NHS England

2025/26 NHS Payment Scheme – a consultation notice

Part C: Impact assessment

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Contents

1. Impact assessment

1.1 Purpose

1. This document presents our assessment of the likely impact of implementing NHS England's proposals for the 2025/26 NHS Payment Scheme (NHSPS). It should be read alongside Part A of the *2025/26 NHS Payment Scheme – a consultation notice* which provides full details of our proposals. The aim of this document is to help providers, integrated care boards (ICBs) and other consultees understand the likely impact of our policy proposals. This should support planning and help inform responses to the consultation on the proposed 2025/26 NHSPS.

2. For the 2025/26 NHSPS, we are proposing to continue with the four payment mechanisms introduced in the 2023/25 NHSPS that cover the provision of NHS-funded secondary healthcare services.

3. In Part A of the consultation notice we present the details of each of our policy proposals, explaining why we think this is the right thing to do. In this document, our aim is to provide an overall qualitative assessment of the 2025/26 NHSPS proposals and a quantitative assessment of the estimated aggregate impact of the NHSPS prices under two simplified scenarios.

4. In detail, this document covers:

    - a qualitative assessment of the proposed 2025/26 NHSPS and the likely impact on patient choice (Section 2)
    - our estimated aggregate financial impact of the proposed 2025/26 NHSPS prices on provider revenue and commissioner expenditure under two complementary scenarios (Section 3)
    - the likely impact of the 2025/26 NHSPS proposals on equality (Section 4)

5. The NHSPS proposals which are the subject of this assessment are subject to consultation. The statutory consultation period is 28 days, ending on 28 February 2025. Responses must be submitted via the online survey. For further details on how to respond, please see Part A of the consultation notice.

1.2 Scope of the analysis

6. We propose that the 2025/26 NHSPS contains rules for four different payment mechanisms:

Payment mechanism	Brief description	Applies to
Aligned payment and incentives (API)	Fixed element, with variable element paying 100% of NHSPS prices for elective activity, up to a payment limit	Almost all NHS provider relationships with • NHS England for any directly commissioned services; and • with any ICB not covered by LVA arrangements
LVA block payments (for low volume activity)	Nationally set payment amounts to cover entire provider/commissioner relationship	Almost all NHS Trust or NHS Foundation Trust 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, inclusive of any services delegated by NHS England)
Activity-based payment	NHSPS unit prices paid for each unit of activity, up to a payment limit	Services with NHSPS unit prices delivered by non-NHS providers
Local agreement	Providers and commissioners agree appropriate approach	Activity not covered by another payment mechanism

7. For the purposes of our quantitative assessment, we have made a number of simplifying assumptions to allow us to present the likely impact of our policy proposals and focus on the effect of price changes into provider revenue and commissioner expenditure.

8. A financial impact of the 2025/26 NHSPS values compared to the equivalent 2024/25 values is presented under two scenarios, using the approach described below in section 1.3. This analysis is intended to help providers and commissioners understand the likely impact of our proposals.

9. The quantitative assessment is based on the 2025/26 contract data in the planning submissions and proposed 2025/26 prices which can be found in Annex DpA. For more information on proposed price changes, see Section 11 of Part A of the consultation notice.

1.3 Our assessment approach

1.3.1 Appraisals overview

10. We have structured our assessment into two appraisals:

    - **Appraisal A**: A brief overall qualitative assessment of the proposals for the 2025/26 NHSPS. See Section 2.
    - **Appraisal B**: A quantitative assessment of the impact on provider income and commissioner expenditure for 2025/26, under two complementary scenarios. For our quantitative assessment, we combine Hospital Episode Statistics (HES) data with the contract information data received in 2024/25 planning templates to create the fixed and variable payments for NHS providers. In our first scenario, the fixed element is set by using data from the commissioner submissions and the variable element is set by reference to the proposed 2025/26 prices and equivalent 2024/25 prices (2024/25 prices used are the pay award prices published in August 2024). However, recognising data limitations and potential data quality issues with planning submissions, we also introduce a second scenario. In our second scenario, we present the impact of proposed price changes on the variable element only where activity is paid for using NHS prices, acknowledging that the fixed element isn't necessarily constructed using NHSPS prices. See Section 3.

11. As required in the Health and Care Act 2022, these appraisals provide an assessment of the likely impact of the proposed NHSPS.

12. These appraisals are intended to provide some useful background to help stakeholders assess the likely impact of our policy proposals in the round. However, due to the assumptions mentioned above, they can only be considered as an indicative impact of our proposals.

1.3.2 Approach to the qualitative assessment

13. In Appraisal A, we consider the overall direction of the proposed 2025/26 NHSPS against the NHS Long Term Plan commitment to reform the payment system and Lord Darzi's recent review of the NHS, providing an overall qualitative assessment of our proposals, including the likely impact on patients and the sector.

1.3.3 Approach to the quantitative assessment

14. In Appraisal B, we present a quantitative impact on NHSPS revenue and expenditure, for providers and ICBs under two complementary scenarios. The reason for having two scenarios is that, while the 2025/26 NHSPS proposes significant increases in the

published guide prices for non-elective, maternity and A&E services, the approach to setting the API fixed payment set out in the NHSPS and in the revenue and contracting guidance means that we do not expect these price increases to translate into increases in provider income. As such, assessing the impact using price x activity for all activity could be misleading. Providing an analysis under two different scenarios is intended to help provide a more useful impact assessment.

15. To measure the effect of the proposed 2025/26 NHSPS on provider revenue, under both scenarios of Appraisal B, we compare provider NHSPS revenue using the proposed 2025/26 prices against the equivalent 2024/25 prices. The 2024/25 prices used are the pay award prices published in August 2024, which reflected agreed 2024/25 pay awards.

16. Under our first scenario, for NHS providers only, we combined HES data with the fixed element contract information received in the commissioner submitted planning templates. We based our analysis of the fixed element on the submitted data for 2024/25 and adjusted for the impact of the net cost uplift and efficiency factors and the MFF adjustment factor to calculate a 2025/26 value. For the variable payment we used NHSPS prices under a constant level of activity for both years (2023/24 activity as published in HES). Doing so allows us to present the isolated impact of proposed price changes (assuming 2023/24 activity levels and casemix).

17. Under our second scenario, we focused on the effect of price changes using variable payments only. As the fixed element is not necessarily constructed using NHSPS prices, we narrowed our quantitative appraisal to consider the variable element only, where activity is paid for using the NHSPS prices. We believe this to be appropriate as the focus of this assessment is to present an isolated impact of our proposed price changes into provider revenue and commissioner expenditure.

18. We assessed the aggregate impact of the 2025/26 NHSPS proposals on NHS providers by type (acute, specialist, teaching and non-acute providers) and on ICBs and NHS England commissioners. As the transition to greater integration in specialised services commissioning arrangements is still ongoing, for the purposes of our quantitative assessment, we assume responsibility of specialised services remains with NHS England as they were prior to delegation.

19. We have assessed the likely impact of the proposed 2025/26 NHSPS on patients. We have also given due regard to our public sector equality duty, under the Equality Act

2010,[1] to eliminate discrimination and advance equality of opportunity for groups with protected characteristics and foster good relations between people who share a relevant protected characteristic and persons who do not share it. This aspect of our analysis, under the simplified assumptions of our second scenario, looks at how the financial impact of our proposals on providers and commissioners are likely to impact on the services provided and how the proposed 2025/26 NHSPS is likely to impact on access to services and the quality of care provided. We also consider our proposals' likely impact on patient choice. See Sections 2 and 4.

1.3.4 Quantitative assessment: limitations and assumptions

20. The scope of our quantitative assessment is limited to income and expenditure of activity that has an NHSPS price. We do not quantitatively assess other changes that may impact on provider revenue and ICB expenditure, such as revenue streams from locally priced services and revenues from outside the NHSPS. This is because of data limitations and our assessment being focused on NHSPS policy proposals. Also, we do not capture planned changes in service provision in integrated care systems (ICSs).

21. In addition, we do not quantitatively assess how the API fixed element is going to be set in practice. We calculate a likely scenario using submitted data under our first quantitative scenario for NHS providers and in our second scenario we assess the likely impact using the simplifying assumption that prices for the variable element only are a reasonable way of estimating or indicating that likely impact. We are continuing to work with stakeholders to understand how systems are implementing the API payment mechanism. We will also continue looking at ways to monitor the implementation of our proposals without adding a burden on the sector.

22. Our quantitative assessment is based on the following assumptions:

- That the price uplift for accident and emergency, maternity and non-elective will not increase NHS providers income in the fixed payment element of the API. This is intended to be used to support the review of fixed payment by providers and commissioners.
- **Duration** – We have assumed the NHSPS is in effect for a full financial year.
- **Activity levels** – Our baseline run uses 2023/24 activity levels and casemix. We consider this to be useful as our aim is to present the isolated impact of our

[1] Under Section 149 of the Equality Act 2010 (Equality Act), NHS England has a duty, in exercising their pricing functions, to have due regard to the need to: eliminate discrimination, harassment, victimisation and any other conduct prohibited by or under the Equality Act, advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it and foster good relations between people who share a relevant protected characteristic and persons who do not share it.

proposed price changes under a given casemix. We recognise that actual 2025/26 activity data could be different to the activity levels and casemix used in our baseline. As a result, the true quantitative impact of our proposals on NHSPS revenue and commissioner expenditure could differ from the impacts presented in this document.

- **Level of use** – Our modelled scenarios assume that providers and commissioners use some parts of the NHSPS prices for the API elements. This assumption allows a comparison of our proposals on prices and the associated impacts on providers and commissioners. However, the more the elements of the agreed API approach differ from our assumptions, the greater the difference between the impact of our quantitative findings and the local impact on systems. Also, we assume that the inflation and efficiency factors set out in Part A of the consultation notice are achieved.

1.3.5 Summary of quantitative findings

23. The quantitative findings of the impact assessment under our simplified scenarios are:

- We anticipate an increase in NHSPS payment revenue under both of our scenarios. With total payments in our first scenario increasing by +£1.4bn (+2.28%) in 2025/26 from 2024/25. And variable payments in our second scenario increasing by +0.4bn (+2.24%).
- The main drivers of this are: i) the net effect of the cost uplift and efficiency factors, and ii) adjustments to price relativities in services areas like Gynaecology, ENT and RPRP BPTs.
- We do not expect the 2025/26 NHSPS proposal to have a disproportionate impact on patients based on different age groups, race, or ethnicity.

1.4 Document structure

24. The rest of this document supports Part A of the statutory consultation notice on the proposed 2025/26 NHSPS. It is structured as follows:

- **Section 2** provides an overall qualitative assessment of the proposed 2025/26 NHSPS.
- **Section 3** presents the estimated aggregate financial impact of the 2025/26 NHSPS proposals on provider revenue and commissioner expenditure, under two complementary simplified scenarios.
- **Section 4** considers the likely impact of our proposals in relation to the protected characteristics as described in the Equality Act 2010.

2. Appraisal A – Qualitative assessment

2.1 The proposed 2025/26 NHS Payment Scheme

25. For 2025/26 we are proposing to set the rules for four payment mechanisms that will cover the amount payable for the provision of NHS-funded secondary healthcare services. These payment mechanisms were first introduced in the 2023/25 NHSPS.

Payment mechanisms

26. Almost all activity delivered by NHS providers would either be delivered by API blended payments or low volume activity (LVA) block payments. The API payment mechanism is a blended payment model comprising of fixed and variable elements for almost all services, including acute, community, mental health and ambulance services.

27. The API payment mechanism proposals for 2025/26 will ensure the payment mechanism remains consistent with our national priorities and payment principles. See Sections 6 and 7 of the consultation notice for our detailed proposals and why we think this is the right thing to do.

28. For 2025/26, we are proposing that commissioners would set payment limits for elective services, and all services paid for on an activity basis, where activity is above planned levels. This would apply to the API variable element, as well as activity-based and local payment arrangements.

29. The proposed 2025/26 prices have been calculated by adjusting 2024/25 pay award prices for the 2025/26 cost uplift factor (CUF) and general efficiency requirement.

30. We propose continuing to set an LVA payment value for all NHS provider/ commissioner relationships in scope. In addition, we are proposing to update the payment values, increase the threshold and improve the design, including delegated specialised services in the payment value. These changes do not significantly change the number of relationships in scope of LVA – details are set out in Section 7 of Part A of the consultation notice. Our proposed changes suggest that a total of 40 relationships will move into API in 2025/26 as these are now above our new threshold. For core ICB services, in 2025/26 we see a small increase in total payments to providers resulting from underlying activity changes and the net effect of the cost uplift factor.

31. For non-NHS providers, we propose to continue with an activity-based payment mechanism for all services with an NHSPS unit price. This would reimburse providers for each unit of activity delivered. For 2025/26, we are proposing that commissioners

would set a payment limit based on a planned level of activity. This would support system level planning to deliver increased activity but at a level that is affordable within each commissioner's budget. Overall, the proposals set out in the 2025/26 NHSPS are expected to have a positive impact on non-NHS providers income using prices for elective care services.

32. There is also a local payment arrangement mechanism, which would apply to any activity not covered by another payment mechanism (for example services delivered by non-NHS providers that do not have an NHSPS unit price). Where local payment arrangements involve payment on an activity basis, we propose that commissioners would set a payment limit for activity above an agreed level.

33. Part A of the consultation notice sets out the detailed proposals for each of these payment mechanisms, and why we think they are the right thing to do. These proposals support national priorities and are intended to ensure resources are allocated efficiently.

2.2 Impact on patient choice

34. The proposals for the 2025/26 NHSPS are intended to ensure delivery of as much activity as is affordable and support continued service transformation.

35. The proposed 2025/26 NHSPS makes no distinction as to which providers should be commissioned to undertake patient care. It recognises the flexibilities that various payment approaches can bring, that are most appropriate for different contract values and the providers who hold these. For example, the API variable element allows the system to adjust provider utilisation (choice) against assumptions in the system plan, while LVA arrangements reduce the transactional burden for small values of activity allowing providers to focus on delivering patient care.

36. None of the proposals have been designed to reduce patient choice and equity of access to NHS services. Funding and payment will continue to follow patients, with NHSPS prices used for the variable payment (up to the payment limit).

37. We are satisfied that payment limits will not, in most cases, cut across patient choice rules as providers would continue to be obliged to accept clinically appropriate referrals and to offer patients choices on where they get their treatment. However, an ICB imposing a payment limit on a provider could possibly impact the length of waits for a treatment option offered by that provider. This may in turn impact how patients exercise their right to choose.

38. NHS England expects ICBs 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 will in effect reduce the choices available to that patient.

2.3 Engagement with the sector

39. Throughout the development of our proposals, we have engaged with a wide range of stakeholders and used this input to shape our policies.

40. Feedback from providers and commissioners has been supportive of the direction of our payment reforms and move towards more system collaboration. However, there are concerns around an increase in complexity of managing the payment approach, especially between the interaction of the API rules, construction of the fixed element and ERF funding. For 2025/26, our proposed approach should encourage more collaborative planning at system level to deliver increased activity but at a level that is affordable within the system's budget, with elective activity paid using NHSPS unit prices on a variable payment basis, up to a set limit. Our proposal for systems to review the current fixed payments for all providers with an API contract should ensure these remain reflective of recent activity levels and reasonable costs. This supports our strategic goal to ensure available resources are used as effectively and efficiently as possible.

41. We have engaged with providers, commissioners, representative bodies, and other appropriate stakeholders throughout the development of our proposals for the 2025/26 NHSPS. In early October, we ran a series of webinars, with a recorded version becoming available shortly afterwards via our FutureNHS payment support page. Some policy areas in development were not covered in these sessions. Through our mailboxes we regularly receive feedback around the implementation of our policies which we consider throughout the development cycle of our proposals. We also had regular discussions with representative bodies and held various co-design sessions with stakeholders and clinical groups.

42. In Section 4 of Part A of the consultation notice we explain in more detail how we have worked with stakeholders to develop our proposals. In the subsequent sections of the notice we describe the feedback received and explain how we have used this to develop our proposals.

43. Consultees are invited to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts of our proposals.

3. Appraisal B – Anticipated aggregate impact of proposed policy changes

3.1 Introduction

44. This section presents a quantitative impact on NHSPS revenue and expenditure, for providers, ICBs and regions, under two complementary scenarios using the approach and simplifying assumptions set out in Section 1.3.

3.2 Scenario 1 – Anticipated aggregate impact of 2025/26 proposals on provider income

45. In our first scenario, we combine HES data with the fixed element contract information received in the commissioner submitted planning templates. As such, this appraisal is focused on NHS providers only. In this analysis, the fixed element is set using the submitted information for 2024/25, and for 2025/26 we adjust the submitted values for the impact of the net cost uplift and efficiency factors and the MFF adjustment neutrality factor. The variable element is calculated using the NHSPS unit prices for both years under a constant level of activity (2023/24 HES).

46. The findings presented include the following price-affecting changes proposed for 2025/26 (See Section 11 of the consultation notice Part A):

- Updating the market forces factor (MFF) values - We propose to update the data used to calculate the MFF. These new values utilise data from 2022/23 instead of 2017/20 and would be implemented in two steps.
- Changes in the Clinical Negligence Scheme for Trusts (CNST) payments put through the NHSPS and allocated across clinical areas (HRG Subchapters).
- Adjusting prices for inflation and efficiency.
- Uplifting A&E, maternity and non-elective prices to ensure prices more accurately reflect current costs
- Adjusting prices for some gynaecology and ENT procedures with the largest waiting list.
- Setting prices for the Right Procedure, Right Place (RPRP) BPT to encourage activity to move from day cases to outpatient procedures
- Adjusting prices for Automated Red Cell Exchange (SA41z)

47. More details on how we propose to calculate 2025/26 prices are available in Annex DpD - Prices and cost adjustments.

48. Figure 1 shows the combined impact of our proposals for 2025/26 on NHSPS provider revenue under scenario one – ie, it shows the difference between what each type of provider would receive in 2025/26 compared to 2024/25.

Figure 1: Total 2025/26 NHSPS difference by NHS provider type

Provider Type	Total Payment NHSPS Income (£'m) - 2024/25	Total Payment NHSPS Income (£'m) - 2025/26	Total Payment NHSPS Income Difference (£'m)	Percentage Difference (NHSPS Income)
Acute - Large	£12,535.73	£12,821.53	£285.81	2.28%
Acute - Medium	£7,451.84	£7,619.10	£167.26	2.24%
Acute - Multi-Service	£2,297.90	£2,350.87	£52.98	2.31%
Acute - Small	£4,690.14	£4,795.95	£105.82	2.26%
Acute - Specialist	£1,623.10	£1,660.73	£37.63	2.32%
Acute - Teaching	£31,351.16	£32,066.71	£715.55	2.28%
Non-Acute	£72.88	£74.51	£1.64	2.25%
Total	**£60,022.74**	**£61,389.41**	**£1,366.67**	**2.28%**

49. This scenario shows total NHSPS revenue for NHS providers increasing from £60.0 billion to £61.4 billion, an increase of +£1.36 billion (+2.28%) in 2025/26 from 2024/25. The main driver of this change are: a) the net effect of the cost uplift factor for inflation and efficiency, and b) specific adjustments to price relativities.

50. The expected percentage increase in NHSPS revenue across NHS acute provider types between 2024/25 and 2025/26 ranges from +2.24% to +2.32% (Figure 1).

Anticipated aggregate impact of 2025/26 proposals by provider type

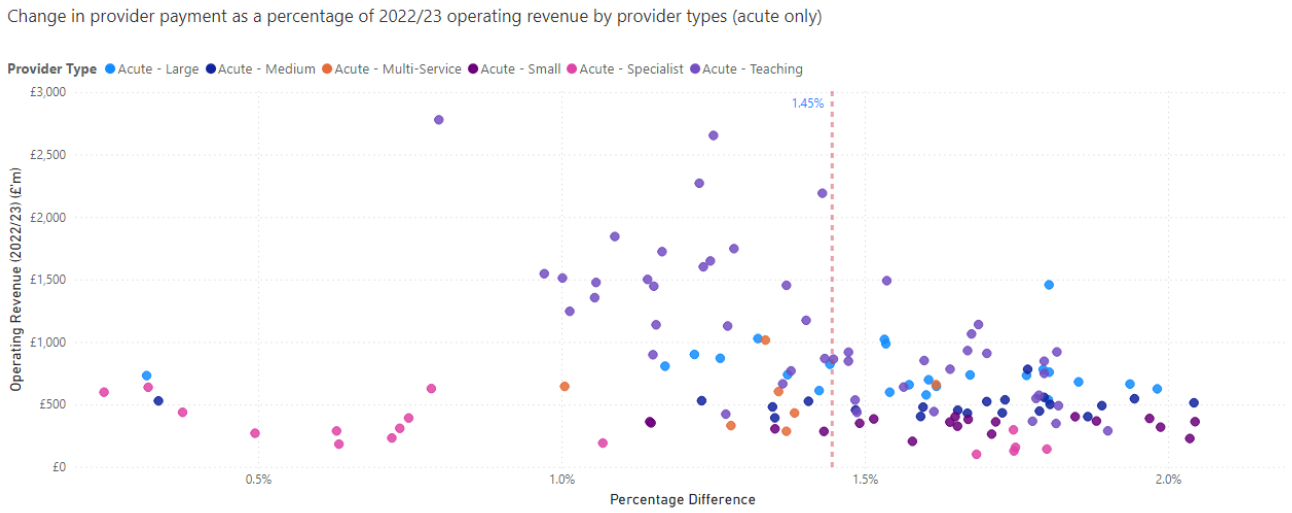
51. We expect that the majority of acute providers will receive an increased income from our proposals in 2025/26. They represent the largest proportion of overall NHSPS revenue and therefore receive a greater share of the overall increase in NHSPS revenue resulting from the adjustment for cost uplift net of efficiency. Figure 2 shows that 71 out of 135 NHS providers will have an above average increase in NHSPS priced revenue.

Figure 2: Number of NHS providers, excluding non-acute, that are above or below the average change in NHSPS revenue in 2025/26

Provider Type	Above Average	Below Average	Number of providers
Acute - Large	14	10	24
Acute - Medium	8	13	21
Acute - Multi-Service	4	3	7
Acute - Small	11	8	19
Acute - Specialist	9	7	16
Acute - Teaching	24	24	48
Total	**70**	**65**	**135**

52. Figure 3 shows that all acute providers are anticipated to see an increase in NHSPS income expressed as a proportion of their 2022/23 operating revenue, with an average increase of 1.45%. Acute NHS providers are anticipated to see changes ranging between 0.25% and 2.04%. Changes in MFF payments contribute to these changes, with the five trusts on the far-left hand-side seeing a reduction in MFF payments, resulting in lower-than-average increases in total revenues. The three trusts on the far right hand-side, with anticipated increases greater than 2.01% have a higher proportion of their income on the ENT, Gynaecology and RPRP BPTs service areas that we are proposing to increase for 2025/26. It is worth noting that the guidance on the application of the MFF set out in the revenue and contracting guidance is intended to affect (reduce in scale) the actual impact on provider payment in practice in 2025/26.

Figure 3: Overall impact of NHSPS proposals on NHSPS payment as % of operating revenue for NHS providers, excluding non-acute, in 2025/26

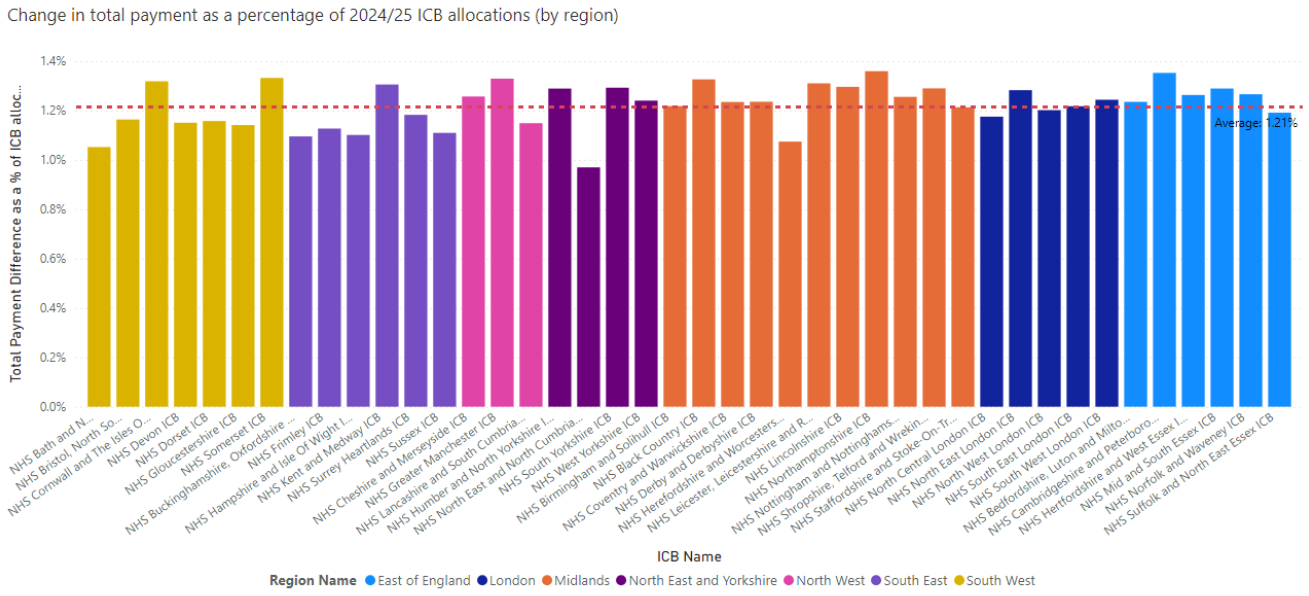


Anticipated aggregate impact of all 2025/26 proposals by ICBs

53. The expected impact of the 2025/26 NHSPS proposal on commissioner spending is presented in the figure 4 below. Non-acute providers are included in the calculation to give the most comprehensive impact at ICB level.

54. Figure 4 also shows the aggregate impact of our proposals for 2025/26 by ICB and region. On average, it is expected that ICBs' overall spending will increase by 1.18%. The majority of ICBs in the South West and South East regions sit below the average of 1.21%. In contrast, the region with the most ICBs, the Midlands, have more ICBs spending above the average. The total payment difference between ICBs in the South East region range between 1.05% to 1.33%. The total payment difference between ICBs in the South West region range between 1.10% to 1.31%.

Figure 4: Change in NHSPS spending in 2025/26 as a percentage of ICB 2024/25 allocations by ICB



3.3 Scenario 2 – Anticipated aggregate impact of 2025/26 proposals on variable element income

Scenario 2 – Variable payment only

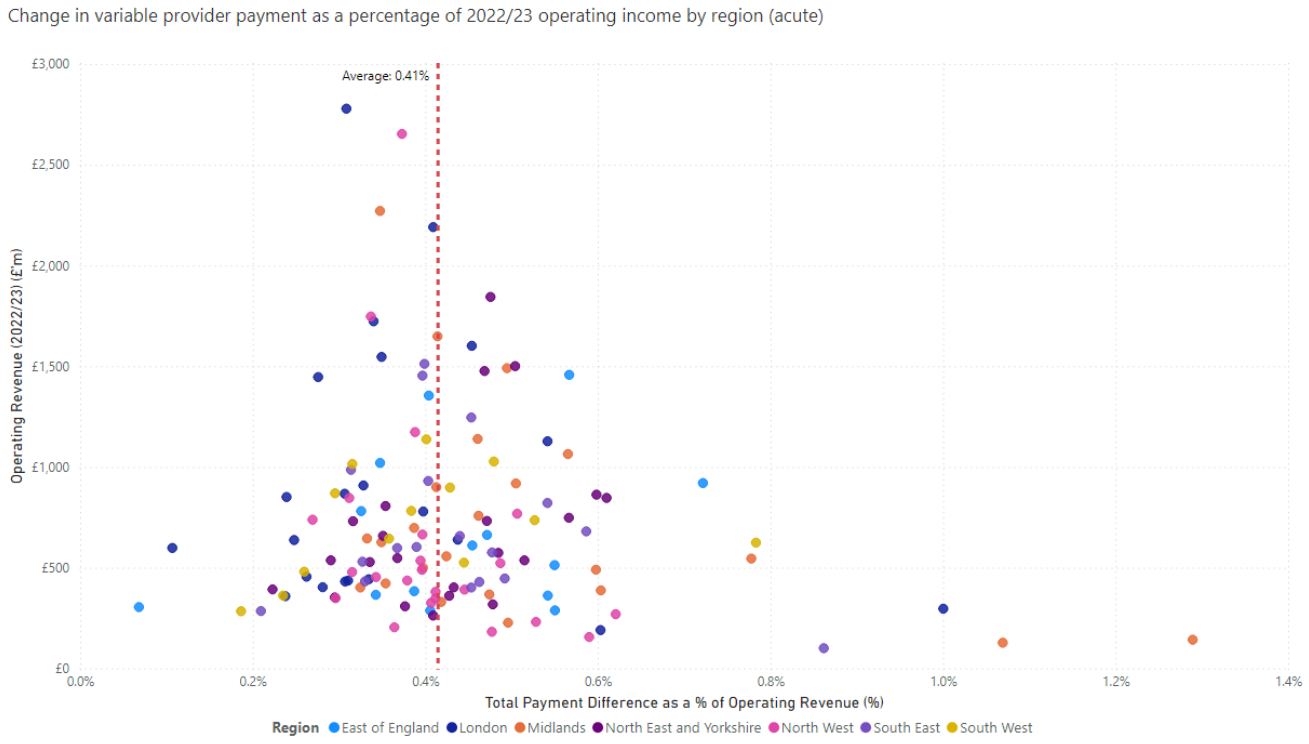
55. In our second scenario, we present the impact of our proposed policies using activity in scope of variable payments only. We believe this assessment will be helpful to providers and commissioners as it presents the likely impact of our proposed policy changes on provider revenue and commissioner expenditure.

56. Under our second scenario, we calculate the variable element using the NHSPS unit prices for both years under a constant level of activity (2023/24 HES).

57. The following graphs highlight the impact across all acute NHS provider types. The analysis then moves on to show the impact from a point of delivery (POD) perspective. The main changes driving the variable element are the same as described in paragraph 46, (with the exception of the uplift of A&E, maternity and non-elective prices, which are not used for variable payments). The net CUF results in increased variable payments uniformly across providers, but changes such as the MFF update and price adjustments for the Gynaecology, ENT and RPRP BPTs have a differential impact on providers. The following graphs and tables highlight the impact across all acute NHS provider types.

58. Figure 5 shows the provider payment difference as a percentage of operating income for the variable element. The total ranges between 0.07% and 1.29%. This is driven by the proposed changes in MFF and prices for the RPRP BPT. Most providers' increases are congregating around the average of 0.41%, with one specialist provider showing a significantly greater increase in revenue.

Figure 5: Change in NHSPS provider payment in 2025/26 as a percentage operating income – (Variable payment only)



59. Figure 6 illustrates the breakdown of the variable payment type by point of delivery.

Figure 6: Change in NHSPS provider payment in 2025/26 by Point of Delivery – (Variable payment only)

Payment Type	Point of Delivery	Total Payment (£'m) - 2024/25	Total Payment (£'m) - 2025/26	Total Payment Difference (£'m)	Percentage Difference
Variable	Daycase	£6,604.94	£6,715.13	£110.19	1.67%
	Elective	£5,726.24	£5,861.03	£134.79	2.35%
	Outpatient First Attendance	£2,634.45	£2,688.46	£54.02	2.05%
	Outpatient Procedure	£2,193.61	£2,282.52	£88.91	4.05%
	Unbundled	£2,619.42	£2,673.65	£54.24	2.07%
Total		**£19,778.65**	**£20,220.79**	**£442.14**	**2.24%**

60. Looking at the variable component in closer detail, our assessment suggests that there is a minor impact in the total payment in 2025/26. Electives and Outpatient Procedures have seen the highest percentage increase within the variable payment type in 2025/26. The above average increase for electives is driven by changes to prices for procedures with the largest waiting list (some gynaecology and ENT HRGs prices). Daycase, and Outpatient first attenders are the areas with the lowest percentage difference at 1.67% and 2.05% respectively. This difference is driven by the proposed prices for the Right Procedure, Right Place (RPRP) BPT.

Figure 7: Total 2025/26 NHSPS difference by Provider type– (Variable payment only)

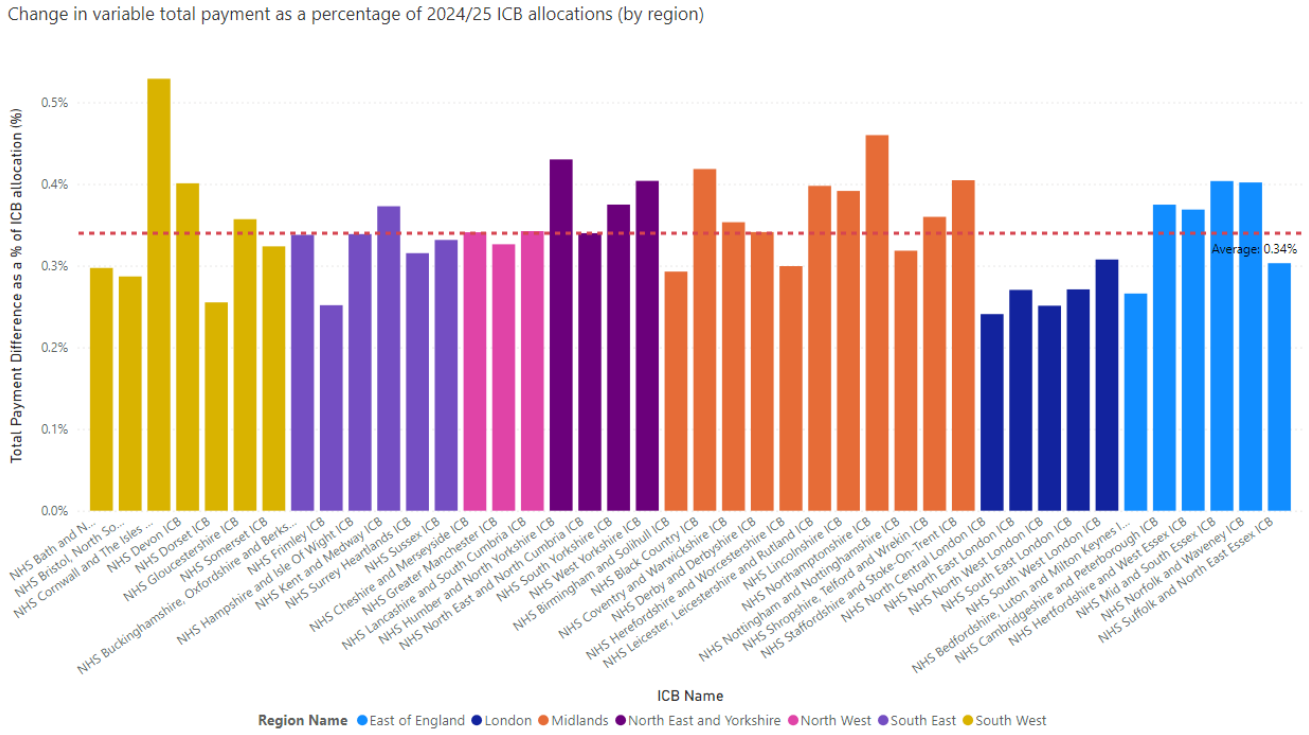
a)

Provider Type	Total Payment NHSPS Income (£'m) - 2024/25	Total Payment NHSPS Income (£'m) - 2025/26	Total Payment NHSPS Income Difference (£'m)	Percentage Difference (NHSPS Income)
Acute - Large	£3,589.89	£3,670.18	£80.28	2.24%
Acute - Medium	£1,944.31	£1,985.04	£40.73	2.09%
Acute - Multi-Service	£565.10	£578.26	£13.16	2.33%
Acute - Small	£1,104.24	£1,127.69	£23.46	2.12%
Acute - Specialist	£980.90	£1,003.76	£22.86	2.33%
Acute - Teaching	£9,798.24	£10,019.14	£220.91	2.25%
Independent Provider	£1,723.69	£1,762.81	£39.11	2.27%
Non-Acute	£72.29	£73.91	£1.62	2.25%
Total	**£19,778.65**	**£20,220.79**	**£442.14**	**2.24%**

b)

Provider Type	Total Payment (£'m) - 2024/25	Total Payment (£'m) - 2025/26	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
Independent Provider	£1,723.69	£1,762.81	£39.11	2.27%
NHS Providers	£18,054.96	£18,457.99	£403.03	2.23%
Total	**£19,778.65**	**£20,220.79**	**£442.14**	**2.24%**

Figure 8: Change in NHSPS priced spending in 2025/26 as a percentage of ICB 2024/25 allocations by ICB (Variable payment only)



4 Impacts relating to equality (Variable element)

4.1 Overview

61. Under Section 149 of the Equality Act 2010 (Equality Act), NHS England has a duty, in exercising its functions, including that of pricing, to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- foster good relations between people who share a relevant protected characteristic and persons who do not share it.

62. Regarding the last two points, we need, in particular, to have due regard to the need to:

- remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic
- take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
- encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low and eliminate discrimination
- tackle prejudice
- promote understanding.

63. The nine characteristics that are protected under the Equality Act are: age, race (including ethnic or national origins, colour or nationality), sex, pregnancy and maternity, sexual orientation, marriage or civil partnership, gender reassignment, disability, and religion or belief (including lack of religion or belief). We also acknowledge the principle of parity of esteem, by which mental health must be given equal priority to physical health.

4.2 Methodology

64. We present the impact of proposed price changes on the variable element only where activity is paid for using NHS prices under our second scenario outlined in paragraph 10, acknowledging that the fixed element is not necessarily constructed using NHSPS prices. The NHSPS may impact people differently based on their characteristics if HRGs with different price uplifts are utilised disproportionality by people with a given characteristic, leading to an unequally distributed growth in funding for care. For the

purposes of this impact assessment, we have considered the impact of our proposals on activity performed under the variable element on the nine protected characteristics listed above. The Index of Multiple Deprivation (IMD) is also used to consider inequality by deprivation.

65. Patient age, race, gender and IMD are recorded in the 2023/24 HES data set and are independently quality assured within NHS England. The use of HES data therefore enables analysis of how the proposed 2025/26 NHSPS prices would affect spending on patients with different recorded age, race, gender and IMD, applying the same assumptions set out in Section 1 of this impact assessment. For some records in HES, these patient variables have not been recorded or have been excluded following quality assurance. We have assessed growth in prices aggregated by these patient variables and individual ICB and clinical areas (as determined by HRG subchapter categorisation).

66. Information concerning the remaining equalities characteristics are not currently recorded in HES. For groups with these characteristics, therefore, we have only assessed the likely impact of our proposals qualitatively.

67. In addition, we have carefully considered whether it is possible to identify any potential positive or adverse equalities or health inequalities impacts of our proposals and have prepared Equality and Health Inequalities Impact Assessment (EHIA) templates to document these considerations and form part of decision making. Based on the available evidence, no unmitigated concerns have been identified to date.

68. The consultation process offers the opportunity for providers, ICBs, and interested agencies, organisations and individuals to comment on our assessment. Each policy and EHIA template will be reviewed as necessary following analysis of consultation feedback.

4.3 Assessment

4.3.1 Age

69. The age of a patient can have a major impact on hospital length of stay and associated healthcare costs. A number of healthcare currencies are split by age to reflect these differences in costs.

70. Figure 9 shows the anticipated change in spending for the different age groups, where the age field was populated in HES. Based on our assessment, we estimate the proposed NHSPS prices would increase spending on activity performed under the

variable element for all age groups by between 1.9% to 2.8%. Age groups 20-29 and 30-39 have a higher growth rate due to an increase in both obstetric prices (e.g. All termination of pregnancy services are now under variable payment) and increased CNST liabilities in this area. Overall we do not expect the 2025/26 NHSPS proposals to have a material disproportionate impact on patients based on age.

Figure 9: Anticipated changes in NHSPS priced income in 2025/26 by age group

Age_band_10_yrs	Total Payment (£'m) - 2024/25	Total Payment (£'m) - 2025/26	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
0-9	£815.83	£834.79	£18.96	2.32%
10-19	£825.77	£846.34	£20.57	2.49%
20-29	£835.90	£859.96	£24.07	2.88%
30-39	£1,302.36	£1,338.31	£35.95	2.76%
40-49	£1,577.49	£1,619.39	£41.90	2.66%
50-59	£2,595.31	£2,658.03	£62.72	2.42%
60-69	£3,359.30	£3,426.51	£67.21	2.00%
70-79	£3,711.45	£3,784.30	£72.84	1.96%
80-89	£1,813.07	£1,850.08	£37.02	2.04%
90-99	£214.65	£218.73	£4.08	1.90%
100 and above	£2.44	£2.49	£0.05	2.12%
Unknown	£2,725.09	£2,781.85	£56.76	2.08%
Total	**£19,778.65**	**£20,220.79**	**£442.14**	**2.24%**

4.3.2 Race (including ethnic or national origin, or nationality)

71. The NHSPS does not distinguish between patients based on their race, ethnicity or nationality. However, there are health conditions that are disproportionately experienced by people from certain ethnic groups and so the NHSPS could have a disproportionate impact on different ethnic groups.

72. Based on our assessment, the proposed NHSPS prices in scenario 2 would increase spending by between 2.1% and 3.8% for all ethnic groups, as illustrated in Figure 10 below.

73. We received clinical feedback concerning the quantity of blood required for automated red cell exchange and how the previous unit price was not reflective of these costs. An additional investment (£7.6 million) has therefore been made to ensure that prices are not a barrier to access and to help address the health inequalities that may otherwise occur. This policy change should have a positive impact on black and ethnic minority patients, improving services for sickle cell patients and supporting the national commitment to the treatment of this disorder. The investment is reflected in the increases identified in figure 10 below.

74. Aside from the intended impact associated with the increase in price of automated red cell exchange, we do not expect the 2025/26 NHSPS proposals to have a disproportionate impact on patients belonging to other ethnic categories represented in Figure 10.

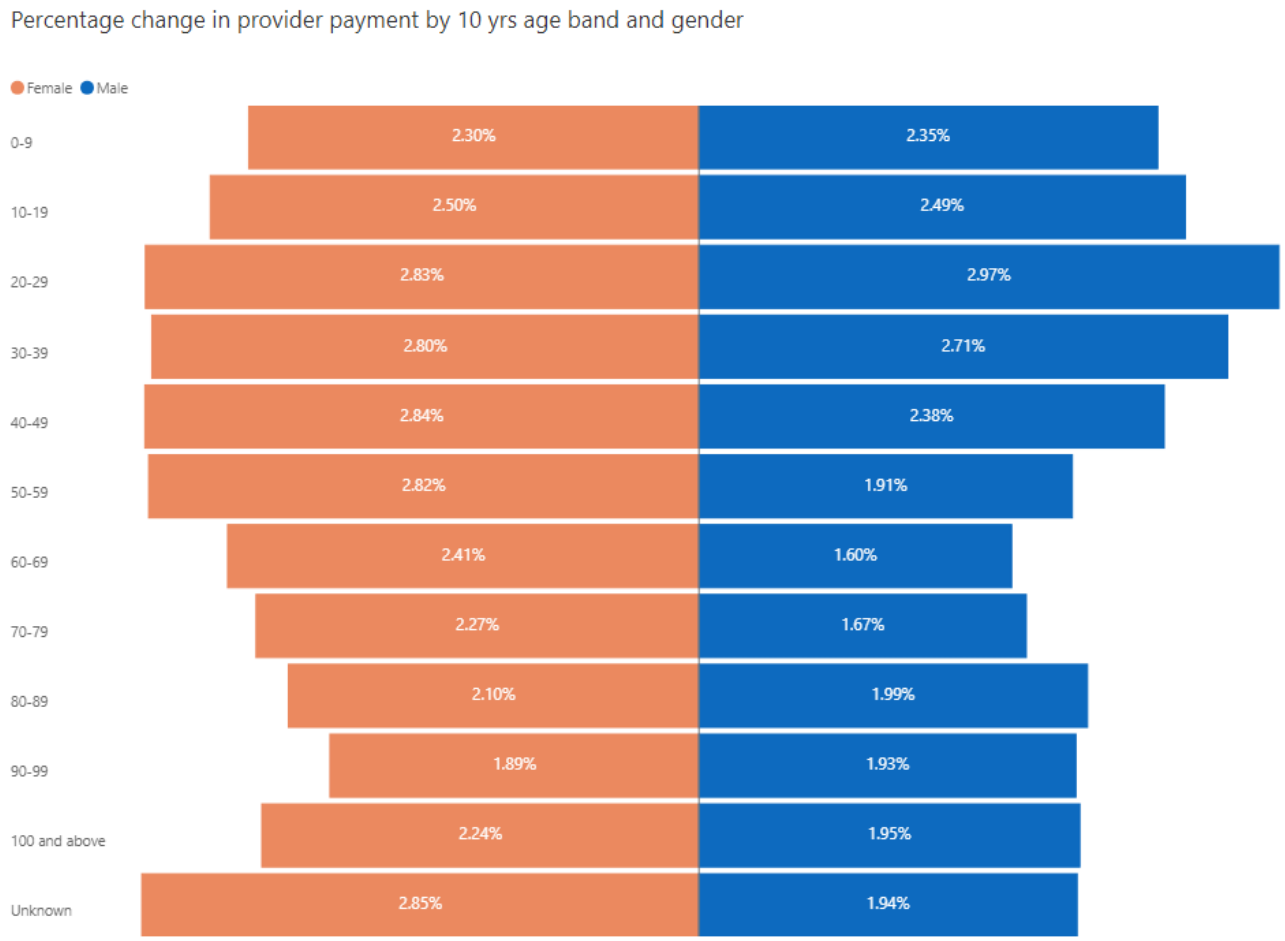
Figure 10: Anticipated changes in NHSPS priced payment in 2025/26, by ethnicity

Ethnic Category	Total Payment NHSPS Income (£'m) - 2024/25	Total Payment NHSPS Income (£'m) - 2025/26	Total Payment NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
Asian or Asian British	£914.06	£934.71	£20.66	2.26%
Black or Black British	£470.09	£488.03	£17.94	3.82%
Mixed	£192.92	£197.49	£4.57	2.37%
Not known/stated	£6,053.10	£6,182.17	£129.06	2.13%
Other ethnic groups	£347.41	£355.01	£7.59	2.19%
White	£11,801.07	£12,063.39	£262.32	2.22%
Total	**£19,778.65**	**£20,220.79**	**£442.14**	**2.24%**

4.3.3 Gender

75. Certain procedures are, by their nature, specific to male and female patients and there are HRG chapters with gender-specific procedures. Based on assessment of the available data, we estimate that the proposed NHSPS prices would increase spending by gender proportionately and slightly more for female patients (Figure 11). The slightly higher growth observed in female patients within the age range 20-39 is due to increases in obstetric prices as a result of increased CNST contributions mentioned previously, price adjustments to gynaecology procedures, and increases as a result of moving termination of pregnancy services to variable payment. Overall, we therefore do not expect the 2025/26 NHSPS proposals to have a material disproportionate impact on men or women.

Figure 11: Anticipated changes in NHSPS priced payment in 2025/26, by gender.



Gender Description	Total Payment (£'m) - 2024/25	Total Payment (£'m) - 2025/26	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
Female	£9,004.73	£9,231.31	£226.58	2.52%
Male	£7,987.38	£8,145.52	£158.14	1.98%
Not known	£146.94	£149.74	£2.80	1.91%
Not specified	£2,639.59	£2,694.22	£54.62	2.07%
Total	**£19,778.65**	**£20,220.79**	**£442.14**	**2.24%**

4.3.4 Pregnancy and maternity

76. Maternity services will continue to be paid and funded as part of the API fixed element of the NHSPS. However, to support better benchmarking and service reviews based on prices, the 2025/26 NHSPS proposals would increase the guide prices for maternity services. Maternity prices will also increase to take account of higher CNST costs.

77. To help address the increasing demand and declining capacity associated with the timely delivery of termination of pregnancy (TOPs) services, for 2025/26 we propose

moving them to the variable payment mechanism. This would remove a potential financial barrier for NHS providers, where increasing activity could result in unfunded costs. The proposal would also ensure that providers who deliver less than the planned level of activity are not inappropriately compensated.

78. Overall, the proposals set out in the 2025/26 NHSPS are expected to have a positive impact on patients using maternity and pregnancy services.

4.3.5 Sexual orientation

79. The NHSPS does not distinguish between patients on the basis on their sexual orientation. We do not hold statistics on the sexual orientation of patients and are not aware of any information that would suggest that the 2025/26 NHSPS proposals would have a disproportionate impact on patients by sexual orientation.

4.3.6 Marriage and civil partnership

80. The NHSPS does not distinguish between patients based on their marital or civil partnership status. We are not aware of any information that would suggest that the 2025/26 NHSPS proposals would have a disproportionate impact on patients by marriage or civil partnership status.

4.3.7 Gender reassignment

81. Gender reassignment is a specialised service provided by the NHS. The NHSPS does not distinguish between patients based on gender reassignment, and we do not currently have data available that would allow us to quantify any such impact. We are not aware of any other information that would suggest that the 2025/26 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.8 Disability

82. The HRG4+ phase 3 currency design enables us to distinguish between care provided to patients with different levels of complexity to reflect the expected higher use of resources to treat patients who do have complications and comorbidities. Comorbidities can be associated with disability, and therefore this currency design helps to ensure that providers are more appropriately reimbursed for providing care to patients with disabilities. We are not aware of any other information that would suggest that the 2025/26 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.9 Religion or belief (including lack of belief)

83. The NHSPS does not distinguish between patients based on their religion, belief, or lack thereof. We are not aware of any information that would suggest that the 2025/26 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.10 Deprivation

84. Patient activity and associated payments have been grouped by geographic area and population deciles representing the comparative level of deprivation in that area. Analysis indicates that the changes observed at each deprivation level are broadly similar, with a trend for increasing payment as the level of deprivation increases. (figure 12).

Figure 12: Anticipated changes in NHSPS priced payment in 2025/26, by deprivation decile

IMD04 Decile Description	Total Payment NHSPS Income (£'m) - 2024/25	Total Payment NHSPS Income (£'m) - 2025/26	Total Payment NHSPS Income Difference (£'m)	Percentage Difference (Total Payment Total Payment NHSPS Income)
Most deprived 10%	£1,525.80	£1,563.20	£37.40	2.45%
More deprived 10-20%	£1,598.83	£1,637.06	£38.23	2.39%
More deprived 20-30%	£1,643.29	£1,681.42	£38.13	2.32%
More deprived 30-40%	£1,677.07	£1,715.40	£38.32	2.29%
More deprived 40-50%	£1,695.66	£1,733.82	£38.16	2.25%
Less deprived 40-50%	£1,737.74	£1,776.41	£38.67	2.23%
Less deprived 30-40%	£1,716.04	£1,754.36	£38.32	2.23%
Less deprived 20-30%	£1,737.46	£1,775.47	£38.01	2.19%
Less deprived 10-20%	£1,715.71	£1,752.68	£36.97	2.15%
Least deprived 10%	£1,657.70	£1,693.19	£35.49	2.14%
Unknown	£3,073.34	£3,137.77	£64.44	2.10%
Total	**£19,778.65**	**£20,220.79**	**£442.14**	**2.24%**

4.3.11 Other considerations

85. While we do not anticipate the 2025/26 NHSPS proposals to have a disproportionate impact on patients with protected characteristics, we acknowledge that the extent of services offered to patients are determined by both local, ICB level and national commissioners, who are themselves expected to commission services that address the

needs of their local populations (with a duty to actively promote advancement of equalities and the reduction of health inequalities). We expect providers and commissioners to take any necessary steps to ensure unintended consequences are mitigated and compliance with the equality duty maintained when designing and/or commissioning services.