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2025/26 NHS Payment Scheme – a consultation notice

NHS provider payment mechanisms

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

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Contents

1. Introduction

1. This document is published in support of the consultation on proposals for the 2025/26 NHS Payment Scheme (NHSPS). It is proposed that it will be published alongside the final 2025/26 NHSPS.

2. The 2025/26 NHS Payment Scheme (NHSPS) contains rules for four payment mechanisms, summarised in Table 1.

Table 1 – Payment mechanism categories

Payment mechanism	Applies to
Aligned payment and incentives (API)	Almost all NHS provider relationships with: • NHS England for any directly commissioned services; and • with any ICB where the relationship is not covered by LVA arrangements.
Low volume activity (LVA) block payments	Almost all NHS provider and ICB relationships for which NHS England has mandated an LVA block payment (this will normally be those with an expected value of annual activity of £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).

3. Two of these – aligned payment and incentive (API) and low volume activity (LVA) block payments – apply to NHS providers only. “NHS providers” refers to NHS trusts and NHS foundation trusts. This document provides additional guidance on API and LVA to support providers and commissioners to implement these rules.

4. We are conscious of the rights of patients enshrined in the NHS Constitution and of our respective responsibilities and duties as set out in the NHS Constitution and related legislation. No API or LVA agreement, or the manner in which participating parties conduct themselves, should infringe or compromise those rights, responsibilities and duties.

5. In addition, Section 3.1 of the 2025/26 NHSPS states that all payment mechanisms (including API and LVA) should reflect the following payment principles:

    - The payment approach must be in the best interests of patients.
    - The approach must promote transparency and data quality to improve accountability and encourage the sharing of best practice.
    - The provider and commissioner(s) must engage constructively with each other when trying to agree payment approaches.
    - The provider and commissioner(s) should consider how the payment approach could contribute to reducing health inequalities.
    - The provider and commissioner(s) should consider how the payment approach contributes to delivering operational planning guidance objectives.

6. Commissioners and providers must review their fixed payments each year. Section 3.2 of this document sets out a methodology to support providers and commissioners with this.

1.1 Aligned payment and incentive

7. The NHS Long Term Plan committed to moving to blended payment for almost all services. API is a type of blended payment, comprising fixed and variable elements. It was initially introduced in the 2021/22 National Tariff Payment System, although the block payment arrangements introduced as part of the NHS response to Covid-19 meant that it was not used in practice until 2022/23.

8. The main aims of API are to:

    - help systems achieve financial balance
    - not be a barrier to delivering system transformation plans
    - provide a consistent payment model across secondary care services
    - support elective recovery.

9. The two components of API arrangements are:

    - a fixed element, based on funding an agreed level of activity (see Section 3)
    - a variable element, which increases or reduces payment based on the actual activity and quality of care delivered (see Section 4).

10. Both of these components combine to help support the aims set out in paragraph 88. Providers have a portion of their income guaranteed through the fixed element. The

variable element then provides further income based on the actual activity undertaken, offering fairness to commissioners and the taxpayer (see Section 4).

11. For acute providers, API aims to support the delivery of as much elective activity as is affordable within the NHS settlement. For 2025/26, elective activity will be funded solely through the variable element. This means that, up to a planned level of activity (see Section 0), 100% of the NHSPS unit price is paid for all activity. The fixed element does not include elective activity (see Section 3.1).

12. API is designed to support the delivery of system plans and encourage providers and commissioners to collaborate to agree the best way to use the resources available to systems and to remain in financial balance. It provides a consistent approach to paying for both acute and non-acute secondary healthcare services, helping to address issues associated with a fragmented payment system.

13. Section 4 of the 2025/26 NHSPS sets out the API rules. Sections 2, 3 and 4 of this document provide more details about the API elements.

1.2 Low volume activity (LVA) block payments

14. The LVA block payment was first introduced in 2022/23. It funds small flows of activity between a provider and a commissioner where historically there has been no contractual arrangement. Where a provider-commissioner relationship is identified as suitable for LVA (based on assessment of the expected annual value and other factors), the ICB pays the provider a single fixed value, set by NHS England.

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

16. The LVA payment mechanism rules are set out in Section 5 of the 2025/26 NHSPS.

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

2. Aligned payment and incentive – scope

18. API applies to almost all services delivered by NHS providers that are within the scope of the NHSPS – that is, secondary care services, including acute, maternity, community, mental health and ambulance services.

19. This section gives more detail about what it covers.

2.1 NHS England commissioned services

20. Almost all NHS England contracts with NHS providers will use API as their primary payment arrangement. For 2025/26, we have removed bespoke payment arrangements for certain specialised services (including radiotherapy and chemotherapy) and standard API arrangements will apply, including the elective payment limits. Genomic testing and treatment costs relating to NICE decisions (such as CAR-T) remain subject to local payment arrangements.

21. Specialist top-ups will be paid by NHS England as part of the API fixed element they agree with providers.

2.2 Non-NHS providers

22. Under the NHSPS rules, services with unit prices that are delivered by non-NHS providers would be subject to activity-based payment rather than API. See Table 1 in this document and Section 6 of the NHSPS.

23. Activity which has been subcontracted to another provider also requires the use of the unit prices (including those for BPTs) published in the NHSPS. For example, when an NHS provider decides, with the agreement of the relevant commissioner, to subcontract some of its elective activity to a non-NHS provider, the commissioner should reimburse the NHS provider using unit prices, rather than API rules.

2.3 CQUIN

24. Since 2024/25, the nationally mandated CQUIN incentive scheme has been paused. As such, no financial adjustments should be made relating to achievement of CQUIN criteria and fixed payments must include the 1.25% funding previously identified for CQUIN.

25. Non-mandatory CQUIN indicators are published on the Payment system support FutureNHS workspace. Providers and commissioners can locally agree to use these in a CQUIN-like scheme, as a variation to API arrangements. These indicators have not been updated since 2024/25.

2.4 Best practice tariffs

26. There are two categories of best practice tariff (BPT): annual BPTs and elective activity BPTs:

    - For services covered by an annual BPT, the level of BPT criteria attainment which the provider is expected to achieve, and associated funding, must be agreed as part of setting the fixed element. Actual achievement of the criteria would then inform the setting of the fixed element in future years, rather than trigger any in-year adjustments.
    - Elective activity BPTs are focussed on elective services. Payment is made based on the actual elective activity undertaken, using the BPT unit prices published in Annex DpA.

27. A new elective activity BPT is proposed to be introduced in 2025/26, supporting the GIRFT Right Procedure Right Place (RPRP) programme and aiming to encourage services to be delivered as outpatient procedures where clinically appropriate. The other elective activity BPTs are: endoscopy procedures, pleural effusion, primary hip and knee replacement outcomes, rapid colorectal diagnostic pathway and spinal surgery (although the spinal surgery BPT operates as an annual BPT for relevant non-elective activity).

28. See Annex DpC for detailed BPT guidance.

2.5 Advice and guidance services

29. Advice and guidance services are a key part of national elective care recovery plans. The fixed element will cover the agreed costs associated with plans for outpatient transformation. This will include the level of advice and guidance activity which should be offered, the appropriate mix of face-to-face and virtual attendances and the shift to patient-initiated follow-up (PIFU) pathways. The variable element also applies to advice and guidance services, with funding increased or reduced based on actual activity undertaken. See Section 4.2 for more details.

2.6 Excluded items

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

31. For API agreements, as API fixed elements are also locally agreed, it makes practical sense to also agree the funding for excluded items within this where possible. However, sometimes it may be more suitable to fund these items on a cost and volume basis. For excluded items, there is no distinction between commissioners, with the same funding approach applying regardless of whether the item is commissioned by NHS England or an ICB. However, where the commissioner is NHS England Specialised Commissioning, a baseline value of excluded drugs is included in API fixed elements. If the actual costs of excluded drugs exceed this baseline value, this will be paid directly by NHS England.

32. Annex DpA, tab 12b contains the list of excluded high cost drugs. Funded high cost drugs which are introduced in-year are also excluded from the fixed element.

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

34. For high cost devices, all NHS England commissioned device categories will be excluded from the API fixed element. The reimbursement process, via the High Cost Tariff-Excluded Devices (HCTED) programme, is published under separate guidance. There are then four device categories which are funded by local NHS commissioners and should be excluded from the fixed element. Annex DpA, tab 12a contains the list of excluded high cost devices.

35. The item costs for all MedTech Funding Mandate products (Annex DpA, tab 12c) are also excluded from the NHSPS, and funding for these should not be included in the API fixed element. The product should be procured through NHS Supply Chain. Providers and commissioners should be aware of their statutory duties to promote the use of innovative products and services to enhance patient care.

36. The **costs of implementing** the products should be included in the fixed element as this helps ensure savings accrue within the provider. See the MedTech Funding Mandate FutureNHS workspace for more information.

2.7 Evidence-based interventions

37. The Evidence-Based Interventions (EBI) Programme is a clinical initiative led by the Academy of Medical Royal Colleges (AoMRC). The programme aims to improve the

quality of care being offered to patients by reducing unnecessary interventions and preventing avoidable harm. In addition, by only offering interventions on the NHS that are evidence-based and appropriate, the programme frees up resources that can be put to use elsewhere in the NHS.

38. API arrangements should incentivise a reduction in the volume of procedures being undertaken in contravention of the EBI guidance. This should be done by providers and commissioners considering the volume of such procedures being undertaken by the provider and setting the API fixed element at an appropriate, realistic lower level, to reflect an agreed reduction that could reasonably be achieved.

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

40. In 2024/25, zero prices were introduced for four Category 1 interventions. These will apply unless the providers have received prior approval from the commissioners. The four procedures are:

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

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

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

42. The clinical codes for the full algorithm used by SUS+ are found in the Academy of Medical Royal Colleges' guidance document, Evidence-based Interventions Clinical coding for all interventions.

43. SUS+ identifies the procedures listed in paragraph 40 as Category 1 interventions and adds two columns to APC spells and full online extracts (and their "plus" equivalents – see SUS PbR guidance). The columns are:

    - Evidence Based Intervention Category
    - Evidence Based Intervention Type:

Code	Intervention type description	AoMRC document page reference*
A_snoring	Adult snoring surgery	132
B_menstr_D&C	Dilation and curettage for heavy menstrual bleeding	102
C_knee_arth	Knee arthroscopy with osteoarthritis	92
D_low_back_pain_inj	Injections for nonspecific low back pain without sciatica	21
* References to guidance document published in December 2023		

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

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

2.8 Overseas visitors

46. Where an overseas visitor is exempt from charges for NHS hospital treatment, or the NHS hospital service they receive is free, the NHS Who Pays? guidance sets out how the responsible commissioner can be identified.

47. The risk-share charging rules between trusts and commissioners for non-elective chargeable overseas visitor activity changed in 2023/24. The requirement for trusts to identify chargeable overseas visitors and bill the patient for services used has remained in place and must continue to be a key focus, as per *Guidance on implementing the overseas visitor charging regulations*.

48. The mandatory requirement to collect payment upfront for any chargeable patient that is not in need of urgent or emergency care remains, and overseas visitors should be billed using the NHSPS unit prices (as was previously the case with tariff prices). Details of the

appropriate charging rates are available in *Improving Systems for Cost Recovery for Overseas Visitors*.

49. The financial risk of non-payment will continue to be a shared risk between trusts and commissioners. In place of the risk-share charging rules for non-elective activity, providers and commissioners must agree annual funding for their shared risk of non-payment as part of setting their API fixed elements. For example, the value could be set based on an historic average rate of non-recovery of patient charges and an agreed rate of income recovery improvement. When agreeing the fixed element, providers and commissioners may wish to consider the element of funding for non-elective chargeable overseas visitor activity which was embedded within previous contract values when these were calculated by NHS England based on 2019/20 payments data during the Covid emergency financial framework.

3. Aligned payment and incentive – fixed element

50. API is comprised of two parts: fixed and variable elements. While there is a degree of local freedom in deriving the expected value of the services captured by the fixed element – drawing on clinical expertise, new models of care and up-to-date information – the information provided here aims to guide providers and commissioners to reach an agreed fixed element. From 2025/26, there is also a requirement to review the fixed element each year (see Section 0).

51. Alongside the payment principles (see Section 3.1 of the 2025/26 NHSPS and paragraph 5 of this document), the fixed element should be:

- reflective of efficient, expected provider costs – maximising the use of every NHS pound
- used for delivering high-quality services agreed between commissioners and providers – patients receive the best possible care and experience
- adjusted to reflect system planning assumptions – the health of populations is considered and improved.

52. Providers and commissioners should consider using the Core20PLUS5 approach when setting payments to achieve better, more sustainable outcomes and reduce healthcare inequalities. They should consider the climate change and net zero duties set out in Health and Care Act 2022, and their local Green Plan objectives when setting their fixed element. Please see the Net Zero strategy, Delivering a 'Net Zero' National Health Service, for options.

53. Appendix 1 gives further guidance on setting the fixed element.

3.1 Identifying services covered by the fixed element

54. The fixed element should include funding for the following items. Please note, this is not an exhaustive list but highlights common categories:

- An agreed level of acute activity outside the scope of the elective activity variable payment (see section 0).
- Maternity, mental health, community and ambulance services. (see Annex DpB and supporting documents for further details of currencies for these services).
- Expected annual BPT achievement.
- Chargeable overseas visitors (see Section 0).
- Agreed high cost drugs and devices, including ustekinumab.

- CNST contributions, having regard to the specific subchapter costs including maternity (Section 2.3 of Annex DpD).
- Implementation costs of MedTech Funding Mandate products and models of care.

55. Providers and commissioners must identify and agree the exact services that the fixed element will cover, including any changes to services based on agreed service transformation plans. Elective activity **will not** be funded through the fixed element (see Section 0). The fixed element will also cover 'business as usual' services (eg, running A&E departments, community care home teams, etc) that the provider will carry forward from the previous year.

56. As set out in Sections 0 and 0, funding for BPTs and advice and guidance are included in fixed payments, with the variable element increasing or decreasing the provider's overall reimbursement based on actual performance (see Section 4).

57. Section 0 also describes the Evidence-Based Interventions (EBI) programme, and the expectation that providers and commissioners consider the volume of procedures being undertaken by the provider in contravention of the EBI guidance. They should then set the API fixed element to reflect the expected reduction in the number of these procedures.

58. Other activities which are not covered by the fixed element include research grants, private patients or car parking. In addition, Section 2 of the 2025/26 NHSPS sets out the services that are not in scope of the payment scheme.

3.2 Reviewing the fixed element

59. In recent years, most provider contract values have been heavily based on the emergency payments used during Covid-19, adjusted annually for inflation, efficiency and planned activity growth. As a result, the fixed payment may not reflect current activity levels and efficient costs.

60. From 2025/26, ICBs will be required to review the current contract value for all providers with which they have an API contract. The review should aim to help systems understand how their current contract values compare to the value of the activity being undertaken. It is not expected that the full value of any identified differences in funding is reflected as an adjustment to 2025/26 contract values, but that it is used to inform contract discussions and areas of focus in future years.

61. Planning return final submissions will need to include confirmation that the review of the fixed payment has been undertaken, and details of key findings will need to be provided.

62. For acute trusts, the review of fixed payment will be supported by a national analysis comparing contract values with a calculation based on activity and unit prices (where these are available). This national analysis will need to be supplemented and adjusted to take account of local information and agreements.

63. To avoid destabilising providers or commissioners, the full value of any identified differences in the funding of a trust should not immediately translate into a change to the fixed payment value. However, it should be considered when applying local efficiency requirements, including convergence or deficit reduction, MFF changes and activity growth. Such requirements should be considered together in aggregate, such as considering that convergence may moderate the impact of MFF changes on allocations, especially when convergence reaches it maximum or minimum level. They should be set at a reasonable level for the trust and an affordable level for the commissioner. Where adjustments in 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.

64. Contract values for providers both within and outside the system should be treated equally.

65. The following steps summarise the process NHS England has used to produce national analysis for acute care providers. The analysis will be shared with systems (along with supporting technical guidance to give more details of the methodology used). This approach should be followed unless a different review process is agreed locally, or systems have already done similar local analysis to support a review of their fixed payments.

- **Step 1:** Calculate total contract value (ie, the sum of fixed and variable payments).
- **Step 2:** Remove block payment exclusions (eg, acute provided mental health services, community and delegated primary care contract values) from the total contract value to better align scope to activities that have a patient-level data flow.
- **Step 3:** Remove estimated spending on high cost drugs and devices, and adjustments for PFI and remoteness excess costs to further align the scope and value of this contract to services under price x activity. Steps 2 and 3 produce an Adjusted Total Contract Value.
- **Step 4:** Estimate the value of activity delivered, using hospital episode statistics (HES) activity multiplied by the price of that activity, with relevant MFF values applied. Where activity cannot be linked to a price, use data from the National Cost Collection. This produces a ‘bottom-up’ estimate that includes activity within scope of the fixed and variable payments.

- **Step 5:** Compare the Adjusted Total Contract Value and 'bottom-up' activity value estimates to calculate a remainder.

66. Remainders may relate to a number of factors, including:

- Growth in activity between the year of activity being used (eg, 2023/24 HES) and the contract year (eg, 2024/25).
- Not all activity in scope of the fixed payment can be identified in activity level dataflows. Data on some services may be poor or incomplete (eg, critical care) and some services such as patient transports or pathology do not flow in HES.
- Gaps between prices and costs. Total contract values will be more reflective of the total cost of service delivery from previous years and may be underestimated by price x activity.

67. To address this last point, and support discussions on the level of fixed payment, the 2025/26 UEC and maternity prices have been increased to align with the pre-pandemic cost base. These should be used as the basis when comparing price x activity, along with the 2025/26 MFF values. Please note: the price uplift does not mean that overall contract values should increase.

68. Comparing contract values with payment based on price (or costs) for different providers should support discussions on overall contract values. It will help systems understand how much may be related to excess costs or increased activity and it will identify opportunities for efficiencies and determine the scope to reduce or increase payment value over time.

69. On undertaking this review, discussions between providers and commissioners should consider:

- Productivity benchmarking (for example length of stay, theatre utilisation and other metrics developed on the Model Health System)
- Efficiency/value for money opportunities regarding temporary staff use, drugs/biosimilars, corporate services etc.

70. Comparing current contract value with price (or cost) x activity can also be used by non-acute services where high quality data is available on activity and costs. However, alternative methods for reviewing the fixed payment for these services might include the following:

- Reviewing current data provision and quality to support segmentation of ICS/provider populations. (The supporting mental health and community currency documents provide information to support a population segmentation approach.)
- The fixed payment could be similarly segmented based on these populations, moving away from a single broad fixed payment allocation.
- Providers could also review current costing data provision, against currency categories.

3.3 Setting the fixed element: other factors

71. The API rules state that for any agreement, including the calculation of the fixed element, providers and commissioners should have regard to the overarching policies set out in Section 3 of the 2025/26 NHSPS. These include the payment principles (see also paragraph 5 of this document).

72. As well as these overarching factors, and the information gained from reviewing their fixed elements, providers and commissioners should also consider factors such as:

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

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

74. The most recent annual cost adjustments are:

Tariff year	2021/22	2022/23	2023/24	2024/25	2025/26 (proposed)
Cost uplift factor	3.1%	4.7%*	2.9%	5.0%†	4.15%
Efficiency factor	1.1%	1.1%	1.1%	1.1%	2.0%

* Set in November 2022, following adjustments for inflation, pay award and changes to National Insurance contributions.

† Figure published in September 2024 to reflect agreed 2024/25 pay awards.

Note: Cost uplift factor to be published at two decimal places from 2025/26.

75. Providers and commissioners should consider whether these national adjustments are appropriate for individual system or organisational circumstances, such as where an organisation's cost base is differently weighted than the NHSPS assumptions. For example, where a provider has a relatively higher proportion of its cost base made up of pay.

76. For acute providers, CNST contributions must also be considered. The cost uplift factor includes unallocated CNST (ie CNST contributions that are not allocated to specific HRG subchapters). The fixed element must also be uplifted to reflect the CNST HRG subchapter adjustments. Special attention should be given to maternity services to ensure the specific maternity CNST uplift set out in Annex DpD is applied. This is to account for the significant difference between CNST costs relating to maternity services in comparison to non-maternity services. For all other HRG sub-chapters, if it is not possible to apply the specific sub-chapter values, a uniform value of 0.01% should be applied. More information on CNST and the HRG sub-chapter figures is available in Section 2.3 of Annex DpD.

77. Providers and commissioners should discuss any changes in MFF values and agree how the effects should be applied to the fixed element value. They should also consider how to take account of eligible provider PSS values and whether any other price adjustments are already captured within the data used to calculate the fixed element and if further amendment would be needed.

78. Local plans should highlight any changes to the delivery of services or new models of care, and any anticipated variations in demand from previous years. This should include both national changes (eg, changes in funding requirement for services between local NHS commissioners and Specialised Commissioning) and local or system-level plans such as those linked to the Core20PLUS5 approach.

79. The fixed payment should reflect the planned level of radiotherapy activity. It should also reflect the revenue costs of additional capital funding for new linear accelerators (LINACs).

80. Regarding on-treatment follow ups for cancer, for treatments such as SACT (systemic anti-cancer therapy) and radiotherapy, including non-commercial clinical trials, patients have appointments with oncologists to review progress of the treatment and, if necessary, adjust treatment plans. These appointments are often on different days to the treatment delivery. These are included in the fixed element.

81. For providers where cancer forms a significant proportion of their activity, consideration should be made for these on-treatment appointments when setting the fixed payment to

ensure providers are appropriately reimbursed for delivering this activity. In particular, it is expected that for relevant providers, the fixed payment should reflect the growth from baseline in the volume of these appointments, to support the aims of cancer recovery.

82. The value of the fixed element will also need to give regard to how any additional funding, such as protected funding for mental health services, passes from commissioners to providers.

4. Aligned payment and incentive – variable element

83. The variable element is intended to support elective activity and to reflect the quality of care provided to service users. This section describes the variable element.

4.1 Elective activity

84. Under the NHSPS, actual elective activity delivered is paid for at a rate of 100% of the NHSPS unit price (or, in the case of first outpatient attendances where a unit price is not calculated, a locally agreed price). The market forces factor (MFF) must be applied to the NHSPS unit price(s) or local price(s) used for the variable element.

85. Commissioners will set a payment limit, based on the financial value of a planned level of activity, and are not required to make further payments above this limit.

86. Providers and commissioners should review performance against the activity plan on a monthly basis, with forecasts updated quarterly. If the provider expects to exceed the payment limit, they should notify the commissioner as soon as possible. The commissioner and provider will then discuss whether the payment limit needs to be imposed or if the commissioner is able to increase it (eg if other providers are underperforming against their plans).

87. Annex DpE gives more detail of the payment limit.

4.2 BPTs, CQUIN and advice and guidance

88. The variable element is also used to reflect actual attainment for elective activity BPTs and levels of advice and guidance activity delivered. Since 2024/25, the nationally mandated CQUIN scheme has been paused, so there are no adjustments to reflect achievement of CQUIN metrics, although fixed payments should include the 1.25% funding previously identified for CQUIN (see Section 0).

89. For BPTs, the variable element only applies to elective activity BPTs (see Section 0). Payment is made based on the actual activity undertaken using the BPT unit prices published in Annex DpA. For more information about BPTs, see Annex DpC.

90. Funding for achievement of advice and guidance should also be included in the fixed element. The exact level of achievement and the corresponding payment is agreed between the provider and commissioner. Funding should then be paid or deducted for activity that is different to the amount agreed in the fixed element. As this amount is locally agreed, the amount to pay or deduct also needs to be agreed between the provider and commissioner. For more detail about expected levels of advice and guidance services, see the Operational Planning Guidance.

5. Low volume activity block payments

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

92. LVA payments are intended to reduce the number of transactions for relatively small amounts of money, reducing administrative burden.

5.1 LVA – scope

93. Provider/commissioner relationships are assigned an LVA following consideration of the expected annual value, on the basis of historical activity. LVAs would usually be put in place for relationships where the annual value of activity is expected to be below £1.5m, including services delegated to ICBs by NHS England. To ensure LVAs are appropriate and consistent, we will also consider:

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

94. Around 90% of provider-commissioner relationships operate on an LVA basis.

95. The LVA arrangements cover all clinical services (acute, mental health and community), with three exceptions:

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

96. Where the LVA arrangements apply, ICBs must pay each trust identified on the LVA payments schedule (published in Annex DpA) the calculated amount.

97. For those relationships not included on the LVA payments schedule, NHSPS payment rules apply, and commissioners and providers must agree and sign a written contract. To minimise administrative workload, use of a collaborative contracting approach across ICBs is very strongly recommended; see Standard Contract Technical Guidance for details.

98. LVA arrangements relate solely to ICBs and NHS providers. For all non-NHS providers, commissioners should normally look to agree and sign contracts. However, where there are small volumes of patient activity being delivered by a non-NHS provider which is geographically distant from the commissioner, the parties may choose to operate under existing Non-Contract Activity (NCA) arrangements, as set out in the Standard Contract Technical Guidance. NCA arrangements may also apply to trust services outside of the scope of LVA as described in paragraph 95 above.

5.2 LVA payment schedule

99. The LVA payments schedule is published in Annex DpA. The 2025/26 LVA payments schedule values combine values for acute, mental health and community, secondary dental and specialised services. Annex DpA contains a breakdown for each of these service areas, as well as the combined value, which is the amount that should be paid.

100. For 2025/26, the LVA values for each service area are 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.
- Mental health and community services – update the 2024/25 LVA values with the 2025/26 cost uplift and efficiency factors.
- 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 and add newly-delegated services.

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

102. Where LVA applies, no further payments or amounts should be transacted during 2025/26, other than for excluded items. For these items, providers are encouraged to limit the number of invoices and payment requests, for example billing twice-yearly, to maintain the reduced administrative burden associated with LVA arrangements.

Appendix 1: Further guidance on setting the API fixed element for 2025/26

Providers and commissioners are advised to consider the following guidelines in establishing their 2025/26 fixed payment values.

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

Item	Guidance
Opening baseline	The opening baseline should be calculated as: • **2024/25 fixed payment value** – this value should not include the value of services on variable terms as defined in the 2024/25 NHS Payment Scheme (NHSPS). It should be adjusted for any non-recurrent and full-year effect items (for example, IFRS 16) • **2024/25 full variable value** – this value should include the relevant proportion of the 2024/25 ERF allocation, which was incorporated into 2024/25 baselines, plus the 2024/25 planned value of chemotherapy delivery, unbundled diagnostic imaging and nuclear medicine Note that this value should include the value of services that were delegated to ICBs in 2024/25, as well as those that are newly in scope for delegation from 2025/26. High-cost exclusions or the 2024/25 value of SDF should not be included.
Service changes from 1 April 2025	The cost of service changes from the point of setting the opening 2025/26 baseline should be reflected in amendments to the API fixed payment. The value of such changes should be locally agreed based on a reasonable phasing of expenditure changes. For elective service changes, the value of any service change should be agreed and adjusted for in this step but will require a consistent and documented locally agreed elective activity target different from the default value published by NHS England. While commissioner to provider targets can be locally adjusted, the overall commissioner target must remain as defined by NHS England and any service changes should still enable achievement of this target overall.
Activity change	Locally agreed activity plans, including for elective services, should be applied against the opening 2025/26 baseline for relevant intra-system, inter-system and NHS England API arrangements.

Item	Guidance
Inflation net of general efficiency	By default, commissioners and trusts should adjust the opening 2025/26 baseline value by the cost uplift factor (CUF), general efficiency factor and CNST, as set out in the NHS Payment Scheme, unless a view of inflationary pressures and efficiency requirements has been locally agreed.
Additional allocation funding	Include other relevant allocation baseline adjustments, as set out in the 2025/26 revenue and finance contracting guidance.
Additional efficiency	In addition to the general efficiency factor, additional efficiency ('convergence') has been applied to allocations to move ICBs towards a fair share distribution of resource at the levels affordable within the settlement. Additional efficiency adjustments should be informed by the outcome of the fixed payment review [LINK] should be reflected, targeted to specific efficiency opportunities.
Adjustment to remove the variable payment element	The payment value should then be adjusted to remove the 2025/26 value of variable payment elements, comprising: • the 2025/26 value weighted ERF target of elective activity (as published by NHS England) • 2025/26 planned value of delivering chemotherapy, unbundled diagnostic imaging and nuclear medicine.
Service development funding (SDF)	Having removed the 2024/25 value of SDF to form the opening baseline value and added the SDF transferred to allocations in the above step (baseline adjustments), the API fixed payment should now be adjusted to include the confirmed level of 2025/26 SDF funding. This should be identified as the full value in the contracts planning tab, split between mental health and non-mental health service expenditure.

Illustrative example

Item	Calculation	Illustrative value
Opening baseline	2024/25 fixed payment = £180m 2024/25 SDF to be removed = - £25m 2024/25 target ERF (variable) = £45m 2024/25 planned chemotherapy = £2m 2024/25 planned unbundled diagnostic imaging = £3m = £175m – £25m + £45m + £2m + £3m	+£205.0m
Service changes from 1 April 2025	An agreed change to a commissioned pathway results in an agreed reduction to the API fixed payment of £2.5m.	-£2.5m
Activity change	A general assumption of 1% is used for the purposes of this worked example.	+£2.0m (1% of adjusted opening baseline of £205m)
Inflation net of general efficiency	Cost uplift factor (CUF) of +4.15% General efficiency factor of -2.0% Appropriate growth in CNST between 2024/25 and 2025/26. The change for each individual trust will reflect its relative risk factors.	+£4.9m (2.15% net CUF of £204.5m plus £0.5m CNST)
Additional allocation funding	Action adjustment to reflect the additional allocation funding items as set out in the 2025/26 revenue and finance contracting guidance.	+£5.0m
Additional efficiency	An example level of additional efficiency requirement, identified through review of fixed payment (see below for methodology) of -1.2%.	-£2.6m (1.2% of £214.4m)
Variable payment adjustment	Target level of ERF performance plus agreed other variable elements £52m.	-£52.0m
Service development funding (SDF)	Add confirmed 2025/26 SDF values to the fixed payment (a value of £26m used for the purpose of this example)	+26.0m

Total fixed payment for 2024/25 = £180m

Total fixed payment for 2025/26 = £185.8m