should be agreed locally between providers and commissioners. This does not impact data collections that are independent of CQUIN but have been used to assess CQUIN performance (such MHSDS).

How this amendment would be implemented

The aligned payment and incentive payment rules for the CQUIN variable payment (2023/25 NHSPS, Section 4, Rule 2 d and Rule 2 f, iii and iv) would be removed. Rules 2 b) and 2e)ii) would be updated to refer to 'fixed payment' rather than 'initial fixed element'. A footnote would be added to rule 2 b) to state that 'The fixed payment must include the 1.25% funding previously identified for CQUIN'.

The reference to CQUIN variable payment in Annex D (Section 2.6, paragraph 49) would be removed. The *NHS provider payment mechanisms* supporting document would also be updated to remove references to the CQUIN variable payment.

Indicators, which providers and commissioners could choose to use in a CQUIN-like scheme as a variation to API arrangements, would be published on FutureNHS.

Ensure payment for some activity covered by the Evidence-Based Interventions programme requires an approved IFR

Proposal

We propose that four procedures within the scope of the Evidence-Based Interventions (EBI) programme should only attract payment when they are accompanied by an approved Individual Funding Request (IFR). To reflect this, we propose setting a zero price for these procedures which would apply when they are not accompanied by an approved IFR.

Why we are proposing this amendment

We want to ensure that the payment system supports the goals of the EBI programme.

Detail

The aim of the EBI programme is to improve the quality of care offered to patients by reducing unnecessary interventions and preventing avoidable harm. In addition, by ensuring that interventions delivered and paid for by the NHS are evidence-based and appropriate, the programme frees up resources that can be put to use elsewhere in the NHS. The 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).

For 2024/25, we are proposing to change the pricing arrangements for four Category 1 interventions:

- 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

These are all procedures that can be readily identified through SUS data. Details of the procedures and the coding used to identify them in SUS data are available in List 1 guidance.

The four procedures group to multiple HRGs. For each of these HRGs, one of two prices could be payable:

- 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 which has an IFR

- A zero price, which would apply to activity within the scope of the EBI programme which does not have an IFR.

These pricing arrangements would apply to all providers.

How this amendment would be implemented

The 2024/25 Annex A would be updated to include the zero prices. A section would be added to Annex B to give details of how the prices should be used. The *NHS provider payment mechanisms* guidance document would also be updated.

Update excluded items lists

Proposal

We propose updating the high cost drugs, high cost devices and MedTech Funding Mandate excluded items lists.

Why we are proposing this amendment

We want to ensure that the lists of excluded items are kept as up to date as possible and minimise risks of confusion between multiple lists.

Detail

We are proposing to update the high cost drugs, high cost devices and MedTech Funding Mandate lists of items that are excluded from core payment mechanisms (subject to the NHSPS Excluded items pricing rule).

For 2024/25, we are proposing to add one item to the MedTech Funding Mandate. We have also reviewed the lists of high cost drugs and devices. This has involved running a nominations process, where stakeholders could submit requests for additions or removals from the lists, as well as horizon scanning to identify new items that might come to market during 2024/25.

For the high cost drugs list, there were nominations for 18 items to be added and one item to be removed. For the high cost devices list, there were nominations for 33 items to be added and one item to be removed. The nominations and findings of the horizon scanning were discussed with the NHS England High Cost Drugs Steering Group and High Cost Devices Steering Group, who provided recommendations.

Following these meetings, and in line with the advice of the steering groups and Specialised Commissioning, we are proposing to:

- add 14 drugs to the high cost drugs list – seven of these were nominated and seven arose from the horizon scanning process

- add nine devices to the high cost devices list – seven of these are subject to a new specialised commissioning process which is in development for a small number of specified devices which have a NICE IPG recommendation of Special Arrangements. These devices will only be reimbursed in specific circumstances through the SSDP programme. The process will include further analysis on cost effectiveness for the NHS and will involve a prioritisation process.

We are also proposing to update the high cost drugs list so it aligns with the Specialised Commissioning high cost drugs list, ensuring consistency and avoiding confusion between the different lists. This would involve adding:

- named cancer drugs
- advanced therapy medicinal products (ATMP).

These changes would add a large number of drugs to the list. However, these are items that were previously covered by a category description so does not change the reimbursement for the items listed. Including these items would also remove the need to distinguish between 'Individual' and 'Group' exclusions, so we propose removing the column that included those details. See the Consultation Annex for the proposed updates.

For devices, the steering group recommended clarifying which devices are subject to special arrangements (eg when used for research). These details would be included in Annex A, tab 12a (HC devices). See the Consultation Annex for the proposed updates.

As prices for 2024/25 will be calculated by updating the 2023/24 prices for inflation (as set out in Annex D), we are not proposing any changes to the exclusion lists that would require changes to price relativities.

How this amendment would be implemented

The exclusion lists in the 2024/25 Annex A workbook would reflect these proposed amendments. See the Consultation Annex for details.

Set MFF value for merged trust

Proposal

We propose to set a new MFF value to reflect a merger of two NHS trusts that has been confirmed since the 2023/25 NHSPS was published.

Why we are proposing this amendment

We want to ensure up-to-date MFF values are available for newly merged organisations.

Detail

The MFF aims to compensate providers for unavoidable cost differences in providing healthcare services. Unavoidable costs include variations in capital and building costs, business rates and labour costs.

Every NHS trust and foundation trust is set an MFF value. Paragraph 104 of the 2023/25 NHSPS states that:

> *Organisations merging or undergoing other organisational restructuring after the publication of the 2023/25 NHSPS will not have a new MFF set during the period covered by this payment scheme.*

However, we are proposing to amend the list of MFF values in the 2024/25 Annex A to include new MFF values to reflect a merger that has taken place since the publication of the 2023/25 NHSPS – Mersey & West Lancashire Teaching Hospitals NHS Trust, resulting from a merger between St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust.

The new value would be calculated using the process described in Section 5.1 of A guide to the market forces factor. We have shared the value with the merged organisation and confirmed how it has been calculated.

This amendment would not change the MFF values used by independent sector providers. Where the merger means a non-NHS provider has a different NHS organisation as its nearest for MFF purposes, they should continue to use their MFF value as calculated for 2023/24.

How this amendment would be implemented

The MFF values in tab 11 of Annex A would be updated to contain the following value:

- Mersey & West Lancashire Teaching Hospitals NHS Trust: 1.030819

The values would be removed for St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust as these organisations have been replaced by Mersey & West Lancashire Teaching Hospitals NHS Trust.

No other MFF values would be changed.

Paragraph 104 of the NHSPS would be updated to state that no new MFF values would be set during the payment scheme period without consultation.

Update LVA values to include delegated services

Proposal

Add the value of delegated services to LVA values, with LVA eligibility based on pre-delegation values.

Why we are proposing this amendment

We want to maintain the reduction in the number of transactions that LVA arrangements have achieved, despite delegation of services increasing the values of many ICB-provider relationships.

Detail

The LVA arrangements introduced in the 2023/25 NHSPS mean that, for every ICB/provider relationship listed in the LVA schedule (published in Annex A), the commissioner should pay the specified amount. As described in Annex D of the 2023/25 NHSPS, the LVA values for 2024/25 will be revised to reflect the application of the cost uplift and efficiency factors.

For 2024/25, a number of specialised services currently commissioned by NHS England are expected to be delegated to ICBs. This would mean additional services are part of ICB/provider relationships currently assigned as LVA.

We are proposing to update LVA values to reflect this delegation of services, and the already delegated secondary dental services, to avoid the need to pay for all delegated services via another method. Details of the updated LVA values are available in the Consultation Annex. The values in the annex are based on 2023/24 figures. The 2024/25 values will reflect the new cost uplift and efficiency factors and will be published in the 2024/25 Annex A.

Almost all LVA relationships would increase in value, with some moving above the current £500k LVA threshold. We propose that LVA eligibility remains based on pre-delegation values (ie current LVA relationships would remain in place). For a small number of relationships (26), we have judged that the value of the relationship means the risk of not having a contract in place is too great. These relationships, which were LVA arrangements in 2023/24, would require API agreements for 2024/25. Appendix 1 lists the relationships affected and the values that would have applied for an LVA arrangement (based on 2023/24 figures). These values would be updated for 2024/25, along with the LVA values for all other relationships, and would be included in Annex A so they are available for reference. Providers and commissioners can also locally agree to move any LVA relationship to an API one if they wish.

Should the delegation of specialised services to ICBs not go ahead, the relevant amounts would be removed from the LVA values (ie, the amount proposed to be delegated would be removed and the LVA value would comprise the 'core' and secondary dental values). In this situation, any ICB/provider relationship proposed to move to an API agreement would revert to being an LVA arrangement.

How this amendment would be implemented

The LVA values in the 2024/25 Annex A workbook would reflect the proposed amendment, with values increased to reflect all delegated services.

Appendix 1 lists the relationships that would not have an LVA value and would be require an API agreement instead. The 2024/25 LVA schedule published in Annex A would reflect these changes.

Change the weighting of the pay element of the cost uplift factor

Proposal

Change the weighting of the pay element of the cost uplift factor so it is consistent with the methodology used for education and training (E&T) tariffs.

Why we are proposing this amendment

We want to ensure that the same cost uplift factor can be used for the NHSPS and E&T tariffs.

Detail

The cost uplift factor (CUF) is an estimate of inflation, calculated by combining a number of different inflation estimates (eg pay, drugs, etc). The CUF calculation method is set out in Annex D of the 2023/25 NHSPS.

For 2024/25, we are proposing to make a minor amendment to the way we weight the pay inflation figure.

In general, pay inflation assumptions in E&T tariffs have not weighted pay awards by staff group. In the August 2023 update to reflect pay awards, when there was a higher pay award for medical than Agenda for Change staff, the CUF weightings needed to be amended to prevent the salary contribution through E&T tariffs to be diminished due to the estimate of inflation. However, the CUF weights used to calculate the NHSPS 'pay award prices' were kept the same as those used in the 2023/25 NHSPS.

We are therefore proposing to change the weighting of the CUF used in the NHSPS so it aligns with the way that E&T tariffs are calculated.

This change would have a minor overall effect on the CUF value. A comparison of the two methods using 2023/24 data showed that the CUF was unaffected to one decimal place. The actual difference for 2024/25 will depend on the relative value of medical vs Agenda for Change pay, as well as pay vs non-pay estimates. However, it is anticipated to be small.

How this amendment would be implemented

The revised weighting would be described in Annex D, Section 4.1, and Table 3 (elements of inflation in the cost uplift factor) would be updated. The updated cost uplift factor would be used to calculate 2024/25 prices and LVA values.

Support the GIRFT Right Procedure Right Place programme

Proposal

Update the 'Best interest of patients' payment principle to ensure providers and commissioners take account of the benefits of treating patients in less intensive settings

when agreeing their payment arrangements. This includes implementing GIRFT Right Procedure Right Place (RPRP) programme guidance.

Why we are proposing this amendment

We want to ensure that providers do not face any financial barrier to implementing RPRP recommendations.

Detail

GIRFT's drive to help providers move more appropriate procedures out of traditional operating theatres and into alternative settings, such as minor procedure rooms, outpatients or in the community, is supported by their Right Procedure, Right Place (RPRP) workstream. As well as being more cost effective, it is also a better experience for patients.

Providers involved in the programme have raised a concern that they will lose out financially if they move activity from a day case to an outpatient setting due to the price differential between the two settings. To address this issue, we propose updating the 'Best interest of patients' national payment principle so that providers and commissioners need to take into account any negative financial impacts on providers from shifting activity to less intensive settings, for example from moving day case activity to outpatients as part of the RPRP programme.

We considered either calculating new outpatient procedure prices, or setting the outpatient procedure price at the same level as day case prices. However, calculating new prices for these services would affect other price relativities, while matching the day case prices for services where there is already a significant amount of outpatient activity could lead to an unwarranted financial pressure. In future years we will look to develop new unit prices for this activity once we have a better understanding of the activity and cost data.

How this amendment would be implemented

The following paragraph would be added to Section 3.1.1 (Best interest of patients) of the NHSPS, after paragraph 49.

"Where activity can be better delivered in a less intensive healthcare setting, and this is in the best interests of patients, providers and commissioners should consider the financial implications of such a movement of activity. For example, activity identified by the GIRFT Right Procedure Right Place programme may involve activity switching from a day case setting to an outpatient setting. The financial effect of this should be explicitly considered. This includes potentially neutralising the financial effect on the provider where they would lose funding as a result of different unit prices for the activity."

Update fragility hip and femur fracture BPT

Proposal

We propose amending the fragility hip and femur fracture best practice tariff (BPT) so the criteria include use of the 4AT screening tool before and after surgery.

Why we are proposing this amendment

We want to ensure the BPT reflects the latest clinical advice.

Detail

The fragility hip and femur fracture BPT aims to promote best practice in the care and secondary prevention of fragility hip and femur fractures. The BPT was initially introduced in 2011. In 2017, it was updated to include a requirement for patients to be assessed for delirium in the 72 hours after surgery, using the 4A test (4AT). However, clinical advice is that current best practice is to use the 4AT for both admission and post-operative assessments – something that the current BPT does not reflect.

As such, we are proposing to amend the BPT criteria so that a 4AT assessment is required both before and after surgery. This change would encourage units to deliver current best practice without affecting their attainment of the BPT. As the 4AT assessment is currently required post-surgery, providers are already familiar with the tool. Clinical advice suggests that the marginal costs of making the change would be minimal.

How this amendment would be implemented

The Fragility hip and femur fracture BPT criteria in Section 14.2 of Annex C would be updated. This would involve the following changes to the bullet points under paragraph 212:

- Replace ‘abbreviated mental health test’ with ‘admissions assessment using the 4AT screening tool’.
- Replace ‘a delirium assessment using the 4AT screening tool during the admission’ with ‘a repeat delirium assessment using the 4AT screening tool following surgery’.

Longer-term payment development

This consultation notice looks solely at proposed amendments to the 2023/25 NHS Payment Scheme. This will continue to remain in force, with prices and LVA values updated for 2024/25 using the approach set out in Annex D.

For 2025/26, we expect to produce a new edition of the NHSPS, with a full consultation. This would also involve recalculation of prices, based on new cost and activity data.

We are already working to develop policies for 2025/26, including in areas including:

- currencies for non-acute services
- payment for specialised services
- fixed payments.

We will also continue to develop tools and products to support implementation of payment rules. Our ICB PLICS Benchmarking Tool is already available and allows systems to look at cost and activity data at an ICB level.

If you would like to hear more about these developments, and opportunities to get involved, please sign up to join our mailing list. You can also contact pricing@england.nhs.uk if you have any questions about the payment system.

Appendix 1: Provider/commissioner relationships moving from LVA to API

We propose the following ICB-Trust relationships move from their current designation as an LVA relationship to requiring a contractual agreement applying the API rules. Please note: these LVA values are for information only as they may be useful for API agreements. They are currently based on 2023/24 figures. The values will be updated to reflect the 2024/25 cost uplift and efficiency factors.

Trust Code	Trust Name	ICB Code	ICB Name	LVA calc (£,000)
RBS	Alder Hey Children's NHS Foundation Trust	QNC	NHS Staffordshire and Stoke-On-Trent ICB	3,329
R1H	Barts Health NHS Trust	QOX	NHS Bath and North East Somerset, Swindon and Wiltshire ICB	2,314
R1H	Barts Health NHS Trust	QMM	NHS Norfolk and Waveney ICB	2,173
RYW	Birmingham Community Healthcare NHS Foundation Trust	QWU	NHS Coventry and Warwickshire ICB	2,103
RQ3	Birmingham Women's and Children's NHS Foundation Trust	QK1	NHS Leicester, Leicestershire and Rutland ICB	2,125
RV3	Central and North West London NHS Foundation Trust	QXU	NHS Surrey Heartlands ICB	1,940
RWH	East and North Hertfordshire NHS Trust	QU9	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	2,311
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QU9	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	5,887
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QMM	NHS Norfolk and Waveney ICB	5,109
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QJG	NHS Suffolk and North East Essex ICB	4,923
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QNX	NHS Sussex ICB	4,697
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QUE	NHS Cambridgeshire and Peterborough ICB	4,311
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QNQ	NHS Frimley ICB	3,836
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QXU	NHS Surrey Heartlands ICB	3,685
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QPM	NHS Northamptonshire ICB	2,855
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	QRL	NHS Hampshire and Isle of Wight ICB	2,001
RJ1	Guy's and St Thomas' NHS Foundation Trust	QMM	NHS Norfolk and Waveney ICB	2,710
RJ1	Guy's and St Thomas' NHS Foundation Trust	QUE	NHS Cambridgeshire and Peterborough ICB	2,443

Trust Code	Trust Name	ICB Code	ICB Name	LVA calc (£,000)
RBQ	Liverpool Heart and Chest Hospital NHS Foundation Trust	QOP	NHS Greater Manchester ICB	3,180
RVJ	North Bristol NHS Trust	QT6	NHS Cornwall and The Isles Of Scilly ICB	2,462
RX1	Nottingham University Hospitals NHS Trust	QF7	NHS South Yorkshire ICB	3,645
RGM	Royal Papworth Hospital NHS Foundation Trust	QPM	NHS Northamptonshire ICB	1,966
RCU	Sheffield Children's NHS Foundation Trust	QWO	NHS West Yorkshire ICB	6,476
RCU	Sheffield Children's NHS Foundation Trust	QJM	NHS Lincolnshire ICB	4,145
RA7	University Hospitals Bristol and Weston NHS Foundation Trust	QVV	NHS Dorset ICB	2,995
RJE	University Hospitals of North Midlands NHS Trust	QOP	NHS Greater Manchester ICB	2,731

The Consultation Annex contains all updated LVA values, based on 2023/24 figures. These values will be adjusted for 2024/25 cost uplift and efficiency factors and published in the 2024/25 Annex A.

While the relationships in the table above should move to API agreements, the LVA calculation values are included for reference and may be useful when formalising API agreements.

Should the delegation to ICBs of specialised services currently commissioned by NHS England not be approved, the relevant values would be removed and any affected ICB–Trust relationship currently proposed to move to an API agreement would revert back to being an LVA arrangement.

For any of the relationships above, if the ICB and Trust jointly agree that an LVA arrangement should remain in place, they should indicate this through their consultation feedback or use the Variations request template.