NHS England

2025/26 NHS Payment Scheme – a consultation notice

Part A: policy proposals

Publication reference: PRN01622

Contents

1. About this document

1. This is the statutory consultation notice for the 2025/26 NHS Payment Scheme (NHSPS).

2. The consultation notice is in three parts:

   - Part A – policy proposals (this document). This contains:
     - an introduction that sets the context for the 2025/26 NHSPS and explains how you can respond to this consultation notice
     - a summary of how we have engaged with stakeholders in developing the proposals in this notice
     - a description of our proposals and our rationale for proposing them.
   - Part B – draft NHSPS. This contains a draft of the proposed NHSPS, shown as it would appear in its final form.
   - Part C – impact assessment. This describes our assessment of the likely impact of our proposals.

3. **Please note:** in this document, “NHS provider” refers to an NHS trust or an NHS foundation trust. “Non-NHS provider” means a provider of NHS services other than an NHS trust or foundation trust (eg an independent sector provider, or a primary care provider).

4. This document should be read in conjunction with its annexes and supporting documents. The annexes labelled with a ‘Cn’ prefix form part of this notice. Those labelled with a ‘Dp’ prefix are part of the draft NHSPS. It is proposed that ‘Dp’ annexes would form part of the 2025/26 NHSPS on publication. Supporting documents will also be updated as needed and published alongside the 2025/26 NHSPS.

5. Table 1 lists the annexes and supporting documents comprising the statutory consultation package.

Table 1: Annexes and supporting documents

Document type	Document
Cn	Annex CnA: How to respond to this consultation and the statutory objection process
Draft NHS Payment Scheme (Dp)	Annex DpA: NHS Payment Scheme prices workbook
Dp	Annex DpB: Guidance on currencies
Dp	Annex DpC: Guidance on best practice tariffs
Dp	Annex DpD: Prices and cost adjustments
Dp	Annex DpE: Elective and other activity-based payments
SD	NHS provider payment mechanisms: Guidance on aligned payment and incentive and low volume activity (LVA) block payments
SD	A guide to the market forces factor
SD	Mental health and neurodevelopment resource groups guidance
SD	Community currency models guidance

2. Introduction

6. The NHSPS governs transactions between providers and commissioners of NHS-funded care. The Health and Social Care Act 2012 (as amended by the Health and Care Act 2022) (the 2012 Act) states that the NHSPS must set rules for determining the amount payable by a commissioner for NHS health care services (see Section 114A of the Act). This includes acute, ambulance, community and mental health services. However, the NHSPS does not apply to primary care services, where payment is determined by provisions of the National Health Service Act 2006.

7. As with the 2023/25 NHSPS, the proposed 2025/26 NHSPS contains rules for different payment mechanisms that apply to activity within its scope. These rules are supported by additional information in annexes and supporting documents.

8. The rules provide for four payment mechanisms:

   - Aligned payment and incentive (API) (fixed element and variable element, paying 100% of NHSPS prices for elective activity).
   - Low volume activity (LVA) block payments (nationally set values).
   - Activity-based payments (activity x unit prices).
   - Local payment arrangements (payment approach is locally determined).

9. While we are not proposing to change this overall structure for 2025/26, we are proposing to introduce a power for commissioners to limit payments for elective services, and other services reimbursed on an activity basis, above planned levels (see Section 6). This would apply to the API variable element (see Section 7.3), activity-based payments (see Section 9.2) and local payment arrangements (see Section 10.2).

10. We are also proposing that providers and commissioners will be required to review their API fixed payment to get a better local understanding of the value of activity being undertaken (see Section 7.2). To support this, we are proposing to uplift the prices for urgent and emergency care (UEC) and maternity services so they reflect the pre-pandemic cost base for these services (see Section 11.3).

11. In Section 5, this consultation notice sets out proposals that apply, regardless of the payment mechanism. This includes proposals to set the scheme for one year, the core principles that should apply to all payment arrangements, to update the excluded items lists, to introduce a new best practice tariff (BPT) and to set the cost uplift factor at 4.15% and efficiency factor at 2.0%.

12. Section 6 sets out the proposal for commissioners to set payment limits for elective services, and other services paid for on an activity basis.

13. We then set out our proposals for each payment mechanism:

    - Aligned payment and incentive (API): Section 7
    - Low volume activity (LVA) block payments: Section 8
    - Activity-based payment: Section 9
    - Local payment arrangements: Section 10.

14. Section 11 sets out our proposals for price calculation and related adjustments. We are proposing to calculate and publish prices based on 2024/25 NHSPS pay award prices (see Section 11 and Annexes DpA and DpD).

15. Section 114A(7) of the amended 2012 Act specifies that, in setting the NHSPS, NHS England must have regard to differences in the costs incurred in providing services to different people, and differences between providers with respect to the services that they provide. This is to ensure a fair level of pay for providers of those services. In this document, we explain how we have done this in developing our proposed payment mechanisms and prices. The impact assessment also sets out the expected impact of our proposals, including an equality assessment.

16. We have worked to ensure the NHSPS proposals are fully aligned with the Operational Planning Guidance and NHS Standard Contract.

17. As described in the Elective Care Reform Plan, during 2025/26 we will work to identify how to link payment more closely to activity that directly ends a patient's wait for their care. We will also develop and test tariffs and payment models, including for validation and remote monitoring, that could be used more widely in 2026/27 and beyond.

18. We will also be introducing small-scale pilots to test out new payment mechanisms to support NHS priorities. The pilots, which will align with our Neighbourhood Health work, will aim to reduce length of stay in hospital, with greater use of same day emergency care, provide more care closer to home (such as avoiding conveyance to hospital, and use of virtual wards and urgent community response services) and assess how to financially incentivise best practice. This may involve the teams taking on the budget for a population subgroup. The findings from the pilots will inform payment development for future years.

19. Please contact england.pricingenquiries@nhs.net if you have questions about anything contained in this consultation.

3. Responding to this consultation

3.1 Statutory consultation on the NHS Payment Scheme and the objection process

20. The proposals for the 2025/26 NHSPS are subject to a statutory consultation process as required by Section 114C of the Health and Social Care Act 2012. As well as enabling parties to provide views on the proposals, which we will consider before final decisions on the NHSPS, the consultation allows ICBs and providers of NHS-funded services to object to the proposed NHSPS. The statutory consultation period is 28 days, ending on 28 February 2025.

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

22. Please submit your feedback through the online survey. The deadline for submitting responses is midnight at the end of **28 February 2025**.

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

4. How we worked with stakeholders to develop our proposals

24. We have engaged with providers, commissioners, representative bodies, other teams and departments within NHS England and other appropriate stakeholders throughout the development of our proposals. We have engaged particularly closely with ICB and NHS provider leaders, as well as colleagues from Government departments to develop our proposals for reimbursement of elective activity.

25. Engagement on our proposals included:

- regular discussions about many of the policies with representative bodies and their members, including the HFMA and Independent Healthcare Providers Network
- taking part in external events relevant to payment policy development, as well as working with colleague across NHS England
- continuing co-design sessions with stakeholders from regions, ICSs, providers, commissioners and think tanks to explore developing policy proposals and longer-term payment system development
- working with clinical groups, including GIRFT clinical leads and National Casemix Office expert working groups, to consider cost data and prices
- running a series of virtual workshops, and accompanying online surveys, to get feedback on initial policy proposals during October 2024. Some policy areas in development were not covered in these sessions.

26. The October workshops proved popular, with more than 700 people attending.

27. An online engagement tool was used during the workshops to gather views on specific questions. Attendees were asked to show their support or otherwise for a policy by giving a score between 1 (strongly oppose) and 10 (strongly support). There was also the opportunity to provide more information via free-text feedback. The surveys were kept open for people to submit feedback after the event. There was then a follow-up survey to allow additional feedback during the week after the workshops.

28. The engagement tool was also used to ask attendees to indicate the type of organisation they represent. Of those that responded to this question (248), 167 (37%) represented providers and 55 (22%) represented commissioners.

29. The follow-up survey received 10 responses; eight from providers and two from commissioners.

30. Thank you to everyone who gave their time and participated in this engagement. Your feedback has helped shape the policies presented here.

31. We will continue to engage on our work as we develop the next NHSPS. In particular, we intend to undertake extensive engagement on the recalculation of prices for 2026/27. Please join the Payment system support FutureNHS workspace to be kept informed of developments.

32. Please contact england.pricingenquiries@nhs.net if you have any queries.

33. The rest of this document sets out our proposals for the 2025/26 NHSPS.

5. Proposals applying to all payment mechanisms

5.1 Duration

- **We propose to set the NHSPS for one year – 2025/26.**
- **We propose to amend the duration of the 2023/25 NHSPS so that it continues to have effect until the 2025/26 NHSPS is published.**

About this proposal

34. We are proposing to set the NHSPS for the period of one year – 2025/26. If a new edition of the NHSPS is not published before the end of this period, we propose the NHSPS will continue to have effect until such time as a new edition is published.

35. We also propose amending the current 2023/25 NHS PS so that, if a new edition of the NHSPS is not published before the end of this period, we the current edition will continue to have effect.

Why we think this is the right thing to do

36. The 2023/25 NHSPS was set for two years, with amendments made for 2024/25 following consultation. While we are aware that setting the NHSPS for a longer period can help to provide certainty, which is welcomed by many stakeholders, we feel that it is appropriate to set the 2025/26 NHSPS for one year. This would be consistent with the one-year Spending Review announced by the government in October 2024, as well as ICB allocations and the NHS operational planning guidance.

37. The Government is planning to publish a 10-year plan for the NHS in Spring 2025, along with a multi-year Spending Review. We will consider how best to take advantage of this in setting the duration of the NHSPS in future years.

38. Additionally, we are aiming to recalculate all prices for 2026/27, using the most recent cost data (2023/24 PLICS). We will undertake full engagement on the recalculated prices, including expert clinical review.

39. We also propose providing for the 2025/26 NHSPS to continue to have effect if a new edition has not been published before 1 April 2026. This will avoid the 2025/26 NHSPS expiring without there being a new NHSPS in place, and the likely confusion that would cause.

40. We propose to update the 2023/25 NHSPS so that it will continue to have effect until a new edition is published, even if that goes beyond 1 April 2025. This would avoid potential confusion in the event of any delay.

5.2 Payment principles

- **We propose that all payment arrangements follow the same core principles.**

About this proposal

41. The 2023/25 NHSPS set the following payment principles that must be applied for all payment approaches:

    - The payment approach must be in the best interests of patients.
    - The approach must promote transparency and good 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.

42. We propose that these principles continue to apply for the 2025/26 NHSPS.

43. One of the amendments to the 2023/25 NHSPS introduced for 2024/25 related to the 'best interest of patients' principle. The amendment aimed to ensure that providers did not face a financial barrier to moving services to less intensive settings. This would continue to apply for 2025/26, and we are also proposing to support moving specific suitable procedures from day case/elective to outpatient settings by introducing a new best practice tariff (BPT) (see Section 5.7).

Why we think this is the right thing to do

44. Any payment mechanism should be used to deliver the best possible care for patients in a timely manner, while ensuring that available resources are used as effectively and efficiently as possible.

45. The proposed payment principles are intended to support providers and commissioners to agree effective payment arrangements. They should be a useful reference point for discussions and should help ensure that no one is unfairly disadvantaged because of the payment approach used.

46. The overall objectives of payment policy have not changed, so we feel it is appropriate to leave these principles unchanged for 2025/26.

5.3 Cost adjustment: 2025/26 cost uplift factor

- **We propose to set the cost uplift factor for 2025/26 at 4.15%.**

About this proposal

47. Every year, the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. The NHSPS therefore includes a forward-looking adjustment to reflect expected cost pressures in future years (the cost uplift factor). This section describes the proposed cost uplift factor for 2025/26.

48. The cost uplift factor is applied to the prices and LVA payment values published as part of the NHSPS. Providers and commissioners must also have regard to it as part of API and local payment arrangements.

49. In previous years, we have published the cost uplift factor using one decimal place, although calculations of prices and allocations are done using unrounded values. However, publication at only one decimal place has led to confusion around in-year pay award uplifts, due to the way the roundings worked. To avoid similar confusion in future, we will start using two decimal places for all future iterations of the cost uplift factor.

50. We have calculated the proposed 2025/26 cost uplift factor based on an assessment of cost pressures. This involved gathering initial estimates across several cost categories and then reviewing them to set an appropriate figure for the NHSPS, which in some instances requires an adjustment to the initial figure. Table 2 outlines the cost categories and the source for initial estimates.

Table 2: Costs included in the 2025/26 cost uplift factor

Cost category	Description	Source for initial estimates
Pay	Assumed pay growth, pay drift and other labour costs	Internal data Department of Health and Social Care
Drugs	Expected changes in drug costs included in the NHSPS	Internal data Office for Budgetary Responsibility
Capital	Expected changes in the revenue consequences of capital	Office for Budgetary Responsibility

Unallocated CNST	Expected changes in CNST contributions that have not gone through the HRG level CNST uplifts	NHS Resolution
Other	General inflation for other operating expenses	Internal data Office for Budgetary Responsibility

51. In setting the general cost uplift factor, each cost category is assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure from published 2022/23 financial accounts. Table 3 shows the weights applied to each cost category.

52. For the cost weights, we used previous National Tariff and NHS Payment Scheme cost uplift factors to adjust the 2022/23 consolidated accounts data to produce a projected set of 2025/26 cost weights.

Table 3: Elements of inflation in the 2025/26 cost uplift factor

Cost	Estimate	Cost weight	Weighted estimate
Pay	4.72%	70.45%	3.33%
Drugs	0.83%	2.34%	0.02%
Capital	2.39%	7.35%	0.18%
Unallocated CNST	0.31%	2.09%	0.01%
Other	3.51%	17.76%	0.62%
Total			**4.15%**

Note: calculations are done unrounded – only two decimal places displayed.

53. We have excluded the following costs from the calculation of the proposed cost weights:

- Purchase of healthcare from other bodies, which includes a combination of costs and cannot be discretely applied to one specific category.
- Education and training, which are not included in the NHSPS.
- High cost drugs and devices, which are not reimbursed through NHSPS prices.

Why we think this is the right thing to do

54. Every year, the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. We therefore

make a forward-looking adjustment to the modelled prices to reflect expected cost pressures in future years (the cost uplift factor).

55. As Table 3 shows, total indicative pay cost change is valued at 4.72% for 2025/26. This reflects a nominal 2.8% for pay currently included in 2025/26 allocations, plus 0.1% for pay drift. The pay figure also includes other pay-related cost pressures on NHS services. As presented here, the pay cost estimate explicitly does not pre-judge the outcome of the pay review body process, the outcome of which will not be known until 2025 and which we will then reflect. If further information is available prior to the publication of the final NHSPS, we will look to update the estimates of the cost uplift factor, where it is practical to do so.

56. The uplift estimates for drugs and capital expenses are reliant on an inflation assumption. Our methodology uses the Office for Budget Responsibility's October 2024 forecast GDP deflator rate for 2025/26 (2.39%).

57. Total drug uplift is estimated at 0.83% for 2025/26. This is calculated based on an assumption of unit costs for generic drugs changing by the inflation rate. The unit costs for branded medicines are assumed to be fixed, so the expected change is set at zero. These estimates are weighted based on the proportions of generic and branded medicine for drugs included in the NHSPS, which calculates the final estimate.

58. Total change in the revenue consequences of capital is estimated at 2.39%, using the GDP deflator rate for 2025/26. This estimate of change would be assumed to apply for depreciation and private finance initiative (PFI).

59. Total change in unallocated CNST, which is included in the NHSPS but cannot be allocated to HRG subchapters, is estimated at 0.31%. This is based on the change in contribution rates for unallocated CNST as a proportion of the total CNST collection from NHS providers for 2024/25.

60. Total change in other operating costs (ie costs not covered by the above categories) is estimated at 3.51%. The reflects a figure of 3% inflation (not including pay or drugs), provided by DHSC, and an uplift of 0.5% to account for the National Living Wage increases set out in the Autumn 2024 Budget.

5.4 Cost adjustment: 2025/26 efficiency factor

- **We propose to set the efficiency factor for 2025/26 at 2.0%.**

About this proposal

61. The cost uplift factor adjusts payments and prices up, reflecting our estimate of inflation. The efficiency factor adjusts them down, reflecting our estimate of the average efficiency providers can be expected to achieve year-on-year.

62. The objective of the efficiency factor is to set a challenging but achievable target to encourage providers to continually improve their use of resources, so that patients receive as much high-quality healthcare as possible.

63. We are proposing to set the efficiency factor for 2025/26 at 2.0%.

Why we think this is the right thing to do

64. Over time, providers are able to treat patients at lower cost, for example by introducing innovative healthcare pathways, technological changes or better use of the labour force. The efficiency factor is intended to encourage this shift.

65. In the Autumn Budget 2024, the Government set a 2% productivity, efficiency and savings target for all government departments, which applies to DHSC (including the NHS). Our judgement is that it is appropriate for NHS-funded services, including those delivered by non-NHS providers, to aim to achieve this target. As such, we are proposing to set the 2025/26 efficiency factor at 2.0%.

66. We will undertake a fuller review of the efficiency factor for 2026/27 onwards, when we are planning to recalculate prices using more up-to-date costs.

67. We are also working to support NHS organisations' productivity and efficiency. A newly launched Efficiency and Productivity landing page on Model Health System allows organisations to benchmark themselves across a range of productivity and efficiency indicators and identify potential sources of improvement. The FutureNHS Productivity and Efficiency Improvement Hub also contains a range of resources and information including a workforce productivity tool.

5.5 Excluded items

- **We propose that certain high cost drugs, devices and listed procedures, and MedTech Funding Mandate products, continue to be excluded from core payment mechanisms.**
- **We are proposing to update the lists of these items for 2025/26.**

About this proposal

68. For 2025/26, we propose to continue with the established excluded items process. Several high cost drugs, devices and listed procedures, and listed innovative products (containing items covered by the MedTech Funding Mandate) are excluded from NHSPS price calculation and reimbursement. Instead, they are subject to local payment arrangements, following the excluded items pricing rule.

69. We are proposing to clarify that inclusion on the excluded items list does not mean that an item will always be paid for. It is a commissioning decision whether, and how, excluded items should be paid for in line with NHSPS guidance. A cost and volume approach would be appropriate for some items, while fixed payment could be used for others. For 2025/26, we are proposing that ustekinumab should be paid as part of the fixed payment (see Section 5.6).

70. We have reviewed the lists of high cost drugs and devices for 2025/26. This has involved running a nominations process, where stakeholders can submit requests for additions or removals from the lists, as well as horizon scanning to identify new items that might come to market during 2025/26. Any NICE-approved items that come to market while the 2025/26 NHSPS is in effect would be treated as high cost exclusions.

71. 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.

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

    - add 127 drugs to the high cost drugs list (124 of these were identified through horizon scanning; three were from the nominations process)
    - remove 67 drugs from the list (items that have not been in use and no licence is expected during 2025/26)
    - clarify that existing categories already cover three nominated devices.

73. Annex DpA shows the high cost exclusions lists with our proposed changes. When considering which items to include in the lists, our guiding principle has been that the item should be high cost and represent a disproportionate cost compared to the other expected costs of care within the HRG, which would affect fair reimbursement.

74. We considered adding devices for capsule sponge tests (non-endoscopic diagnostic tests for oesophageal cancer and Barrett's oesophagus) to the high cost devices list.

However, these items did not meet the high cost exclusion criteria and, as such, we are not proposing to add them to the exclusion list. However, to ensure that patients benefit from the devices, we are proposing to make a price adjustment to support their use – see Section 11.3.

75. There is also an exclusion list of innovative products covered by the MedTech Funding Mandate (MTFM). For 2025/26, we are proposing to remove Spectra Optia from the MTFM list.

Why we think this is the right thing to do

76. Paying for high cost drugs and devices in addition to reimbursement for the related service should ensure that providers are appropriately reimbursed for the use of these items, and that patients are able to benefit from clinically appropriate treatments. As medical practice changes and new drugs and devices are developed and adopted, the lists of high cost drugs and devices needs to be kept as current as practically possible, requiring input from the health sector for changes to the lists.

77. The nominations form is intended to allow any stakeholders to submit suggested changes to the exclusion lists, providing evidence to support their nomination. This is supplemented by the horizon-scanning work to give as full a picture as possible of items that should be considered for exclusion.

78. Our proposals do not accept all of the nominations for additions to the drugs and devices lists. This was for a range of reasons, including nominations relating to items already covered by categories on the lists (for example, chemotherapy drugs). Others were not recommended for inclusion on the list either because they were not felt to be sufficiently high cost, were unlikely to be approved for use within 2025/26 or would be subject to alternative payment routes. Some nominations did not include sufficient evidence in support of their submission, meaning they could not be accepted.

79. For the MedTech Funding Mandate list, we worked with the NHS England innovation team to review products against the criteria for inclusion on the list. We are proposing to remove Spectra Optia from the list of MTFM products as the Spectra Optia machines are a capital, rather than a revenue cost. The revenue cost is covered by the HRG payment for the procedure, and we are proposing to increase the price for Automated Red Cell Exchange (SA41Z) to reflect the cost of delivery (including blood) – see Section 11.3.

80. Annex DpA shows our proposed high cost drugs, devices and listed procedures, and MedTech Funding Mandate products lists for 2025/26.

5.6 Excluded items: ustekinumab

- **We propose that funding for ustekinumab should be included in the fixed element.**

About this proposal

81. One of the items included on the high cost drugs exclusion list is ustekinumab. This is in the group of cytokine modulators.

82. For 2025/26, we are proposing that funding for ustekinumab is included in the fixed element, rather than paid on a cost and volume basis. Providers and commissioners would need to agree the amount added to the fixed payment, taking into account the shift to the biosimilars. The Specialised Commissioning drugs list would be updated to reflect this change.

83. Providers and commissioners who have already put in place a different local solution to address switching to ustekinumab biosimilar can continue to use the local approach.

Why we think this is the right thing to do

84. In July 2024, the patent for Stelara (the brand name for the original ustekinumab) expired. As such, biosimilar versions of ustekinumab are becoming available to use.

85. Moving ustekinumab to fixed payment would encourage use of biosimilars, where appropriate.

5.7 Best practice tariffs

- **We propose to continue to use a mix of elective activity and annual BPTs, making updates to the acute stroke and early inflammatory arthritis BPTs**
- **We propose introducing a new elective activity BPT to encourage delivery of appropriate activity as outpatient procedures, aligned with the GIRFT Right Procedure Right Place (RPRP) initiative.**

About this proposal

86. Since they were first introduced in 2010/11, BPTs have been designed to incentivise quality and cost-effective care. The 2023/25 NHSPS updated the design of BPTs so there are two types – annual BPTs and elective activity BPTs. These categories draw a distinction between BPTs relating to elective services activity (which are then paid on an activity basis, with BPT prices being unit prices) and those that apply to other services, which have funding agreed as part of the API fixed element.

87. For 2025/26, we are proposing to continue to use the mix of elective activity and annual BPTs, calculating BPT prices using the process set out in Section 11.2.

88. We are proposing to update the acute stroke care BPT to reflect NICE recommendations and to use the least expensive option of the available treatments (including tenecteplase and alteplase). This would mean that use of either drug would meet the BPT criteria. We are also proposing to update the early inflammatory arthritis BPT to reflect a change to NICE guidelines, which now contain five standards of care (the 2019/20 guideline contained six). See Annex DtC for details. We are not proposing any other changes to the design of existing BPTs.

89. One of the amendments to the 2023/25 NHSPS introduced for 2024/25 was to update the 'Best interest of patients' payment principle to say that providers and commissioners should consider the financial implications of moving activity to less intensive healthcare settings.

90. For 2025/26, in line with the Elective Care Reform Plan, we are proposing to further support shifting suitable procedures to outpatient settings by introducing a new right procedure right place (RPRP) BPT. This would be an elective activity BPT and would align with the GIRFT RPRP initiative, which aims to help providers move appropriate procedures out of traditional operating theatres and into alternative settings, such as procedure rooms.

91. The RPRP programme team have developed a longlist of procedures that they considered suitable to move from being performed as a day case (or elective) to outpatient. We worked with the team to agree a list of procedures to focus on including in the BPT for 2025/26. These procedures:

- are considered suitable to be undertaken in an outpatient setting
- have a price differential when undertaken as day case/elective vs outpatient
- have a high level of activity
- have a proportion of outpatient (vs day case/elective) below the British Association of Day Surgery (BADS) target ratio (where applicable)
- map to a single HRG.

92. As such, we are proposing the following procedures to be included in the RPRP BPT for 2025/26:

- Various minor skin procedures (S081, S083, S131, S132, S141, S142, S148, S149, S151, S152, S158, S159, grouping to HRG JC43C: Minor skin procedures and biopsy of skin)
- Injection into vitreous body NEC (OPCS C794, grouping to HRG BZ86B: Intermediate vitreous retinal procedures, 19 years and over, with cc score 0-1)

- Carpal tunnel release (OPCS A651, grouping to HRG HN45A: Minor hand procedures for non-trauma, 19 years and over)
- Perineal needle biopsy of prostate (OPCS M702, grouping to HRG LB77Z: Transperineal Template Biopsy of Prostate)
- Biopsy of lesion of tongue or mouth (OPCS F241/F421, grouping to HRG CA66A: Excision or Biopsy of Lesion of Mouth, 19 years and over)
- Large loop excision of transformation zone (OPCS Q014, grouping to HRG MA23Z: Minimal Lower Genital Tract Procedures).

93. BPT prices will apply for the procedures listed above that group to the relevant HRGs, whether they are recorded as outpatient, day case or elective.

94. Prices would be set by assessing BADS target ratios and calculating an equalised price for day case, elective and outpatient settings (see Section 11.2 for details of the price setting process). Prices would be introduced using a two-step transition path, so the 2025/26 price would be halfway between the current activity ratio and the BADS target ratio. The only exception is the procedure in HRG HN45A (carpal tunnel release, OCPS A651), where the proposed price is based on 20% of the outpatient price and 80% of the day case/elective price (compared to a BADS target ratio of 80% outpatient/20% day case/elective).

95. The prices proposed for 2025/26 (set out in Annex DpA) represent the first step of this transition path. We will assess whether to propose moving to the next step of the path (full implementation of BADS ratio prices for some or all procedures) for 2026/27.

96. We are focusing on a limited number of procedures for 2025/26. However, if the approach is successful, we would consider proposing to expand the list of procedures covered by the BPT in future years.

97. Annex DtC contains full details of the design and criteria for the proposed RPRP BPT.

Why we think this is the right thing to do

98. The NHSPS BPT design is intended to flow money to and from providers to reflect actual performance, reinforcing the financial incentive to maintain or improve quality in these priority areas. Ensuring that BPT reimbursement operates in the same way as the overall payment approach for the relevant services (ie fixed or variable) should allow the incentives to operate effectively.

99. We are proposing to update the acute stroke BPT in light of the positive NICE appraisal of tenecteplase so that clinicians are not discouraged from using the new drug where

clinically indicated. The update to the early inflammatory arthritis BPT would reflect NICE guideline *NG100: Rheumatoid arthritis in adults: management* and the focus on timely initiation of treatment.

100. We are proposing to introduce the RPRP BPT to support use of less resource-intensive settings. Moving activity to these settings has potential to deliver efficiencies by freeing up capacity in operating theatres and staff time for more complex procedures.

101. It has been reported that NHSPS unit prices can be a barrier to shifting services, due to higher unit prices for the same procedure when performed on an elective or day case basis versus an outpatient basis. This would mean providers potentially losing income by undertaking procedures on an outpatient basis.

102. The BADS target ratios set out the proportion of procedures that should be delivered as outpatient or day case. The ratios highlight expected best practice and we feel it is appropriate for the ratios to be reflected in prices. BADS ratios were previously used for the day case procedures BPT, which was retired from the National Tariff in 2020/21, having effectively contributed to increases in the rates of procedures being delivered as day case.

103. We are proposing to use a transition path to introduce prices based on BADS ratios to reduce the risk of volatility, as well as allowing providers time to change their service models where necessary. The 2025/26 prices in Annex DpA represent the first step of the glidepath, which is halfway to the target values. The price for HN45A (carpal tunnel release) uses a different ratio in recognition of concerns that moving immediately to BADS pricing could be destabilising due to a large price differential and a relatively low proportion of outpatient activity for this procedure.

104. In deciding on the list of procedures to target in 2025/26, the pricing and RPRP teams have engaged with a range of stakeholders. This has included GIRFT clinical leads, national clinical directors and the National Casemix Office clinical expert working groups (EWGs), all of whom provided helpful feedback.

105. The proposals were also discussed at the October engagement workshops. There was very strong support for adjusting prices to support providers to deliver procedures in outpatient settings (60% of respondents score 8-10 and only 6% scored 1-3). There was a broader range of views for using BADS target ratios (36% score 8-10, 44% scored 5-7 and 20% scored 1-4).

6. Elective and activity-based payments

6.1 Elective and activity-based payments

- **We propose that commissioners will be required to set payment limits for elective services, and all services paid for on an activity basis, based on the value of planned levels of activity.**

About this proposal

106. We propose that commissioners will be required to set a payment limit for elective services, and all services paid for on an activity basis, where the planned value of activity is above £0.1m. This would cover nationally and locally priced services and apply to both NHS and independent sector providers, including Community Diagnostic Centres (CDCs).

107. Payment limits would be set for API, activity-based and locally agreed payment mechanisms and cover services including:

- Ordinary electives
- Day cases
- Outpatient first attendances
- Outpatient procedures
- Unbundled diagnostic imaging
- Unbundled nuclear medicine
- Chemotherapy delivery

108. The payment limit would be the value of activity above which the commissioner is not required to make further payments. A payment limit should be set for each commissioner/provider relationship above the £0.1m threshold, except where the relationship is on an LVA basis and the provider will receive a fixed payment.

109. The payment limit would operate as follows:

- Providers and commissioners would need to agree and document a planned level of activity, and associated financial value, to be reimbursed on a variable or activity basis. This financial value represents the payment limit – the maximum amount the commissioner would be required to pay the provider for elective/variable activity.
- As a minimum, commissioners need to ensure that the planned level of activity would deliver their activity floor and the target RTT improvement, taking into account affordability – NHS England will seek assurance on commissioned levels

of elective activity. Commissioners should also ensure that all their elective recovery funding is committed in the payment limits they set, when combined with any expected expenditure on variable activity below the payment limit threshold.

- Commissioners have the option of breaking down the planned level of activity into specific limits set at service, specialty or procedure level. These could take into account where additional activity is required and where waiting times are already within the 18-week standard. However, there would be no requirement to break the limit down in this way.
- If provider and commissioner do not agree a planned level of activity and financial value, the commissioner would be able to set a payment limit for that provider.
- For non-contract activity (NCA) above the £0.1m threshold, the commissioner would set an appropriate payment limit, following consideration of current activity levels and activity targets.
- Commissioners should notify providers in writing of the payment limit which applies to them by 30 April. Where limits are then set at service, specialty or procedure level, commissioners should notify providers of these specific limits in writing by 30 June. A payment limit would not be notified in-year other than as a result of the provider reaching the £0.1m threshold or if a new provider starts to provide services for a commissioner.
- Where a new provider starts to provide services for an ICB during the year, a payment limit should be set for activity with an expected value above £0.1m.
- Commissioners and providers should review performance against the activity plan on a monthly basis and update activity forecasts quarterly. Providers (including of NCA) should inform the commissioner as soon as possible if they expect to exceed the payment limit. The commissioner and provider should then discuss whether the payment limit needs to be applied, or if it can be increased (eg, if other providers are underperforming against their plans).

110. The commissioner should use a fair and consistent approach to agreeing activity plans with providers, regardless of whether the provider is within their system or in another system and whether the provider is on an API contract or is paid on an activity basis. NHS England will also produce a national analysis of activity volumes consistent with the allocated funding for each NHS provider/commissioner relationship, which could be used to inform the payment limit. This would be shared on FutureNHS.

111. Commissioners and providers of specialised services would also be required to agree planned levels of activity, and payment limits, for specialised commissioning. For elective activity previously in the scope of the ERF, this should be done on a host provider basis for delegated specialised commissioning. For each of their host

providers, ICBs would have separate payment limits for ICB commissioning and delegated specialised commissioning. They would be able to flex between these limits. NHS England regional specialised commissioners, and national commissioners where relevant, would agree activity plans and payment limits with providers for retained specialised services.

112. Commissioners would not be able to change overall payment levels in-year but, in agreement with providers, could increase payment limits for individual providers.

113. Where providers have contracts of significant value with multiple commissioners, it is possible the provider could be within their overall payment limit (ie the combined value of their payment limits with all commissioners), but be above the payment limit for some commissioners and below it for others. In this situation, commissioners and providers should work together to agree arrangements and manage funding flows in-year to ensure providers are reimbursed for the total activity they do within their overall payment limit. We will provide guidance to support this.

114. Annex DpE gives more details of the proposed payment limit.

Why we think this is the right thing to do

115. As set out in the Revenue finance and contracting guidance, commissioners will receive a fixed allocation for elective recovery for 2025/26. There will be no additional funding for overperformance.

116. The proposal for commissioners to set payment limits is consistent with fixed allocations and the need for the NHS as a whole not to spend more than the resources it has available. The Elective Care Reform Plan also sets out that ICBs will be set individual activity targets and allocated funding needed to deliver the 18-week RTT standard.

117. We are proposing that the limit applies to elective activity, as well as all services paid for on an activity basis for all providers, including CDCs. This means it would apply to nationally and locally priced services and cover both NHS and independent sector providers. This should ensure consistency and support using available resources to meet activity targets as effectively as possible. Commissioners would be required to use a fair and consistent approach to agreeing activity plans with providers to ensure that individual providers are not disadvantaged through the limit-setting process.

118. Allowing the option of setting limits at service, specialty or procedure level would enable providers and commissioners to target available funding at services with the

longest wait times. It would not cut across patient choice rules as providers would continue to be obliged to accept referrals and to offer patients choices on where they get their treatment. ICBs would be expected to actively manage activity volumes and patient waits to identify and appropriately manage cases where, due to the urgency associated with the clinical need of a patient, a longer wait caused by imposition of a payment limit could reduce the choices available to that patient.

119. We recognise that setting limits at service, specialty or procedure level won't be appropriate or feasible in all situations. We will consider whether additional support and guidance is needed to help commissioners and providers set and implement limits in a practical way, while delivering the objective of ensuring overall expenditure control. We are also proposing to produce analysis of activity volumes consistent with the allocated funding for each provider/commissioner relationship. This can be used to inform payment limits.

120. We are proposing to set a threshold of £0.1m for the expected value of commissioner-provider relationships. This is intended to avoid introducing disproportionate administrative burdens for lower value contracts. The payment limit would not apply to commissioner-provider relationships covered by LVA arrangements, under which the provider receives a fixed payment (see Section 8.2).

121. As a potential alternative to using variable payments with a limit to the amount paid, we considered moving elective activity to a fixed payment basis. While this approach could provide systems with greater ability to control budget allocation in their larger contracts, it removes the direct connection between activity and payment. In addition, it would only provide commissioners with the ability to manage expenditure on providers within the scope of API. As such, we decided to propose the payment limit approach.

7. Payment mechanism: Aligned payment and incentive (API)

7.1 Scope

- **We propose that API arrangements continue to apply to almost all NHS provider/ commissioner relationships.**

About this proposal

122. We propose that API rules cover almost all secondary healthcare commissioned between NHS trusts, foundation trusts and NHS commissioning bodies. This includes acute, community, mental health and ambulance services.

123. As with the 2023/25 NHSPS, this would mean the only NHS provider activity excluded would be:

- where there is an LVA arrangement in place (please note: we are proposing to change the LVA threshold for 2025/26 – see Section 8.1)
- the service is a single specialised or non-acute service individually procured from an NHS provider under a separate contract.

124. Activity outside the scope of API would be subject to either LVA or local payment arrangements (see Section 10.1).

125. Activity delivered by non-NHS providers would not be in scope of API. Instead, this activity would either use activity-based payments (for services with NHSPS unit prices – see Section 9) or local payment arrangements (where unit prices are not available – see Section 10).

Why we think this is the right thing to do

126. We believe that using the same payment approach for almost all services and sectors encourages collaboration and supports providers and commissioners to deliver appropriate services for their populations.

127. We do not want to introduce uncertainty by changing the scope of API (other than updating the LVA threshold – see Section 8.1).

7.2 Design: fixed element

- **We propose that the fixed element continues to cover almost all activity other than elective services.**

- **We propose that providers and commissioners must review their fixed payment to get a better local understanding of the value of activity being undertaken.**

About this proposal

128. As in 2023/25, we propose that the 2025/26 API fixed element covers funding for services including:

    - an agreed level of acute activity outside the scope of the elective activity variable element (see Section 7.3)
    - maternity, mental health, community and ambulance services
    - expected annual BPT achievement and levels of advice and guidance delivered
    - chargeable overseas visitors
    - CNST contributions
    - services and drugs delivered via homecare
    - implementation costs of MedTech Funding Mandate products and models of care.

129. Many provider contract values are still heavily based on the emergency payments agreed under Covid-19 measures, adjusted for subsequent inflation, efficiency and planned activity growth. As a result, the fixed payment may not reflect current activity and efficient costs. We are therefore proposing that commissioners will be required to review the current fixed payment for all providers with which they have an API contract. The review should help identify areas of potential efficiency savings, as well as, over time, leading to payments which are more reflective of activity levels and reasonable costs.

130. To help ensure meaningful discussion on the level of fixed payments, we are proposing to uplift accident and emergency, non-elective and maternity prices to align with the pre-pandemic cost base for these services (see Section 11.3).

131. To support ICB and provider discussions about acute services, we have carried out a national analysis comparing the payments included in 2024/25 plans with the payment that would be made if the provider was paid on a price x activity basis. The analysis, and details of the methodology used, will be shared directly with systems. It is based on 2023/24 activity recorded in HES and 2024/25 prices, updated for the proposed uplifts to accident and emergency, maternity and non-elective guide prices.

132. This national analysis is not comprehensive and will need to be supplemented by, or adjusted so that it better reflects, local information, and by using the ICB PLICS benchmarking tool (available via FutureNHS).

133. The supporting document *NHS provider payment mechanisms* contains more information about the proposed review of fixed payments and how conclusions should be implemented over time to avoid destabilising providers or commissioners. It also includes information to support community, mental health and ambulance services to review their fixed payment.

134. We will consider how to provide further analysis for these sectors in future years, led by sector engagement and feedback. The longer-term ambition for mental health, community and ambulance services is for currency models to inform payment. Details of the currency models and the requirements for 2025/26 are available in Annex DpB and the currency models supporting documents.

Why we think this is the right thing to do

135. The fixed element covers the majority of funding for most providers. This is intended to help provide financial stability and support longer-term planning and transformation. However, if payment amounts are based on the Covid-19 emergency payments, they may not reflect current activity and efficient costs. Therefore, it is important for commissioners and providers with API contracts to review their fixed payments.

136. For acute services, developing an understanding of the difference between fixed payments in 2024/25 plans and the amount that would be paid based on a price x activity approach, including how much may be related to excess costs or increased activity, can help determine the scope to reduce or increase payment value over time. We know that some systems have already conducted local analysis for this purpose. The approach is intended to support thinking on efficiency opportunities, distribution of resources between providers and allocation of convergence or other financial improvement requirements.

137. The proposal was discussed at the October engagement events, with questions asked in the accompanying survey. The survey asked people to score proposals from 1 to 10, with 1 representing strongly oppose and 10 strongly support. Respondents strongly supported reviewing fixed payment values (50% gave a score of 8 or more out of 10, while only 19% scored between 1 and 3) and using a national approach to reviewing payment levels (58% scoring 8-10 and 9% scoring 1-3). There was also support for using price x activity (39% scoring 8-10 and 21% scoring 1-3) and cost benchmarking

information to inform discussions on fixed payments (36% scoring 8-10 and 23% scoring 1-3).

138. In the free text, some respondents expressed concern about the feasibility of doing the review in the available time, with concerns about an increase in complexity. A number of comments highlighted the difference between prices and costs, and the fact that prices are based on pre-Covid costs and activity.

139. To help address the concerns about the difference between price and costs, we are proposing to increase the level of accident and emergency, non-elective and maternity guide prices (see Section 11.3). The national analysis of price x activity includes these proposed uplifts in the 2024/25 prices used – see the methodology that accompanies the analysis for more detail.

140. We are also proposing that fixed payments for non-acute services are reviewed, although for 2025/26 this would need to be based on local data rather than national analysis. We are working to improve support for non-acute services in future years.

141. While using currencies to pay for acute health services is well-established, it has long been an ambition to develop currency models for community and mental health care. The absence of these models has meant that:

- providers struggle to understand care in a consistent way
- there is a lack of evidence to support commissioning decision making
- lack of standardisation creates a barrier to collaboration and benchmarking.

142. Currency models for mental health and community services have been developed (see Annex DpB and the currencies supporting documents). During 2025/26, providers should ensure that the data items required to populate each currency model are collected and submitted to relevant national data sets. This will also support the National Cost Collection for community and mental health services.

143. Currency models already exist for ambulance services (see Annex DpB). However, work is underway to consider how costing data can best support discussions around fixed payment values for ambulance services.

144. Further context and latest developments on the work to develop non-acute currencies can be found in the Currency models, support and guidance FutureNHS workspace.

7.3 Design: variable element

- **We propose that providers are paid 100% of NHSPS prices for elective services, up to a planned level of activity.**
- **We propose that fixed payments are also varied based on the levels of advice and guidance delivered.**

About this proposal

145. For 2025/26, we propose that providers are paid 100% of NHSPS unit prices, with relevant MFF value applied, for elective services and all services paid for on an activity basis. We are proposing to introduce a requirement for commissioners to limit payments for activity above planned levels (see Section 6 and Annex DpE).

146. As in the 2023/25 NHSPS, we propose that providers and commissioners should include funding for an agreed level of advice and guidance activity in as part of the API fixed element. If the amount delivered is different to what was expected, the amount paid should be increased or decreased accordingly.

147. One of the amendments to the 2023/25 NHSPS introduced for 2024/25 was to pause the nationally mandated CQUIN scheme. This meant there were no variable payments relating to achievement of CQUIN criteria. We are proposing to continue this pause for 2025/26.

Why we think this is the right thing to do

148. We want payment arrangements to support providers to deliver as much elective activity as is affordable. Using NHSPS unit prices to pay for elective activity on a variable basis supports this intention.

149. As set out in Section 6, we are proposing that commissioners set limits for the amount paid to providers for elective activity to avoid spending beyond the available resources, and ensure the payment approach is consistent with commissioners receiving fixed allocations for elective recovery in 2025/26. See Section 6 and Annex DpE for more details.

150. In the consultation on amendments to the 2023/25 NHSPS, the proposal to pause the CQUIN scheme for 2024/25 was extremely strongly supported. This was consistent with feedback in previous years. We are proposing to continue to pause the scheme for 2025/26. Non-mandatory CQUIN indicators will continue to be available on FutureNHS to support systems which choose to implement a CQUIN-like scheme as a variation to the API rules.

7.4 Design: specialised services

- **We propose that specialist top-up funding becomes part of the fixed payment from NHS England to providers of specialised services.**
- **We propose to remove the exceptions for some transplantations in the API rules, meaning they are subject to fixed and variable elements, rather than being subject to local payment arrangements.**

About this proposal

151. Almost all activity delivered by NHS providers is in scope of API. This includes specialised services commissioned by NHS England Specialised Commissioning. Since April 2024, a significant volume of specialised activity has been delegated to ICBs. Further delegation is expected in April 2025.

152. The 2023/25 NHSPS introduced some specific payment arrangements for certain specialised services to support the ongoing delegation of the commissioning of these services to ICBs. There were further changes made for 2024/25, following consultation, including setting a minimum specialist top-up payment that providers would receive, with additional top-ups earned for relevant elective activity.

153. For 2025/26, we are proposing that specialist top-ups become part of the API fixed payment between NHS England and specialised providers, with top-ups not paid on a variable basis. Top-ups would be funded by NHS England commissioners on a host provider basis and payment made to providers on this basis. The total eligible amount for the fixed payment will continue to be set as part of the 2025/26 NHSPS.

154. To make sure payment appropriately supports commissioning of specialised services, we are proposing a small number of price adjustments (see Section 11.3). We are also proposing to remove some transplantations from API rule 4 (exceptions), which would mean that these services are subject to the API fixed and variable rules, rather than local payment arrangements. Treatment costs relating to NICE decisions (such as CAR-T) and genomic testing would remain as exceptions (ie subject to local payment arrangements) and we propose removing the requirement for genomic testing to be paid on an activity basis.

155. At the October engagement workshops, we discussed moving some services (renal dialysis, renal transplants, HSCT and brachytherapy) from fixed to variable payment. However, following feedback from the workshops and national and regional finance colleagues, we are not proposing these changes for 2025/26.

Why we think this is the right thing to do

156. By their nature, specialised services are uncommon – and often high cost. It is therefore appropriate that different payment arrangements are applied to these services to make sure that they can operate as effectively as possible. Payment signals also need to be correct to support the ongoing delegation of commissioning these services to ICBs.

157. The 2023/25 NHSPS introduced some changes to the default API payment model to support appropriate reimbursement of specialised services. Further changes were then made as amendments for 2024/25.

158. For 2025/26, we do not want to introduce uncertainty and want to continue to support specialised services and the delegation of commissioning. As such, we are proposing including specialist top-ups in fixed payments to guarantee the amount that each specialist provider will receive. This would mean that specialist top-ups would not be subject to the elective payment limit set out in Section 6.

159. We are proposing to stop certain transplantations from being subject to local payment arrangements so that a consistent payment approach is used for specialised services. This is particularly important to ensure that any limits on elective activity are applied fairly and consistently. This would also help ensure consistency of approach for services commissioned by both ICBs and NHS England. We are proposing to continue to make exceptions for genomic testing and treatment costs relating to NICE decisions, as local payment arrangements are likely to be most appropriate for these services. Where local payment arrangements are activity-based, the proposed payment limit set out in Section 6 would apply.

160. We had considered moving renal dialysis, renal transplants, HSCT and brachytherapy to variable payments. However, feedback from the October workshops and from regional and national colleagues raised questions about the feasibility of doing this for 2025/26, highlighting a lack of data flows, affordability concerns and questions about capacity to implement the changes. As such, we are not proposing to make these changes.

7.5 Design: abortion services

- **We propose to move abortion services to variable payment, rather than being part of the fixed element.**

About this proposal

161. In April 2024, NHS England published the NHS vision for abortion services. This vision has the stated objective of 'Improved access and care for all those who need abortion services'.

162. It highlights the need for an 'NHS Payment Scheme that promotes sustainability for both independent and NHS providers'. In the context of rising demand and prolonged waits, it also recognises a need to increase NHS capacity, particularly in relation to surgical abortions.

163. In response to this, for 2025/26 we are proposing to move abortion services delivered by NHS providers to variable payment, rather than being covered by the fixed element. This would include non-elective activity.

164. Variable payments for termination of pregnancy activity for NHS providers covers the core spell for all terminations, including for women with complex comorbidities, as set out in the NHSE Specialised Commissioning service specification. However, they do not include the additional top-up funding for the specialist centres. These will be managed by ICBs from April 2025 (with management by NHSE Specialised Commissioning regional teams and ICBs prior to this).

Why we think this is the right thing to do

165. Abortion is one of the most common procedures in the NHS, and the sector is facing significant challenges. Demand is rising rapidly, up 17% in 2022 compared to the previous year. Alongside this, the sector is experiencing declining NHS capacity, resilience challenges and workforce constraints. This is resulting in prolonged waits and unmet need for surgical services, significant travel distances at later gestations and constrained access – all of which impacts on patient care. Providers report wait times for surgical abortions (circa 13% of procedures) often being three weeks or longer in some parts of the country (against a NICE standard of two weeks).

166. In the 2023/25 NHSPS, we changed the price relativities for termination of pregnancy services and set separate day case/elective and non-elective prices, as well as publishing additional guidance on how prices could be used. We continue to ask ICBs to ensure that contracts are sustainable and follow this guidance. To further support service sustainability and NHS capacity, we are proposing the move to variable payment for 2025/26.

167. Variable payment creates a direct link between activity levels and payment. This would remove a potential financial barrier for NHS providers, where increasing activity could

create unfunded costs, while ensuring providers who deliver less than the planned level of activity are not inappropriately compensated.

168. To support this change, and to begin to increase surgical abortion capacity to reduce wait times, commissioning guidance is expected to ask ICBs to stabilise NHS capacity in 2025/26 and support increases where appropriate. They will also be asked to plan for growth of overall surgical capacity in NHS trusts as well as independent providers. We will work with ICBs to develop national commissioning guidance and uniform metrics to support commissioners and help deliver the NHS vision for abortion services.

7.6 Design: community diagnostic centres

- **We propose setting NHSPS unit prices to be used for community diagnostic centre activity.**

About this proposal

169. Community diagnostic centres (CDCs) are currently paid for by a host ICB on an activity basis, using a price list exclusively for CDC activity. This requires a variation to the standard NHSPS rules.

170. We want payment arrangements for CDC activity to align with those for equivalent activity carried out in non-CDC settings. As such, we propose setting NHSPS unit prices for CDC activity, so that all CDC activity is paid for using these prices. This would remove the need for a variation as well as ensuring consistent payment for equivalent services.

171. A new CDC tab in Annex DpA sets out the proposed unit prices for CDC services. These prices include CDC activity that maps to an existing HRG with a unit price. Annex DpB contains more information about the currencies used.

172. Any remaining national CDC revenue funding to cover specific and time-limited start-up and other costs for the current cohort of CDCs would be transacted through the API fixed payment as a non-recurrent adjustment. As a condition of receiving this national CDC funding, ICBs and CDC providers are required to submit activity data to:

- the national CDC programme through NCDR (as they currently do), and
- SUS, using the approved CDC site code to ensure clarity between CDC and non-CDC diagnostic activity.

173. The intention is to align SUS data submissions across CDC and non-CDC sites. If data is submitted (or not submitted) to SUS for the non-CDC equivalent, the same would be expected for a CDC site.

Why we think this is the right thing to do

174. The national CDC programme is now in its third year and has approved 170 CDC sites across England. As described in the Elective Care Reform Plan, CDCs have a vital role in increasing access to diagnostic services, offering patients a wide range of tests closer to home and with a greater choice on where and how they are undertaken.

175. Diagnostic activity continues to be undertaken in non-CDC settings, as well as in CDCs. We want to ensure that the same payment approach is used for all diagnostic activity, ensuring that the payment system is not a barrier to delivery.

176. Setting unit prices for CDC activity, and including the CDC prices tab in Annex DpA, would mean there is a consistent payment approach for diagnostic services, regardless of the setting. This would also help ensure appropriate levels of activity, reflecting the high number of people currently waiting for diagnostic tests.

177. The proposals were discussed at the October engagement workshops and received strong support. 37% of attendees gave a score of 8-10 for using variable payments for CDC, with 17% scoring 1-3. 45% scored 8-10 for submitting CDC activity to SUS, with 15% scoring 1-3.

7.7 Design: teledermatology

- **We propose that teledermatology for patients on the urgent suspected skin cancer pathway is part of the variable payment.**

About this proposal

178. Teledermatology refers to the use of specialist camera equipment (a dermatoscope) to take pictures of new or changing skin lesions where patients have seen their GP and there is a concern about the possibility of skin cancer. Dermatoscope images can be taken either by the GP, at a CDC or by a medical photographer or suitable trained staff in secondary care. A dermatologist then reviews the images virtually (without the patient in attendance) and a decision is made on whether to discharge the patient or to bring them in for a first outpatient appointment.

179. We are proposing that teledermatology for patients on the urgent skin cancer pathway would be paid for on an activity basis, as part of the variable element. Proposed unit prices for these services are published in Annex DpA.

180. Where the dermatoscopy and virtual review takes place in a hospital, the teledermatology price would be set to be the same as the CDC price for "Dermatoscopy and Report". When only the virtual review element takes place in hospital, and the dermatoscope image has been taken by the GP, then the providers and commissioners should agree an appropriate split to apply to the review element. Services for patients on a routine pathway, where the GP sends a regular image to secondary care, would continue to be treated as advice and guidance.

Why we think this is the right thing to do

181. In the 2023/25 NHSPS, teledermatology was classified as advice and guidance. However, feedback from providers suggested that Urgent Suspected Cancer teledermatology does not fit the typical advice and guidance criteria. Feedback also highlighted inconsistencies in how it is coded.

182. Including teledermatology in the variable payment would help ensure that urgent suspected cancer teledermatology services are reported, and paid for, consistently. Ensuring that the price for teledermatology in hospital is aligned with the CDC price would avoid any barriers to the activity being delivered in the most appropriate location.

7.8 Variations from API design

- **We propose that any variations to the API design would continue to need approval by NHS England.**

About this proposal

183. For 2025/26, we propose to continue to allow providers and commissioners to vary API payment arrangements on condition that:

- the arrangement is consistent with the payment principles
- both provider and commissioner agree to the variation.

184. Any variations to the API design would need to be approved by NHS England.

Why we think this is the right thing to do

185. We want to ensure a consistent payment approach is used for all provider/ commissioner relationships. This ensures that payment is consistent with agreed targets and makes the most efficient use of available funding. However, local circumstances may mean that different approaches are more appropriate, so we want to allow flexibility to support these where needed.

186. Where providers and commissioners want to move away from the default API approach, requiring NHS England approval will ensure that this is done in a way that is consistent with system goals.

8. Payment mechanism: low volume activity (LVA) block payments

8.1 Scope

- **We propose that low volume activity (LVA) arrangements apply for almost all NHS provider/commissioner relationships with an annual value of less than £1.5m.**

About this proposal

187. LVA arrangements govern the relationships between NHS providers and ICBs where the estimated value of activity is below a certain threshold.

188. When LVAs first became part of the payment system, in the 2023/25 NHSPS, the threshold was set at £0.5m. When NHS England delegated the commissioning of some specialised services to ICBs, the expected value of these services was added to the LVA payment value covering the services already commissioned by an ICB. The LVA threshold was applied without reference to the delegated services, meaning that the final LVA value for some provider/commissioner relationships was above the £0.5m threshold.

189. For 2025/26, we are proposing to increase the threshold to £1.5m. We would also consider the following criteria when deciding whether to set an LVA for a provider/commissioner relationship:

- proximity of the provider to the commissioner
- value of the LVA payment compared to the trust's overall income
- whether the provider delivers specialised services.

190. We aim to maintain the scope of LVA such that around 90% of provider/commissioner relationships operate on an LVA basis.

191. The following would continue to be excluded from LVA arrangements:

- 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 to allow meaningful choice, including making use of alternative providers if people have been waiting a long time for treatment.

Why we think this is the right thing to do

192. The purpose of the LVA approach is to reduce the number of transactions for relatively small amounts of money. This has been shown to reduce the administrative burden of processing these transactions.

193. We are proposing that LVA arrangements continue to apply only to NHS providers. Non-NHS providers would require a billing relationship with the commissioner, meaning the LVA approach would not be suitable.

194. When considering where to set the LVA threshold, we want around 90% of provider/commissioner relationships in scope of LVA, even after allowing for delegation of services from NHS England. This is consistent with the proportion of relationships covered by LVA in 2024/25. We feel that this strikes the appropriate balance between capturing large numbers of transactions and retaining appropriate levels of control.

195. As well as increasing the threshold, we are proposing to consider additional criteria when deciding whether to set an LVA. This would allow us flexibility to better manage the list of LVA relationships and reduce the likelihood of relationships that are close to the threshold frequently moving in and out of API arrangements.

196. The additional criteria would also address concerns about a higher threshold moving more specialised services contracts onto LVA. Specialist providers had raised concerns that this could impact on their income from elective activity, which has increased substantially since 2019/20 and 2022/23. Commissioners were also keen to ensure that there is a contractual relationship when the majority of their specialised activity is delivered by a single provider.

8.2 Design

- **We propose to update the values ICBs pay providers and include services where commissioning has been delegated to ICBs from NHS England.**

About this proposal

197. Section 8.1 describes where LVA arrangements apply. For each provider/commissioner relationship with an LVA, ICBs must pay each provider identified on the 2025/26 LVA payments schedule the calculated amount. The LVA payments schedule is published in Annex DpA.

198. We are proposing to calculate the 2025/26 LVA payments schedule values as follows:

- **Acute services** – use a three-year average based on SUS activity from 2019/20, 2022/23 and 2023/24, priced using 2024/25 prices with 2025/26 cost adjustments applied, including the proposed uplift to UEC prices (see Section 11.3).
- **Mental health and community services** – update the 2024/25 LVA values with the 2025/26 cost uplift and efficiency factors (see Sections 5.3 and 5.4).
- **Secondary dental services** – use a three-year average based on SUS activity from 2019/20, 2022/23 and 2023/24, priced using 2024/25 prices with 2025/26 cost adjustments applied.
- **Specialised services** – update the 2024/25 LVA values with the 2025/26 cost uplift and efficiency factors (see Sections 5.3 and 5.4) and add newly delegated services.

199. To minimise the number of financial transactions, ICBs should ideally pay each trust identified on the schedule the calculated amount once any in-year updates have been made to reflect the impact of any agreed pay award or by the end of quarter two, whichever is sooner. Where LVA payments are made prior to the impact of any in-year changes, commissioners would be required to pay any difference in value. Additional payments should be made in the month after the updated LVA schedule is published.

200. Where providers and commissioners choose to do so, they would be able to agree a variation away from the LVA arrangements and agree to use a contract for the services, informing NHS England via the variations process.

Why we think this is the right thing to do

201. The proposed LVA design continues the approach used in the 2023/25 NHSPS. The LVA approach has been very strongly supported since its introduction, with stakeholders reporting that it has led to a significant reduction in the administrative burden.

202. We are proposing to update the LVA values to ensure they are as accurate as possible. As outlined in paragraph 198, this would involve different approaches for different service areas. Calculation of LVA values will reflect the price adjustments for UEC services proposed in Section 11.3 as well as more recent activity data.

203. We are proposing to calculate LVA values for acute services using three years' data to ensure any anomalies do not have a disproportionate effect. We would not include data from 2020/21 or 2021/22, given the significant impact of Covid-19 on the data.

204. At the October engagement sessions, we discussed introducing an uplift factor to account for costs not reported in SUS. While the proposal was well supported, with

62% of respondents who giving a score of 8-10, we have decided not to introduce this for 2025/26. The proposed uplift to UEC prices increases LVA values, while the more recent activity data also ensures they reflect actual activity more closely.

205. For mental health and community services, the move to LVA arrangements has meant that providers are no longer able to provide the transaction data that had been used to calculate their LVA values. We are therefore proposing to set 2025/26 values by updating the 2024/25 values. To make more accurate updates in future, we need to find a consistent way to understand how activity flows between ICBs and distant mental health and community providers. We welcome suggestions of ways to do this, either in a response to this consultation or by emailing england.pricingenquiries@nhs.net.

206. We are proposing to calculate LVA values for secondary dental services using historic average SUS data. This follows feedback from dental colleagues. This approach will produce more accurate values, as well as encouraging accurate reporting of SUS data. We have analysed the difference between 2024/25 LVA values and secondary dental activity in SUS. Although this identified some variation, the use of SUS increased the accuracy of the values compared to the previous baseline setting method.

207. For specialised services, we are proposing to uplift the 2024/25 values to reflect average 2025/26 cost adjustments. Services newly designated for delegation from 2025/26 will be added to values, and regions where ICBs did not take on delegated specialised services in 2024/25 but are now doing so in 2025/26 will be reflected in the values. This would ensure the values reflect changes in services over time. Where appropriate, providers and commissioners could decide to amend values for specific services to reflect planned service or other changes, moving from LVA to a contract arrangement via the variations process.

208. The LVA proposals were discussed at the October engagement workshops. There was very strong support for updating the LVA values with more recent data (71% of respondents gave a score of 8-10). The proposal to update mental health and community values by applying the 25/26 cost adjustments had a less certain reaction – while 36% of respondents scored 8-10, 44% scored 5 or 6. However, only 11% scored 1-3. There was a similar spread of views for the approaches to update values for specialised and secondary dental services, with more support than opposition but many respondents choosing to give a mid-range score.

9. Payment mechanism: activity-based payment

9.1 Scope

- **We propose that activity-based payment continues to be used for all services delivered by non-NHS providers where there is an NHSPS unit price for the activity, up to a planned level of activity.**

About this proposal

209. We propose that, as in the 2023/25 NHSPS, activity-based payment applies to all services with NHSPS unit prices delivered by non-NHS providers.

210. The proposed payment limit for elective services, and all services paid for on an activity basis, described in Section 6 would apply.

Why we think this is the right thing to do

211. This proposal would mean that non-NHS providers and NHS providers are both paid 100% of unit prices for elective activity, up to a planned level of activity.

212. We recognise that the cost base and casemix of NHS and non-NHS providers can vary, while NHSPS prices are calculated based on NHS cost and activity data alone (see Section 11.2). However, non-NHS providers primarily deliver elective services so using the same prices as the API elective variable element (described in Section 7.3) is the best approach to aid elective recovery, as well as facilitating patient choice, with funding following the patient. This is consistent with the partnership agreement between the NHS and the independent sector, published alongside the Elective Care Reform Plan.

213. Non-NHS providers do not have to submit cost data so only NHS provider cost and activity data can be used to set prices. The lack of available cost data would also make it difficult for commissioners to agree fixed elements if non-NHS provider activity were in scope of API.

9.2 Design

- **We propose that unit prices continue to be paid for activity, with market forces factor applied, up to a planned level of activity.**

About this proposal

214. The proposed activity-based payment rules mean NHSPS unit prices are used for each unit of activity delivered, up to a planned level of activity. The amount paid would be the unit price, multiplied by the provider's market forces factor (MFF) value.

215. As in 2023/25, providers and commissioners would be able to agree to vary away from published prices where appropriate. They would need to submit details of the variation to NHS England. Provider and commissioner would be required to consider the NHSPS payment principles when agreeing any variation to the published prices.

216. The MFF value for non-NHS providers should be that of the NHS trust or foundation trust nearest to the location where the services are being provided (see Section 11.4 and *A guide to the market forces factor*).

217. As set out in Section 6, we are proposing that commissioners limit payments to providers for elective services, and other services paid on an activity basis, above planned levels. Commissioners could choose to set planned levels of activity at service, specialty or procedure level to enable them to target the funding available at services with the longest waiting times.

Why we think this is the right thing to do

218. The activity-based payment approach is well understood and has been widely used.

219. As in previous years, we propose that MFF values apply whenever NHSPS prices are used. This offsets the financial implications of unavoidable cost differences between healthcare providers (see Section 11.4).

220. The proposal for commissioners to limit payments for elective services, and all services paid on an activity basis, for non-NHS providers ensures that the same rules apply to both NHS and non-NHS providers (see Section 6).

221. The proposals for both the API and activity-based payment mechanisms intend to ensure that NHS and non-NHS providers of elective services are treated equally. This will support commissioners to manage available resources as effectively as possible.

10. Payment mechanism: local payment arrangements

10.1 Scope

- **We propose that local payment arrangements continue to be used for any activity not covered by another payment mechanism.**

About this proposal

222. As in 2023/25, we propose that local payment rules apply for services delivered by non-NHS providers where a unit price is not published in the NHSPS, and for services delivered by NHS providers that are excluded from API or LVA.

223. Where a guide price is published, this could be used to support local payment arrangements, but there is no requirement to use these prices. Local payment arrangements can be used by any commissioner – both ICBs and NHS England.

Why we think this is the right thing to do

224. The detailed rules in the NHSPS help ensure that the payment system supports effective and efficient use of NHS resources.

225. The rules for API, LVA and activity-based payment would cover almost all activity in scope of the NHSPS. The rules for local payment arrangements support providers and commissioners to agree appropriate payment methods that are not otherwise covered.

10.2 Design

- **We propose that providers and commissioners choose a payment approach that reflects the payment principles and has regard to the NHSPS cost uplift and efficiency factors.**

About this proposal

226. We propose that any services not covered by any other payment mechanism rules would follow the following rules:

- Providers and commissioners may agree the payment approach but, when doing so, they must:
  - apply the NHSPS payment principles (see Section 5.2)
  - have regard to the cost uplift and efficiency factors specified in the NHSPS (see Sections 5.3 and 5.4).

227. Where providers and commissioners are not able to agree on the payment approach, they should speak to their NHS England regional team, who will help them to find a resolution.

228. Any payment arrangements that involved activity-based payments would be subject to the proposed payment limit described in Section 6.

Why we think this is the right thing to do

229. The proposed local payment rules would require providers and commissioners to apply the payment principles and have regard to the cost adjustments. This would mean that local arrangements are aligned with the other payment mechanisms, while allowing local flexibility for areas to choose the approach that is going to be most suitable for their situation.

230. The proposed payment limit set out in Section 6 would apply to all services paid for on an activity basis. This would include activity-based local payment arrangements, ensuring a consistent approach. See Annex DpE for more details of the proposed payment limit.

11. Prices: role, calculation and related adjustments

11.1 The role of prices

- **We propose that the NHSPS continues to contain two categories of price: unit prices and guide prices**

About this proposal

231. Under the 2012 Act, the NHSPS rules can specify prices. As in 2023/25, we are proposing to publish two categories of price for 2025/26:

- Unit prices – to be used for API elective variable element and activity-based payment. They can also be used as benchmark information to support API fixed element setting. BPT prices are a type of unit price.
- Guide prices – to be used as benchmark information and to support local payment arrangements.

232. All prices are published in Annex DpA, with unit prices and guide prices included on different tabs.

Why we think this is the right thing to do

233. We believe it is helpful to clearly differentiate between unit prices, which must be used in certain circumstances, and guide prices, which are never mandatory. This is intended to avoid confusion about the status of the prices.

234. The use of prices is discussed in each payment mechanism section.

11.2 Calculating 2025/26 prices

- **We propose that 2025/26 prices are calculated by updating 2024/25 NHSPS pay award prices for inflation and efficiency.**
- **We propose increasing the prices cost base by £3bn to uplift prices for accident and emergency, non-elective and maternity services.**
- **We propose to set new unit prices for the Right Procedure Right Place best practice tariff and for community diagnostic centre (CDC) services, as well as making some guide price updates.**

About this proposal

235. We propose to calculate NHSPS prices for 2025/26 by updating the 2024/25 NHSPS prices that were published with adjustments for pay awards (2024/25 pay award

prices). For 2025/26, we would adjust these prices for inflation and efficiency (the cost uplift and efficiency factors – see Sections 5.3 and 5.4).

236. This would mean that prices continue to be based on 2018/19 cost and activity data. It would also mean that the following aspects of the 2024/25 NHSPS price calculation are rolled over:

- Currency specification (see Annex DpB for guidance on certain currencies).
- Manual adjustments used for 2022/23, 2023/24 and 2024/25 prices.
- Top-slice for specialist top-ups (see Section 7.4 for details of how the specialist top-ups would be applied).
- Adjustments for high cost drugs and devices.

237. We propose to set the prices cost base in largely the same way as in previous years. The cost base is the level of cost that the NHSPS would allow providers to recover (were prices used), before adjustments are made for cost uplifts and the efficiency factor is applied. We are proposing to set the initial prices cost base by equalising it to that which was set in the previous year, adjusted for activity and scope changes (see Annex DpD for details). We then propose to increase the cost base by £3bn to uplift prices for accident and emergency, maternity and non-elective services (see Section 11.3). These would continue to be guide prices, used to support calculation of API fixed payments (see Section 7.2).

238. The 2024/25 NHSPS prices were initially calculated with a 1.7% cost uplift factor and 1.1% efficiency factor. However, a revised set of prices was published in September 2024, which had been updated to reflect the 2024/25 pay awards. This increased the cost uplift factor to 5.0%. The proposed prices for 2025/26 are based on updating these NHSPS pay award prices.

239. The proposed 2025/26 prices would be calculated using largely the same method as previous NHSPS and National Tariff prices. This is described in detail in Annex DpD. In summary, this would involve the following steps:

- Setting draft price relativities – for 2025/26, these would be the 2024/25 NHSPS pay award prices published in September 2024.
- Making manual adjustments to the price relativities (see Section 11.3 for details of the proposed manual adjustments).
- Scaling prices to the cost base.
- Adjusting prices for inflation and efficiency (see Sections 5.3 and 5.4).

240. We are proposing to set new unit prices for CDC activity that is not covered by existing HRGs (see Section 7.6). We are also proposing to calculate new unit prices for the RPRP BPT (see Section 5.6). These prices would be calculated by assessing BADS target ratios for outpatients and day cases. We would then use these rates to calculate an equalised price for day case, elective and outpatient settings. For example, if the BADS target is for a procedure to be performed as outpatient 80% of the time and as day case/elective 20% of the time, the target price would be 80% of the outpatient price and 20% of the day case/elective price for the procedure.

241. We are proposing to use a two-step transition path to move to the new BPT prices. For most of the procedures, this would mean that the price for 2025/26 is halfway between the current activity ratio and the BADS target ratio. For the procedure in HRG HN45A (carpal tunnel release, OCPS A651), the 2025/26 price is based on 20% of the outpatient price and 80% of the day case/elective price (compared to a BADS target ratio of 80% outpatient/20% day case/elective).

242. Guide prices should be used to inform local payment arrangements. We are proposing to update the guide prices for cardiothoracic transplants and set new guide prices for:

- haematopoietic stem cell transplantation (HSCT)
- diabetic eye screening and optical coherence tomography.

243. See Annex DpB for more information on the currencies used.

Why we think this is the right thing to do

244. Under the 2023/25 NHSPS, the prices published for both 2023/24 and 2024/25 were calculated using 2018/19 cost and activity data – patient-level costs (PLICS) and hospital episode statistics (HES). This data was also used for the 2022/23 National Tariff prices.

245. We considered using more recent data to calculate a new set of prices. However, final 2022/23 National Cost Collection PLICS data was not available in sufficient time for it to be used for price calculations.

246. Rolling over the 2024/25 price relativities requires the rolling over of the currency design used for the prices. It also means that manual adjustments and other price changes, such as the top-slice of prices for specialist top-ups, continue to be applied.

247. We are proposing to increase the cost base to uplift prices for accident and emergency, maternity and non-elective services to ensure that these prices can be used effectively

to support commissioners and providers to review their fixed payments (see Section 7.2).

248. The new unit prices for the RPRP BPT would encourage shifting suitable procedures to outpatient setting. We are proposing using BADS ratios to calculate the prices as they highlight expected best practice. The prices would be introduced using a transition path to reduce the risk of instability. See Section 5.6 for more details about the RPRP BPT.

249. The proposed guide prices should provide a starting point for providers and commissioners to discuss appropriate local payment arrangements.

11.3 Price adjustments

- **We propose to make manual adjustments to price relativities in the following areas:**
  - **A&E, maternity and non-elective services**
  - **gynaecology and ear nose and throat (ENT) services**
  - **upper gastrointestinal tract procedures**
  - **specialised services**

About this proposal

250. As set out in Section 11.2, the proposed prices for 2025/26 would be calculated using 2024/25 NHSPS pay award prices as initial price relativities. We are then proposing to make changes to the following price relativities for 2025/26.

251. Other than the uplift to prices for A&E, maternity and non-elective services, the changes to price relativities described below would not affect the overall amount of money allocated to each HRG chapter, meaning other prices in the affected chapters would slightly change to compensate.

252. Annex DpA shows the proposed prices. Annex DpD gives more detail of the proposed calculation method and the cash in/cash out approach used to make the adjustments described here.

253. As described in Section 11.2, we are proposing to increase the prices cost base by £3bn and uplift the A&E, maternity and non-elective prices to align prices to the pre-pandemic cost base for these services.

254. This would involve an overall uplift of 13%, implemented differentially:

- A&E – 18%

- Maternity – 11%
- Non-elective – 12%.

255. We are also proposing to increase prices for the following eligible HRGs by 15%:

- Gynaecology: MA07E, MA07F, MA07G, MA08A, MA08B, MA10Z, MA31Z, MA32Z, MA33Z, MA34Z
- ENT: CA11A, CA28Z, CA32A, CA35A, CA61Z.

256. We propose to change the price for HRG FF05Z (Intermediate Upper Gastrointestinal Tract Procedures, 19 years and over) to support use of the capsule sponge test, which is a non-endoscopic diagnostic test for oesophageal cancer and Barrett's oesophagus. This would increase the price from £256 in 2024/25 to £454 in 2025/26.

257. We propose to make the following changes to support commissioning of specialised services:

- adjusting the prices for SA41Z (Automated Red Cell Exchange)
- set a price for TFC 352 (Tropical Medicine Service), setting it at the same as TFC 350 (Infectious Diseases Service).

Why we think this is the right thing to do

258. We are proposing to make these manual adjustments to address specific issues that have been identified.

259. The proposed uplift to A&E, maternity and non-elective prices is to ensure that the prices more accurately reflect current costs. Since the pandemic, the reported costs of these services have increased more rapidly than those of other services. This proposal would base prices on the pre-pandemic cost base for these services. Even though these prices would not be used for payment on an activity basis, they have a key role in helping ICBs and providers effectively review their fixed payments (see Section 7.2).

260. The proposed changes to prices for gynaecology and ENT services are intended to address particularly high numbers of patients on the waiting lists for these specialties. We are proposing to change prices where the procedures can be mapped to specific HRGs. Higher prices could encourage providers to target these procedures in additional sessions or expand into providing these services where they had not previously. This would help address the relatively high waiting lists for these services.

261. The proposed change to the price for HRG FF05Z is intended to support use of the capsule sponge test. This follows a national NHS pilot of the test between 2020 and 2023. In 2023, the NHS Cancer Programme funded an additional capsule sponge pilot through the Innovation Open Call until the end of March 2024. During 2024/25, the NHSPS encouraged providers and commissioners to agree funding in the fixed element to pay for the additional cost. For 2025/26, the device was assessed by the high cost devices steering group and was not deemed to meet the exclusion criteria for being high cost (see Section 5.5). However, we want to reduce the risk of patients not being able to access the device. As such, we are proposing to increase the price for the HRG the device is currently mapped to (FF05Z).

262. We are proposing the price changes to support commissioning of specialised services for the following reasons:

- **Automated Red Cell Exchange**: Feedback from clinicians and providers highlighted that the current Automated Red Cell Exchange price (HRG SA41Z) is too low to reflect the amount of blood required for delivering this HRG. As such, we are proposing to increase the price to cover the minimum of eight bags of red cells, which account for 60% of the total cost. The baseline adjustment is being funded from NHS England Specialised Commissioning as part of the national MedTech Funding Mandate work programme for Spectra Optia. Following the change to the price and baseline funding, Spectra Optia will be removed from the list of MFTM products (see Section 5.5).
- **Tropical Medicine**: The specialised commissioning infectious diseases clinical reference group have raised a concern that the lack of price for TFC 352 (Tropical Medicine Service) may mean the activity is wrongly counted and coded. We are proposing to set the price for TFC 352 to be the same as TFC 350 (Infectious Disease Service) to increase the incentive to record the activity correctly.

11.4 Market forces factor

- **We propose that the market forces factor (MFF) continues to be applied to prices. We propose to update the data used to set MFF values and implement the changed values over a two-step transition path.**

About this proposal

263. The market forces factor (MFF) is a measure of unavoidable cost differences between healthcare providers, and a means of offsetting the financial implications of these cost differences. Each NHS provider is assigned an individual MFF value. This is used to

adjust commissioner allocations and is applied wherever prices are used (so the total amount paid is price x MFF value).

264. The MFF was comprehensively reviewed and updated in 2019/20, with the new values phased in using a five-step transition path.

265. For 2023/24, rather than moving to the fifth step of the transition path, the data used to calculate MFF values was updated. The same MFF values were then used for 2024/25.

266. For 2025/26, we are proposing to update the underlying data used to calculate MFF values, to use 2022/23 data where possible. The non-medical and dental component uses three pooled years of Annual Survey of Hours and Earnings (ASHE) data, and would be updated to 2021-23, from 2017-19.

267. This update would mean all NHS providers received new MFF values. We are proposing to use a two-step transition path to introduce the new values. This would limit the absolute change in annual MFF values to 1.53%. The change in MFF values between those published in 2024/25 and year one of the proposed transition path (2025/26 values) range from 0.93 to -1.53%.

268. Annex DpA contains the proposed MFF values for 2025/26, representing the first step of the transition path.

269. The proposed change in MFF values would reduce the total amount paid through the MFF, compared to using 2024/25 MFF values, if all activity was reimbursed using unit prices. There is therefore a compensating increase in the proposed 2025/26 prices of 0.41%. The *Revenue finance and contracting guidance* sets out how commissioners should consider MFF changes alongside other factors when setting contract values.

270. We will also clarify the guidance on the use of MFF for fixed and variable payments and which MFF values should be used for outsourced activity and remote/virtual services. See *A guide to the market forces factor*.

Why we think this is the right thing to do

271. The 2019/20 MFF update introduced significant changes to MFF values, such that a five-step transition path was required. The main reason the changes were so significant was that the underlying data had not been updated for almost 10 years. As such, we undertook to review the MFF more frequently to limit the scale of future change.

272. In addition, using more recent data ensures that MFF values more accurately reflect the unavoidable costs currently faced by providers. Not updating the data may mean MFF values do not reflect these costs.

273. We are therefore proposing to use the most recent available data to update MFF values. The changes in values therefore reflect the underlying data.

274. The impact assessment contains details of the impact of the proposed change on providers and commissioners. In order to limit unacceptable volatility as a result of the change, we are proposing to introduce the new MFF values using a two-step transition path. Values would move to the first step in 2025/26. We would then consider whether to propose moving to the next step of the transition path in the consultation on the NHSPS for 2026/27.

275. During the October engagement events, there was strong support for the principle of updating the data underlying MFF calculations: 37% of respondents gave a score of 8-10, while 15% scored 1-3. When asked about the maximum annual change in MFF values they would prefer, 46% of respondents chose ‘don’t know’, 30% chose 0-1%, 14% chose 1-2% and 10% chose 2% or more. The supporting free text responses suggested that many people wanted to see detail of the values before deciding.