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2025/26 NHS Payment Scheme – a consultation notice

Part B: Draft 2025/26 NHS Payment Scheme

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1. Introduction

1. This document specifies the proposed NHS Payment Scheme for the NHS in England for 2025/26, subject to the consultation on proposals for the 2025/26 NHS Payment Scheme (NHSPS). The NHSPS sets rules for determining the amount payable by a commissioner for the provision of NHS health care services and some public health services.

2. This document is published in exercise of functions conferred on NHS England by section 114A of the Health and Social Care Act 2012 (the 2012 Act), as amended by the Health and Care Act 2022.

3. This NHSPS has effect for the period beginning on 1 April 2025 and ending on 31 March 2026, or if the next edition of the scheme has not come into effect by 1 April 2026 the day before that edition comes into effect, whichever is the later. In addition, if a new edition of the NHSPS was to be introduced before 31 March 2026, this NHSPS would cease to have effect when the new edition takes effect.

4. The NHSPS allows different payment mechanisms to be used in different circumstances – although there are some things that must be considered regardless of the payment mechanism used.

5. **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).

6. Table 1 summarises the payment mechanisms:

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Table 1: Payment mechanisms

Payment mechanism	Applies to
Aligned payment and incentives (API)	Almost all NHS provider relationships with • NHS England for any directly commissioned services; and • with any ICB where the relationship is not covered by LVA arrangements
Low volume activity (LVA) block payments	Almost all NHS provider and ICB relationships for which NHS England has mandated an LVA block payment (this will normally be those with an expected value of annual activity of £1.5m or less)
Activity-based payment	Services with NHSPS unit prices delivered by non-NHS providers
Local agreement	Activity not covered by another payment mechanism (including non-NHS provider services without NHSPS unit prices and NHS provider activity excluded from API and LVA)

7. The document is split into the following sections:

- Section 2: the scope of the payment scheme
- Section 3: overarching policies – payment principles and cost adjustments
- Section 4: aligned payment and incentive rules
- Section 5: rules for LVA block payments
- Section 6: activity-based payment rules
- Section 7: rules for local payment arrangements
- Section 8: prices and related adjustments
- Section 9: rules for making payments.

8. In summary, Section 3 covers policies that apply to all payment mechanisms, while Sections 4-7 set out the rules for each payment mechanism. Section 8 gives details of the NHSPS prices, and adjustments to those prices.

9. There are five annexes, listed in Table 2.

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Table 2: 2025/26 NHSPS annexes

Annex	Description
DpA	NHSPS prices workbook
DpB	Guidance on currencies
DpC	Guidance on best practice tariffs
DpD	Prices and cost adjustments
DpE	Elective and other activity-based payments
Please note: the prefix 'Dp' refers to draft annexes that are part of the consultation on the proposed 2025/26 NHSPS.	

10. The NHSPS is also supported by documents containing guidance and other information, listed in Table 3.

Table 3: Supporting documents to the 2025/26 NHSPS

Title
A guide to the market forces factor
NHS provider payment mechanisms: Guidance on aligned payment and incentive and low volume activity (LVA) block payments
Mental health and neurodevelopment resource groups guidance
Community currency models guidance

11. All annexes and supporting materials for the consultation on the 20205/26 NHSPS can be downloaded from the NHS England website.

12. Additional information and support can be found on the Payment System Support FutureNHS workspace. This includes examples and uses cases of local payment variations, such as an alternative pathway for hysteroscopy which aligns to NICE guidelines.

13. The NHSPS forms part of a set of materials that inform planning and payment of healthcare services. Related materials include NHS Operational Planning and Contracting Guidance and the NHS Standard Contract.

2. Scope of the NHS Payment Scheme

14. As set out in the amended 2012 Act, the NHSPS covers the pricing of healthcare services provided for the purposes of the NHS.

15. Other than the exclusions described in Sections 2.1-2.7, this covers all forms of NHS healthcare provided to individuals, whether relating to physical or mental health and whether commissioned by integrated care boards (ICBs), NHS England, ICBs exercising functions delegated to them by NHS England, or local authorities acting on behalf of NHS commissioners under partnership arrangements.

16. Various healthcare services are, however, outside the scope of the NHSPS. The rest of this section explains these exclusions.

2.1 Public health services

17. The NHS payment scheme does not apply to public health services that are:

- provided or commissioned by local authorities or United Kingdom Health Security Agency
- commissioned by NHS England or an ICB on behalf of a local authority pursuant to a partnership agreement under section 75 of the National Health Service Act 2006 (the 2006 Act).

18. Public health services commissioned by local authorities include local open access sexual health services and universal health visitor reviews.

19. The Health and Care Act 2022 removed the prohibition on setting national payment rules for services commissioned by NHS England or an ICB in exercise of the Secretary of State's public health functions (as set out in section 7A or 7B of the National Health Service Act 2006). These services are subject to the NHSPS payment rules.

2.2 Primary care services

20. The NHS payment scheme does not apply to primary care services (general practice, community pharmacy, general dental practice and community optometry) where payment for the services is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the 2006 Act. (See Parts 4 to 7 of the 2006 Act and related instruments: for example, the Statement of Financial Entitlements for GMS GP Services, and the drug tariff for community pharmaceutical services.)

21. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act then the 2025/26 NHSPS rules on local payment arrangements apply (see Section 7). For instance, minor surgical procedures performed by GPs and commissioned by ICBs would be subject to local payment arrangements.

2.3 Personal health budgets

22. A personal health budget (PHB) is a set amount of money to support the identified health and wellbeing needs of a particular patient, planned and agreed between that patient and their local NHS.

23. There are three types of PHB:

- **Notional budget; no money changes hands:** the patient and their NHS commissioner agree how to spend the money; the NHS will then arrange the agreed care.
- **Real budget held by a third party:** an organisation legally independent of the patient and their NHS commissioner will hold the budget and pay for the care in the agreed care plan.
- **Direct payment for healthcare:** the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.

24. If an ICB uses a notional budget to pay providers of NHS services, this is in the scope of the 2025/26 NHSPS. Payment will be governed by the rules applicable to the services in question.

25. A notional budget may also be used to buy integrated health and social care services to facilitate more personalised care planning. Where these services and products are not NHS services, the 2025/26 NHSPS does not apply.

26. If a PHB takes the form of a direct payment to the patient or budget held by a third party, the payments for health and care services agreed in the care plan and funded from the PHB are not in the scope of the 2025/26 NHSPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act (see National Health Service (Direct Payments) Regulations 2013 (SI 2013/1617, as amended)).

27. The following are not in the scope of the 2025/26 NHSPS, as they do not involve paying for provision of NHS healthcare services:

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- Payment for assessing an individual's needs to determine a PHB.
- Payment for advocacy (advice to individuals and their carers about how to use their PHB).
- Payment for the use of a third party to manage an individual's PHB on their behalf.

28. More information about PHBs can be found on the NHS Personal Health Budgets page.

2.4 Integrated health and social care

29. Section 75 of the 2006 Act provides for the delegation of a local authority's health-related functions (statutory powers or duties) to its NHS partner, and vice versa, to help meet partnership objectives and create joint funding arrangements.

30. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain in the scope of the 2025/26 NHSPS even if commissioned by a local authority. This also applies to NHS services commissioned by local authorities under arrangements made under section 65Z5 (joint working and delegation arrangements) of the Health and Care Act 2022.

31. Payment to providers of NHS services that are jointly commissioned are governed by the rules applicable to those services, as set out in this document.

32. Local authority social care or public health services commissioned under joint commissioning arrangements are outside the scope of the 2025/26 NHSPS.

2.5 Contractual sanctions

33. The NHS Standard Contract includes certain provisions under which commissioners may withhold payment from providers. Where these contractual provisions are used and change the amount paid for the provision of an NHS service, this is permitted under the rules relating to the making of payments to providers (see Section 9).

2.6 Devolved administrations

34. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, the 2025/26 NHSPS applies in some but not all circumstances.

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35. Table 4 summarises how the 2025/26 NHSPS applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

Table 4: How the 2025/26 NHSPS applies to devolved administrations

Scenario	NHSPS applies to provider	NHSPS applies to commissioner	Examples
DA patient treated in England and paid for by commissioner in England	✓	✓	A Scottish patient attends A&E in England
DA patient treated in England and paid for by DA commissioner	✗	✗	A Welsh patient, who is the responsibility of a local health board in Wales, has elective surgery in England which is commissioned and paid for by that local health board
English patient treated in DA and paid for by DA commissioner	✗	✗	An English patient, who is the responsibility of an ICB, attends A&E in Scotland
English patient treated in DA and paid for by commissioner in England	✗	✓	An English patient has surgery in Scotland which is commissioned and paid for by their ICB in England

36. In the final scenario above, the commissioner in England must follow the 2025/26 NHSPS rules. However, there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally in the country in question, or use a different currency from that specified by the NHSPS. In such cases, the commissioner must follow the rules for local payment arrangements (see Section 7).

37. Providers and commissioners should also be aware of guidance relating to cross-border payment responsibility. The England/Wales cross border healthcare services: statement of values and principles sets out the values and principles agreed between

the NHS in Wales and the NHS in England to ensure smooth and efficient interaction between NHS organisations for patients along the England-Wales border.

38. NHS England's Who Pays? document provides comprehensive rules on determining the responsible NHS commissioner in England. For queries, contact england.responsiblecommissioner@nhs.net

39. The payment responsibility rules set out in these documents should be applied as well as any applicable provisions of the 2025/26 NHSPS. The scope of the 2025/26 NHSPS does not cover the payment responsibility rules.

2.7 Overseas visitors

40. Overseas visitors who are liable to pay a charge under the relevant regulations are NHS patients where the cost of treatment is to be recovered from the individual. As such, where they receive treatment that falls within the scope of the NHSPS, they should be charged based on commissioned prices determined in accordance with the NHSPS. The charges will either be 100% or 150% of the commissioned price – see *Improving Systems for Cost Recovery for Overseas Visitors* for the appropriate charging rates.

41. For more details, please see the DHSC guidance on NHS cost recovery – overseas visitors.

42. It is important to be aware of exemptions from charges. This may be services (for example accident and emergency or family planning services) or individuals (including vulnerable people such as refugees or asylum seekers). Please see Chapter 1 of the Guidance on implementing the overseas visitor charging regulations for details of exempt services and individuals.

43. For details on how funding for chargeable overseas visitors should be included in API arrangements, see the supporting document, *NHS provider payment mechanisms.*

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3. Overarching policies

44. Under the NHSPS, some overarching policies apply regardless of the payment mechanism used. All payment arrangements must apply the NHSPS payment principles and have regard to the cost uplift and efficiency factors.

45. Where providers and commissioners are not able to agree a payment arrangement, they should speak to their NHS England regional team or, if there is no applicable regional team, the NHS England Pricing team (england.pricingenquiries@nhs.net), who will work with them to find a resolution.

3.1 Payment principles

46. Commissioners and providers must apply the following principles when agreeing any payment approach:

- 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.

47. These principles are explained in more detail in Sections 3.1.1 to 3.1.5 and are additional to other legal obligations on commissioners and providers. These obligations include other rules set out in the NHSPS, and the requirements of competition law, procurement regulations under section 12ZB of the 2006 Act, and the NHS provider licence.

3.1.1 Best interest of patients

48. Payment arrangements must be in the best interests of patients today and in the future. Commissioners and providers must therefore consider the following factors:

- **Quality**: how will the agreement maintain or improve the clinical effectiveness, patient experience, timeliness of access and safety of healthcare today and in the future?

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- **Cost-effectiveness**: how will the agreement make healthcare more cost effective, without reducing quality, to enable more effective use of resources for patients today and in the future?
- **Innovation**: how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interests of patients today and in the future?
- **Allocation of risk**: how will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

49. The extent to which, and way in which, these factors need to be considered will differ according to the characteristics of the services and the circumstances of the agreement.

50. To have considered a relevant factor properly, we would expect providers and commissioners to have:

- obtained sufficient information
- used appropriately qualified/experienced individuals to assess the information
- followed an appropriate process to arrive at a conclusion.

51. It is up to providers and commissioners to determine how to consider the factors set out above based on the matter in hand.

52. Where activity can be better delivered in a less intensive healthcare setting, and this is in the best interests of patients, providers and commissioners should consider the financial implications of such a movement of activity. For example, activity identified by the GIRFT Right Procedure Right Place (RPRP) programme may involve activity switching from a day case setting to an outpatient setting. The financial effect of this should be explicitly considered. This includes potentially neutralising the financial effect on the provider where they would lose funding as a result of different unit prices for the activity. The RPRP best practice tariff (BPT) also supports a shift of activity to less resource intensive settings – see Annex DpC for details.

3.1.2 Transparency and data quality

53. Payment arrangements must be transparent. Increased transparency will make commissioners and providers more accountable to each other, patients, the general public and other interested stakeholders. Transparent agreements also mean that best practice examples and innovation in service delivery models or payment approaches

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can be shared more widely. Commissioners and providers must therefore consider the following factors:

- **Accountability**: how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the public and other stakeholders?
- **Sharing best practice**: how will innovations in service delivery or payment approaches be shared in a way that spreads best practice?

54. Ensuring good data quality is also vital for effective payment arrangements. Both provider(s) and commissioner(s) must ensure they have confidence the underlying patient level data (including the coded clinical information) submitted is accurate, complete and fit for the purposes of payment under the NHSPS.

3.1.3 Constructive engagement

55. Where payment arrangements require provider and commissioner agreement of the level and mix of activity to be delivered within the payment specified, they must engage constructively with each other to decide on the mix of services and delivery model that delivers the best value for patients in their local area. This process should involve clinicians, patient groups and other relevant stakeholders where possible. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time. Constructive engagement is intended to support better and more informed decision making in both the short and long term.

56. Commissioners and providers must therefore consider the following factors:

- **Framework for negotiations (where appropriate)**: Have the parties agreed a framework for negotiations that is consistent with the existing guidelines in the NHS Standard Contract and procurement law (as applicable)?
- **Information sharing**: Are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?
- **Involvement of relevant clinicians and other stakeholders**: Are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
- **Short- and long-term objectives**: Are clearly defined short- and long-term strategic objectives for service improvement and development agreed before starting price negotiations?

3.1.4 Health inequalities

57. Addressing health inequalities is a key priority for the NHS and, following the 2022 Act, a statutory obligation. When agreeing payment arrangements, commissioners and providers must ask how the agreement could facilitate equitable access, excellent experience and optimal outcomes for seldom heard population cohorts. This should be underpinned by analysis of suitably disaggregated data, where available.

58. The agreement must not adversely affect other national and local initiatives which seek to tackle health inequalities. Where all or part of the agreement is specifically tailored to enhance equality of healthcare provision, commissioners and providers must jointly recognise both the expected cost of this and the anticipated benefit. This should be reflected in the locally determined price.

59. In agreeing payment arrangements, it is recommended commissioners and providers visit the NHS Equality and Health Inequalities Hub to consider their legal duties with regard to health inequalities and to learn more on how the NHS aims to reduce health inequalities. Providers and commissioners should also consider using the Core20PLUS5 approach to achieve better, more sustainable outcomes and reduce healthcare inequalities.

3.1.5 Operational Planning Guidance

60. The Operational Planning Guidance and associated materials set out detailed guidance on what commissioners and providers are expected to deliver. Providers and commissioners should carefully consider this guidance and use it to inform their priorities as they are agreeing payment arrangements.

3.2 Cost uplifts

61. 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 set a forward-looking adjustment to reflect expected cost changes in future years deemed outside providers' control. We refer to this as the cost uplift factor.

62. The cost uplift factor for 2025/26 is 4.15%. All payment arrangements must have regard to this figure.

63. Table 5 shows the categories of cost pressure considered in setting the cost uplift factor, and the weight each cost category is assigned (reflecting the proportion of total expenditure). For more details of the cost uplift calculation, see Annex DpD.

64. The following costs are excluded from the calculation of 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 costs relating to placements which have been funded directly by Health Education England (trainee salaries are included within pay costs).
- High cost drugs, which are not reimbursed through NHSPS prices.

Table 5: Elements of inflation in the cost uplift factor for 2025/26

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.

65. Please note: Table 5 shows total indicative pay cost change is valued at 4.72% for 2025/26. This reflects the fact that allocations for 2025/26 include a nominal 2.8% for pay, and then allows a 0.1% increase 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 reflect final pay arrangements for 2025/26, which have not yet been agreed.

3.3 Efficiency

66. Payments are adjusted up by the cost uplift factor (see Section 3.2), reflecting our estimate of inflation, and down by the efficiency factor, reflecting our estimate of the average efficiency providers can be expected to achieve year-on-year. This approach is consistent with other sectors where prices and payments are regulated centrally.

67. The efficiency factor for 2025/26 is 2.0%. All payment arrangements must have regard to this figure. For more information on the efficiency factor, see Annex DpD.

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3.4 Excluded items

68. Several high cost drugs, devices and listed procedures, and MedTech Funding Mandate products are unbundled and excluded from the associated core payment mechanisms or prices. These items are listed on tabs 12a, 12b and 12c of Annex DpA and are subject to local payment arrangements, with commissioners deciding whether, and how, they should be paid for. High cost drug excluded items under NHS England Specialised Commissioning are either eligible for block or cost and volume payments (see the Specialised Commissioning drugs list). Where items are categorised as block, a fixed amount will be agreed by the commissioner and provider at the start of the year.

69. For items that are not on the exclusion lists and are part of a priced treatment or service, the cost of the drug, device or listed procedure is covered by the NHSPS unit price, or under the API arrangements.

70. While the 2025/26 NHSPS is in effect, any newly introduced items that are funded by commissioners and available for use by providers are excluded from core payment mechanisms and should be paid for separately.

71. Homecare services (drugs, devices and their related costs) are also excluded from core payment mechanisms or prices. For these items and their related costs, local funding arrangements must be agreed by the commissioner and provider, in accordance with the excluded items pricing rule set out below.

72. For some high cost drugs, a reference price is set at a level to incentivise provider uptake of that drug. Please note: The national reference price for adalimumab (set for financial year 2019/20) no longer applies. As such, adalimumab should be reimbursed in the same way as other high cost excluded drugs that do not have a reference price.

73. A number of high cost devices are directly commissioned by NHS England. Providers will be reimbursed directly for any purchases made via the NHS England Central Procurement process with NHS Supply Chain (the Visible Cost Model). Any device categories or specific products not available via NHS Supply Chain will be reimbursed directly based on the Device Patient Level Contract Monitoring (DePLCM) template. Trusts will not be reimbursed for expenditure reported on the DePLCM which should have been ordered via NHS Supply Chain.

74. Annex DpA, tab 12c, contains a list of MedTech Funding Mandate products, which are also excluded from core payment mechanisms. These products should be commissioned by ICBs and reimbursed following the excluded items pricing rule set out

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below. As part of these arrangements, the NHS England Innovation team may publish ‘reference prices’ for some of these listed products.

75. Under the rules for low volume activity (LVA), the LVA payment value covers all services delivered by an NHS provider for an ICB where, historically, there has not been a written contract. No invoicing should take place outside of this payment (other than where the LVA rules specify particular exceptions), so the excluded items pricing rule does not apply for LVA arrangements.

Excluded items pricing rule

a) This rule applies to high cost drugs, devices and listed products and MedTech Funding Mandate products which are listed in Annex DpA and which:

   i. are used in the delivery of services commissioned by either NHS England or an ICB; or
   ii. are being commissioned as part of a service to which API does not apply (see rules 1(c) and 4 in Section 4),

   and should be read alongside Service Condition 39 of the NHS Standard Contract (Procurement of Goods and Services).

b) A commissioner and provider must agree the price to be paid for a high cost drug, device or listed procedure or MedTech Funding Mandate product to which this rule applies. However, the price for that item must be adjusted to reflect any part of the cost already captured by an NHSPS unit price or API fixed element.

c) The price agreed should reflect:

   i. in the case of a high cost drug for which a reference price has been set at a level to incentivise provider uptake of that drug, that reference price;
   ii. in the case of a MedTech Funding Mandate product for which a reference price has been set, that reference price;
   iii. in all other cases, the actual cost to the provider, or the nominated supply cost, or any other applicable reference price, whichever is lowest.

d) As the price agreed should reflect either the actual cost, or the nominated supply cost, or a reference price, the requirement to have regard to the efficiency factor and cost uplift factor (see Sections 3.2 and 3.3) does not apply.

e) The ‘nominated supply cost’ is the cost which would be payable by the provider if the high cost device, high cost drug or MedTech Funding Mandate product was purchased

via an NHS Medicines Framework Agreement or via NHS Supply Chain (as appropriate) as required in accordance with Service Condition 39 of the NHS Standard Contract (Procurement of Goods and Services). The reference prices are set by NHS England and are based on the current best procured price achieved for a product or group of products by the NHS, or set at a level to incentivise provider uptake of a particular drug.

3.5 Terms used in payment mechanism rules

76. In the NHSPS rules set out in Sections 4-7, the following terms have the meanings defined here:

- “community diagnostic activity” means diagnostic activity delivered both in community diagnostic centres (CDCs) and non-CDC locations.
- “expected annual contract value” means:
  - the amount agreed by the commissioner and provider as the expected value of the contract between them for the provision of secondary care services for the relevant financial year, or
  - if no such contract has been agreed but the commissioner and provider accept that such services are to be provided by the provider (for the benefit of persons for which the commissioner is responsible) during some or all of that year, the amount agreed by the commissioner and provider as the expected amount to be paid for provision of those services if a contract was agreed, calculated on the same basis as referred to in the payment mechanism rules;
- “elective activity” means the number of elective spells, first outpatient attendances, outpatient procedures which group to a non-WF HRG with a published HRG price, chemotherapy delivery and unbundled diagnostic imaging and nuclear medicine activity (see Annex DpE for full definition);
- “secondary care services” means health care services provided for the purposes of the NHS, including hospital, community, mental health and ambulance services, but excluding services provided pursuant to the public health functions of local authorities or the Secretary of State. It does not include primary care services where the payments made to providers of those services are determined by, or in accordance with, regulations or directions, and related instruments, made under the primary care provisions of the National Health Act 2006 (Parts 4 to 7).

4. Payment mechanism: aligned payment and incentive

77. This section sets out the aligned payment and incentive (API) rules for 2025/26. These rules apply only to services provided by NHS providers (ie NHS trusts and NHS foundation trusts). Almost all contractual relationships between a commissioner and an NHS provider under which there is an expected annual value of activity is above £1.5m are subject to API rules. Section 3.5 defines the meanings of some terms used in these rules.

78. NHS providers and commissioners must apply the rules set out here to agree the amounts payable for the specified services, subject to certain exceptions.

79. The API approach does not change the requirements to report activity data (see Section 9.2).

80. The API approach is a type of blended payment, based on the model introduced in the 2019/20 National Tariff. In line with the commitments in the NHS Long Term Plan, a blended payment approach remains the direction of travel for the NHS payment system.

Rule 1 (general rule)

a) Commissioners and NHS providers (ie NHS trusts and NHS foundation trusts) must determine the prices payable for the provision of all secondary care services, except elective activity, in accordance with this rule, rules 2 to 6 below, and having regard to the overarching policies set out in Section 3 and guidance published by NHS England in relation to the pricing of those services.

b) Elective and community diagnostic activity will be reimbursed in accordance with rule 2 (e)(i) below.

c) Subject to rules 4 and 5 (exceptions), rule 2, and the aligned payment and incentive specified in that rule, applies to all secondary care services where the provider of the service is an NHS provider.

Rule 2 (agreeing the aligned payment and incentive)

a) Where this rule applies, the price payable by a commissioner to a provider for the provision of secondary care services shall be a single payment for the financial year, calculated in accordance with the following paragraphs. The supporting document *NHS provider payment mechanisms* provides more detail on calculating this payment.

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b) The provider and commissioner must agree a fixed element representing funding for the provision of secondary care services, except for elective and community diagnostic activity, for the financial year, applying the payment principles specified in Section 3.1. Commissioners and providers must review their fixed payments each year. The *NHS provider payment mechanisms* document sets out a methodology to support providers and commissioners with this. Providers and commissioners must also have regard to the cost uplift and efficiency factors for the financial year (as set out in Sections 3.2 and 3.3). This should also include agreed funding for CNST contributions, having regard to the subchapter costs, particularly for maternity services, shown in Section 2.3 of Annex DpD, and the implementation costs of the MedTech Funding Mandate products in Annex DpA, tab 12c.

c) High cost drugs, devices and listed procedures, and MedTech Funding Mandate products in Annex DpA (tabs 12a, 12b and 12c), as well as homecare services (drugs, devices and their related costs), will be reimbursed in accordance with excluded items pricing rule (see Section 3.4)

d) The provider and commissioner must also agree:

   i. for the annual best practice tariffs (BPTs), the expected level of BPT criteria attainment which the provider will achieve in delivering those services
   ii. the expected level of advice and guidance activity for the financial year which is intended to be reflected in the fixed element

e) Subject to rule 3, the price payable shall be the fixed payment, varied as set out below:

   i. Where the provider delivers elective or community diagnostic activity, the amount payable for this activity must be added to the fixed payment, subject to paragraph (f). The amount payable must be calculated by reference to the volume of elective and community diagnostic activity, priced using the unit prices set out in Annex DpA. Any elective activity BPT payment and the relevant market forces factor (MFF – see Section 8.2) should be applied. A locally agreed price should be used where no unit price is published.
   ii. If the level of advice and guidance activity is different to that agreed pursuant to paragraph (d) above, the fixed payment should be increased or decreased as agreed by the commissioner and provider in accordance with guidance issued by NHS England.

f) For elective and community diagnostic activity with an expected value over £0.1m, the commissioner must set a notified payment limit based on the value of a planned level of activity:

i. The financial value for the planned level of activity described in paragraph (e)(i) is the maximum amount the commissioner is required to pay the provider.
ii. Commissioners can choose to break down the planned level of activity into specific limits set at service, specialty or procedure level.
iii. If a planned level of activity is not agreed, the commissioner is able to set the plan and financial value of the notified payment limit, having regard to the guidance in Annex DpE.
iv. Commissioners should notify providers in writing of the payment limit which applies to them by 30 April 2025. Where limits are then set at service, specialty or procedure level, commissioners should notify providers of these specific limits in writing by 30 June 2025.
v. If a provider expects to exceed the notified payment limit, they should notify the commissioner as soon as possible. Commissioners cannot reduce the payment limit in-year but, in agreement with providers, can increase payment limits for individual providers.
vi. In setting the notified payment limit, commissioners must have regard to the guidance in Annex DpE.

Rule 3 (locally agreed adjustments)

a) The commissioner and provider may agree an adjustment to the price payable under rule 2, including a change as to how the fixed payment is calculated or a variation to the fixed payment other than as provided for in rule 2(e), provided that:

i. they comply with paragraphs (b) to (e) of this rule 3; and
ii. the agreement is approved by NHS England following an application by the commissioner and provider.

b) The commissioner and provider must apply the local pricing principles in Section 3.1.

c) Once approved by NHS England, the agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers the services in question.

d) The commissioner must maintain and publish a written statement of the agreement, using an approved template provided by NHS England, within 30 days of the relevant

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contract being signed, or in the case of an agreement during the term of an existing contract, the date of the agreement.

e) The commissioner must submit the written statement to NHS England.

Rule 4 (exceptions – services in scope of the aligned payment and incentive)

a) Rules 2 and 3 do not apply for the following specialised services:

i. Treatment costs relating to NICE decisions (such as CAR-T)
ii. Genomic testing.

b) For these services, the provider and commissioner must apply the payment principles specified in Section 3.1, and have regard to the cost uplift and efficiency factors for 2025/26 (as set out in Sections 3.2 and 3.3). They must locally agree payment arrangements, having regard to NHS England Specialised Commissioning guidance.

Rule 5 (exceptions – services outside the aligned payment and incentive)

a) Rules 2 and 3 do not apply where:

i. there is an LVA arrangement in place
ii. there is an individually procured service for a clinical area identified by NHS England Specialised Commissioning
iii. there is a single non-acute service procured by an ICB from an NHS provider.

b) In those cases, the prices payable for the provision of secondary care services for the financial year must be determined as follows:

i. in cases falling within paragraph (a)(i):

a. The value set out in the LVA payments schedule in Annex DpA

or

ii. in cases falling within paragraph (a)(ii) or (a)(iii) (whether or not also falling within paragraph (a)(i)), the unit prices set out in Annex DpA (to the extent those prices apply to the services – where no unit price exists for the service, a local price must be agreed), subject to the relevant market forces factor.
iii. the payment mechanism as detailed in the original procurement invitation and subsequent contract awarded.

5. Payment mechanism: low volume activity block payments

81. This section sets out the low volume activity (LVA) rules for 2025/26. Almost all activity delivered by NHS providers with an expected annual value below £1.5m is subject to LVA rules. Section 3.5 defines the meanings of some terms used in these rules. The NHS provider payment mechanisms document provides more guidance on the LVA.

82. The LVA arrangements do not change the requirements to report activity data (see Section 9.2).

Rule 1 (general rule)

a) Commissioners and providers must determine the prices payable for the provision of secondary care services in accordance with this rule, and rules 2 to 3 below, and having regard to guidance published by NHS England in relation to the pricing of those services.

Subject to rule 3 (exceptions), rule 2 and the low volume activity specified in that rule applies to all secondary care services where:

i. the annual activity between a commissioner and NHS provider is expected to have a value of less than £1.5 million, and
ii. NHS England judges an LVA is appropriate, following consideration of:
   a. proximity of the provider to the commissioner
   b. value of the LVA payment compared to the trust's overall income
   c. whether the provider delivers specialised services.

Rule 2 (LVA payment)

a) For any LVA arrangement identified in the LVA payment schedule, published in Annex DpA, the commissioner must pay the provider the amount specified in the schedule 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 pay award, any required additional payments should be made in the month after the updated LVA schedule is published.

b) No invoicing should take place outside of this payment.

Rule 3 (exceptions)

a) The LVA arrangements cover all clinical services (acute, mental health and community) provided by NHS providers, with three exceptions:

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

b) Where both parties agree to do so, providers and commissioners can choose to enter into a contract in place of the LVA arrangements. This contract would be subject to the NHSPS local payment arrangement rules in Section 7.

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6. Payment mechanism: activity-based payment

83. This section sets out the activity-based payment rules for 2025/26. Almost all activity delivered by non-NHS providers for services where there are NHSPS unit prices are subject to these rules. Section 3.5 defines the meanings of some terms used in these rules.

84. Providers and commissioners must apply the rules set out here to agree the amounts payable for the specified services.

85. The activity-based payment approach does not change the requirements to report activity data (see Section 9.2).

86. Almost all activity delivered by NHS providers (trusts and foundation trusts) would be subject to either API or LVA rules (see Sections 4 and 5), although some exceptions be subject to local payment arrangements (see Section 7). The rules here apply only to non-NHS providers

Rule 1 (general rule)

a) Commissioners and providers must determine the prices payable for the provision of secondary care services in accordance with rules 2 and 3 where the following conditions apply:

   i. the provider is not an NHS trust or an NHS foundation trust, and
   ii. the service has an NHSPS unit price, published in Annex DpA.

Rule 2 (the activity-based payment)

a) The price payable by a commissioner to a provider for the provision of secondary care services shall be a payment for each unit of activity delivered, subject to the payment limits set out in paragraph (b) of this rule 2, calculated in accordance with the following paragraphs.

   i. The NHSPS unit price for the service, published in Annex DpA, must be paid for each unit of activity delivered, up to the payment limit.
      a) Where the criteria set out in Annex DpC are achieved, best practice tariff (BPT) unit prices should be paid for elective activity BPTs.
      b) The amount paid should be the NHSPS unit price after the application of the relevant market forces factor (MFF – see Section 8.2).

b) Where the value of the provider-commissioner relationship, including non-contract activity, is above £0.1m, the commissioner must set a notified payment limit based on the value of a planned level of activity:

i. The provider and commissioner must agree a planned level of activity, expressed as a financial value. The financial value for the planned level of activity is the payment limit – the maximum amount the commissioner is required to pay the provider.
ii. Commissioners can choose to break down the planned level of activity into specific limits set at service, specialty or procedure level.
iii. If a planned level of activity is not agreed, the commissioner is able to set the plan and financial value of the notified payment limit, having regard to the guidance in Annex DpE.
iv. Commissioners should notify providers in writing of the payment limit which applies to them by 30 April 2025. Where limits are then set at service, specialty or procedure level, commissioners should notify providers of these specific limits in writing by 30 June 2025.
v. Where a new provider starts to provide services during the year with an expected value above the £0.1m threshold, the commissioner should notify the provider and, if applicable, co-ordinating commissioner of the payment limit.
vi. For non-contract activity with an expected value above £0.1m, the commissioner must set an appropriate payment limit, having regard to the guidance in Annex DpE.
vii. If a provider expects to exceed the notified payment limit, they should notify the commissioner as soon as possible. Commissioners cannot reduce the payment limit in-year but, in agreement with providers, can increase payment limits for individual providers.
viii. In setting the notified payment limits, commissioners should have regard to the guidance in Annex DpE.

Rule 3 (locally agreed adjustments)

a) The commissioner and provider may agree an adjustment to the price payable under rule 2, provided that they comply with paragraphs (b) to (e) of this Rule 3.

b) The commissioner and provider must apply the local pricing principles in Section 3.1.

c) The agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers the services in question.

d) The commissioner must maintain and publish a written statement of the agreement, using the template and guidance provided by NHS England, within 30 days of the relevant contract being signed, or in the case of an agreement during the term of an existing contract, the date of the agreement.

e) The commissioner must submit the written statement to NHS England.

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7. Payment mechanism: local payment arrangements

87. This section sets out the local payment arrangement rules for 2025/26. Where one of the payment mechanisms set out in Sections 4 to 6 does not apply, local payment arrangement rules should be used. Section 3.5 defines the meanings of some terms used in these rules.

88. Where payment arrangements are determined locally, it is the responsibility of commissioners to have regard to relevant factors, including opportunities for efficiency and the actual costs reported by their providers. Providers and commissioners should also bear in mind the requirements set out in the NHS Standard Contract, such as in relation to counting and coding.

89. Rule 2 requires commissioners and providers to have regard to NHSPS cost uplift and efficiency factors. In effect they should be used as a benchmark to inform local negotiations. However, these are not the only factors that should be considered. Other relevant factors may include, but are not restricted to:

- commissioners agreeing to fund service development improvements
- additional costs incurred as part of any agreed service transformation
- funding of initiatives to address health inequalities
- taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
- comparative information (eg benchmarking) about provider costs and opportunities for local efficiency gains
- differences in costs incurred by different types of provider.

90. Where a commissioner and provider cannot agree a local payment arrangement, they should speak to their NHS England regional team to help resolve the situation.

Rule 1 (general rule)

a) Where the payment rules set out in Sections 4 to 6 do not apply, a provider and commissioner may agree the price payable for services.

b) Providers and commissioners must apply the payment principles in Section 3.1 when agreeing the amount payable for services.

c) Where the local payment arrangement involves payment being made on a per unit of activity basis, and the annual activity between the commissioner and provider is

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expected to have a value of more than £0.1m, the commissioner must set a notified payment limit based on the value of a planned level of activity:

i. The provider and commissioner must agree a planned level of activity, expressed as a financial value. This financial value is the payment limit – the maximum amount the commissioner is required to pay the provider.
ii. Commissioners can choose to break down the planned level of activity into specific limits set at service, specialty or procedure level.
iii. If a planned level of activity is not agreed, the commissioner is able to set the plan and financial value of the notified payment limit, having regard to the guidance in Annex DpE.
iv. Commissioners should notify providers in writing of the payment limit which applies to them by 30 April 2025. Where limits are then set at service, specialty or procedure level, commissioners should notify providers of these specific limits in writing by 30 June 2025.
v. Where a new provider starts to provide services during the year with an expected value above the £0.1m threshold, the commissioner should notify the provider and, if applicable, the co-ordinating commissioner of the payment limit.
vi. For non-contract activity with an expected value above £0.1m, the commissioner must set an appropriate payment limit, following the guidance in Annex DpE.
vii. If a provider expects to exceed the notified payment limit, they should notify the commissioner as soon as possible. Commissioners cannot reduce the payment limit in-year but, in agreement with providers, can increase payment limits for individual providers.
viii. In setting the payment limits, commissioners should follow the guidance in Annex DpE.

Rule 2 (cost adjustments)

a) Commissioners and providers must have regard to the cost uplift and efficiency factors for the relevant financial year (as described in Sections 3.2 and 3.3), and CQUIN funding, which was transferred into the National Tariff in 2021/22, when agreeing local payment arrangements.

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8. Prices and related adjustments

91. Our aim in setting prices is to support the highest quality patient care, delivered in the most efficient way.

92. Annex DpA contains the 2025/26 NHSPS prices.

93. In the NHSPS there are two types of price:

- **unit price**: unit prices should be used for all services within scope of an activity-based payment mechanism and for the API elective variable element.
- **guide price**: guide prices can be used to support local payment arrangements and as a source of benchmarking data. Guide prices include prices for non-elective services and for some services that previously had non-mandatory prices.

94. Whenever prices are used, the relevant market forces factor (MFF – see Section 8.2) should be applied to calculate the final price to be used.

95. The LVA payments schedule is also published in Annex DpA. This sets out the amounts to be paid under the LVA arrangements set out in Section 5.

8.1 Calculating prices

96. We calculated NHSPS prices for 2025/26 by updating 2024/25 NHSPS prices for inflation and efficiency, rather than calculating new price relativities. This means the prices are based on 2018/19 cost and activity data and we have used the same currency design as 2024/25, with the healthcare resource group HRG4+ phase 3 as the basis for prices for many services, including admitted patient care and outpatient procedures. 2025/26 prices have been calculated by updating 2024/25 pay award prices (published in September 2024) for inflation and efficiency (see Sections 3.2 and 3.3). The 2025/26 and prices use the version of the currency design that was used for 2018/19 reference costs.

97. The methodology for 2025/26 prices closely follows that used in past national tariffs. Annex DpD contains a step-by-step description of the method, but it is briefly summarised here:

- Set draft price relativities (the 2024/25 pay award prices, published in September 2024).
- Make manual adjustments to the price relativities (details in Annex DpD):
- Scale to the 2025/26 prices cost base, described in Section 2.6 of Annex DpD.

- Adjust prices for 2025/26 inflation and efficiency (see Sections 3.2 and 3.3).

8.2 The market forces factor

98. The purpose of the market forces factor (MFF) is to compensate providers for unavoidable cost differences in providing healthcare services. Unavoidable costs include variations in capital and building costs, business rates and labour costs.

99. The MFF takes the form of an index. This allows a provider's location-specific costs to be compared with every other organisation. The index is constructed so that it always has a minimum value of 1.00. The MFF payment index operates as a multiplier to each unit of activity.

100. For 2025/26, we updated the data used to calculate MFF values for each NHS provider. All MFF values are available in Annex DpA, tab 11.

101. Updating the data used to calculate MFF values reduced the total amount of money that would have been paid through the MFF (if all activity was reimbursed using unit prices), with compensating increases in the prices. The resulting increase in 2025/26 prices, compared to using 2024/25 MFF values, is 0.41%.

102. Changes in MFF should not immediately translate into a change to API fixed payment values. However, it should be considered when applying local efficiency requirements, including convergence or deficit reduction, activity growth and changes in MFF. Such requirements should be considered in aggregate; for example, convergence may moderate the impact of MFF changes for a commissioner. Where adjustments in API fixed payment are agreed to be actioned over time, a clear plan should be documented on what changes are expected and when they will be actioned. For elective services and all services paid for on an activity basis, providers are paid 100% of NHSPS unit prices with relevant MFF value applied, up to the relevant payment limit.

103. The MFF value for independent sector providers is the MFF value of the NHS trust or foundation trust nearest to the location where the services are being provided.

104. Organisations merging or undergoing other organisational restructuring after the publication of the 2025/26 NHSPS will not have a new MFF set during the period covered by this payment scheme without consultation.

105. Further information on the calculation and application of the MFF is provided in the supporting document, *A guide to the market forces factor*.

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106. Providers should notify NHS England of any planned changes that might affect their MFF value. Please contact england.pricingenquiries@nhs.net.

8.3 PSS top-up payments

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

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

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

110. The amounts paid and the providers that are eligible are based on the PSS definitions and the list of eligible providers is contained within the PSS operational tool.

111. PSS top-up payments are only made for inpatient care where prices are used. A list of the services eligible for PSS top-ups, the adjustments and their flags can be found in Annex DpA, tab 13.

112. Each eligible provider will receive specialist top-up payment from NHS England as part of the API fixed element. The payment of top-ups remains the responsibility of NHS England, even if the specialised activity has been delegated to ICBs.

8.4 Calculating LVA payment values

113. Section 5 sets out where LVA arrangements apply.

114. The 2025/26 LVA payments schedule values were calculated 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 (see Annex DpD).
- Mental health and community services – update the 2024/25 LVA values with the 2025/26 cost uplift and efficiency factors.

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- 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 3.2 and 3.3) and add newly-delegated services.

115. A breakdown of these values is provided in the Annex DpA.

9. Rules for making payments

116. Section 114A(8) of the 2012 Act allows for the setting of rules relating to the making of payments to providers where health services have been provided for the purposes of the NHS (in England).

9.1 Billing and payment

117. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS Standard Contract. Application of provisions within the NHS Standard Contract may lead to payments to providers being reduced or withheld.

9.2 Activity reporting

118. For NHS activity where there is no NHSPS price, providers must adhere to any reporting requirements set out in the NHS Standard Contract.

119. For services with NHSPS prices, providers must submit data as required under SUS guidance.

120. We will publish the dates for reporting activity and making the reports available.

121. NHS England has approval from the Secretary of State to allow ICBs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online about these conditions and sets the actions that ICBs, CSUs and providers must take to ensure they act lawfully.

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