Classification: Official

NHS England

Consultation on the 2026/27 NHS Payment Scheme

NHS provider payment mechanisms

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

Publication reference: PRN02097

Contents

1. Introduction

1. This document is published in support of the consultation on the proposed 2026/27NHS Payment Scheme (NHSPS).

2. The 2026/27 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 (Sections 2-5) and LVA (Section 6) 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 2026/27 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 medium-term planning framework objectives.

2. Aligned payment and incentive – scope

6. 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.

7. This section gives more detail about what API covers.

2.1 NHS England commissioned services

8. Almost all NHS England contracts with NHS providers will use API as their primary payment arrangement. However, treatment costs relating to NICE decisions (such as CAR-T) are subject to local payment arrangements.

9. For armed forces, payment arrangements should be informed by previous years' activity. Contracts would usually be on an API basis, with a fixed payment agreed where the value is below £0.5m.

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

2.2 Non-NHS providers

11. 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.

12. 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

13. 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.

14. 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

15. There are two categories of best practice tariff (BPT): annual BPTs and 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.
    - For activity BPTs, payment is made based on the actual activity undertaken, using the BPT unit prices published in Annex DpA. These include the Right Procedure Right Place (RPRP), Day Case and 10YHP RTT BPTs. BPTs that are wholly or in part related to UEC activity, would form part of the UEC blended payment (see Section 5.1).

16. Detailed guidance on BPTs is set out in Annex DpC and BPT prices are included in Annex DpA.

2.5 Advice and guidance services

17. 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

18. 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.

19. For API agreements, providers and commissioners can locally agree an amount of funding for excluded items to be part of the fixed payment. 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.

20. 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.

21. Most homecare services (drugs, devices and their related costs) are subject to local funding arrangements which must be agreed by the commissioner and provider, in accordance with the NHSPS excluded items pricing rule. However, where funding for previously excluded drugs has been moved into unit prices, and these drugs are identified as being part of prices in Annex DpA, services should be paid on a price basis regardless of whether they are delivered via homecare or other setting. For a list of these drugs and prices, see Annex DpA.

22. 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 in 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.

23. The item costs for all MedTech Funding Mandate products (Annex DpA, tab 12c) are also excluded from core payment mechanisms and subject to the excluded items pricing rule. Funding for these items should not be included in the API fixed element. Products 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.

24. 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 Futures workspace for more information.

2.7 Evidence-based interventions

25. 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.

26. 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.

27. 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).

28. 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

29. 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.

30. 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.

31. SUS+ identifies the procedures listed in paragraph 28 as Category 1 interventions and adds two columns to admitted patient care (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

32. 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.

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

2.8 Overseas visitors

34. Where an overseas visitor is exempt from charges for NHS hospital treatment, the NHS Who Pays? guidance sets out how the responsible commissioner can be identified.

35. Overseas visitors who are liable to pay a charge under the relevant regulations are NHS patients where the cost of treatment is to be recovered from the individual. As such, where they receive treatment that falls within the scope of the NHSPS, they should be charged based on commissioned prices determined in accordance with the NHSPS, or locally agreed prices where a national price doesn't apply. The charges will be either 100%, for those patients who hold a European Settlement Scheme Status, or 150% of the commissioned price for all others.

36. There is a statutory requirement to collect payment upfront for any chargeable patient that is not in need of care that is considered clinically immediately necessary or urgent. For more details, please see the DHSC guidance on Charging overseas visitors in England.

37. The financial risk of non-payment is shared between providers and commissioners, who 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.

38. It is important to be aware of exemptions from charges. This may be services (for example accident and emergency or family planning services) or individuals (including armed forces personnel and their families and vulnerable people such as refugees or asylum seekers). Please refer to Charging overseas visitors in England for details of exempt services and individuals.

2.9 Mental health and community services

39. As set out in Annex DpB, currency models for mental health and community services were introduced in the 2025/26 NHSPS. These models have been developed further for the 2026/27 NHSPS. These models should be used to support an evidence-based approach to commissioning and contracting. Implementing these models will require the providers and commissioners to do the following:

Providers should:

- Ensure that all data items for the currency models are collected and stored locally and submitted to national data sets.
- Use the currency data to support service planning and local benchmarking.

ICBs should:

- Expect providers to collect currency-related data.
- Use currency data as part of planning across the system and to evaluate service provision.

40. As supporting documents to the 2026/27 NHSPS, we have published guidance for the Mental Health and Neurocognitive Resource Groups, Community Currency Models and Attention Deficit/Hyperactivity Disorder (ADHD) and Autism.

41. The Payment Team and Community Insight Unit have also developed a Data Quality Improvement Framework to support improvement in local community data collection and, provision to national data set. The Framework sets out clear expectations on how providers can improve their data capture, and how ICBs should work with providers to monitor improvement.

2.10 Variations from API arrangements

42. Providers and commissioners are able to vary API payment arrangements on condition that:

- the arrangement is consistent with the payment principles (see paragraph 5)
- both provider and commissioner agree to the variation.

43. Any variations to the API design or unit prices would need to be approved by NHS England. Requests should be made using the variation request submission template.

44. We would be particularly supportive of any variations intended to test payment approaches for neighbourhood health services. For example, we are aiming to develop a new payment model that incentivises a reduction in avoidable non-elective care amongst high priority cohorts – please contact england.pricingenquiries@nhs.net to find out more.

3. Aligned payment and incentive – fixed element

45. The fixed element is a key part of the API model. 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. The 2025/26 NHSPS introduced a requirement to review the fixed element each year (see Section 3.2). For 2026/27, this review should draw on the work done during 2025 to deconstruct fixed payments. Where necessary, any changes to payment values should be introduced over time to avoid destabilising services.

46. For 2026/27, UEC, radiotherapy (external beam and SABR) and genomic testing services will be subject to a blended approach, consisting of both a fixed element and a variable element (see Section 5).

47. The calculation of 2026/27 fixed payments can incorporate the planned UEC, radiotherapy and genomics changes by deducting from the overall envelope (i.e. the adjusted baseline) the planned UEC, radiotherapy and genomics payments after deducting the planned variable payment. The remaining balance will form the planned fixed payment.

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

3.1 Identifying services covered by the fixed element

49. 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 for services not covered by other parts of the API model (ie excluding elective activity (see Section 4.1) and UEC, radiotherapy and genomics services covered by a blended payment model (see Section 5)).
- 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.
- Expected volume of advice and guidance delivered.
- Chargeable overseas visitors (see Section 2.8).
- Agreed high cost drugs and devices (see Section 2.6).
- CNST contributions, having regard to the specific subchapter costs including maternity (Section 2.3 of Annex D).
- Implementation costs of MedTech Funding Mandate products and models of care.

50. 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. The fixed element will also cover 'business as usual' services (e.g. community care home teams, etc) that the provider will carry forward from the previous year.

51. As set out in Sections 2.4 and 2.5, funding for some 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).

52. Section 2.7 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.

53. Other activities which are not covered by the fixed element include research grants, private patients or car parking. In addition, Section 2 of the 2026/27 NHSPS sets out the services that are not in scope of the payment scheme.

3.2 API fixed payment review

54. Each year, commissioners are 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.

55. The review should identify funding for individual services, including for services not funded on an activity basis and where payments for services are in excess of the unit price value of activity being undertaken. The difference in funding between baseline contract values and the combined value of these elements should be agreed.

56. 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.

57. The review should involve comparing contract values with payment based on price (or costs) for different providers, supporting 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.

58. 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.

59. During 2025, providers and ICBs undertook work to 'deconstruct' fixed payments (blocks) and the findings of this work should inform 2026/27 fixed payments for acute services (see "Findings from deconstructing blocks" below).

60. 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.

Findings from deconstructing blocks

61. For acute services commissioned by ICBs (including specialised services), the following should apply to fixed payment setting:

- The outcome of work to deconstruct blocks and review fixed payments should be used to inform prospective adjustments when setting the fixed payment value, and to inform contract discussions and areas of focus in future years.
- To avoid destabilising providers or commissioners, the value of any identified differences in funding should not immediately be applied in full as an adjustment to the fixed payment value. However, it should be considered when applying local efficiency requirements, including convergence.
- Adjustments as a result of work to deconstruct blocks and review fixed payments should be set at a reasonable level for the trust and an affordable level for the commissioner.

- They should be considered in aggregate, alongside other funding adjustments including allocations convergence, organisational deficit reduction, market forces factor (MFF) changes, and activity growth.
- Commissioners and providers should agree adjustments to 2026/27 fixed payment values for agreed funding differences of up to +/- 2.5% of total contract values. The goal is to reduce these funding differences. These adjustments should be additional to those made for service changes, activity changes, net CUF & CNST, and additional baseline adjustments (where applicable), but should be inclusive of other pricing changes, including updated MFF values.
- Where NHS trusts are already expected to deliver efficiency as a result of reduced deficit plan limits, adjustments for agreed funding differences should be moderated, so that the combined efficiency requirement from deficit reduction and adjustments for agreed funding differences is no more than 2.5% of the total contract value.
- Where NHS trusts are already expected to deliver efficiency as a result of reduced deficit plan limits that exceeds 2.5% of NHS contract income, no additional adjustments for agreed funding differences should be made.
- Adjustments exceeding +/- 2.5% should only be agreed in exceptional circumstances.
- Providers and commissioners must collaborate to ensure that any funding changes do not destabilise services. This should be supported by clear commissioning intentions, including any necessary decommissioning decisions, along with detailed demand and capacity plans. These plans must be aligned between providers and commissioners before any funding changes can be reinvested into alternative services. This approach ensures both parties are aligned in managing resources effectively while safeguarding service delivery and patient care.
- Where adjustments in fixed payment are agreed to be actioned over time, a plan should be documented on what changes are expected and when they will be actioned.
- Contract values for providers both within and outside the system should be treated equally.

3.3 Setting the fixed element: other factors

62. 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 2026/27 NHSPS. These include the payment principles (see also paragraph 5 of this document).

63. 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
- change in MFF values
- demand for services
- other funding for specific services
- service changes resulting from system plans
- the overall amount of funding available to systems.

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

65. The most recent annual cost adjustments are:

Tariff year	2023/24	2024/25	2025/26	2026/27 (proposed)
Cost uplift factor	5.2%*	5.0%†	4.15%	2.03%
Efficiency factor	1.1%	1.1%	2.0%	2.0%

* Figure published in August 2023 to reflect agreed 2023/24 pay awards.

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

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

66. 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.

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

68. 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.

69. 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 whether any other price adjustments are already captured within the data used to calculate the fixed element and if further amendment would be needed.

70. 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.

71. 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.

72. 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.

4. Aligned payment and incentive – variable element

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

4.1 Elective and community diagnostic activity

74. The variable element is the sole method for funding elective services. This covers: most elective ordinary and day case spells, outpatient procedures with an NHSPS unit price, outpatient first attendances, unbundled diagnostic imaging and nuclear medicine, and chemotherapy delivery. It does not include outpatient follow up attendances, which are funded through the fixed element.

75. Community diagnostic activity is also paid for by the variable element, using the Community Diagnostic Centre (CDC) unit prices in Annex DpA.

76. Actual elective and community diagnostic 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.

77. The MFF must be applied to the NHSPS unit price(s) or local price(s) used for the variable element.

4.2 BPTs, CQUIN and advice and guidance

78. The variable element is also used to reflect actual attainment for 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 2.3).

79. For BPTs, the variable element only applies to activity BPTs (see Section 2.4). 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.

80. 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.

5. Aligned payment and incentive – blended payments

81. The 2026/27 NHSPS introduced blended payment models for UEC, radiotherapy (external beam radiotherapy and SABR) and genomic testing services.

5.1 UEC blended payment

82. The blended payment model for UEC services covers A&E, overnight non-elective, same day emergency care (SDEC) and other same day pathways. Critical care, maternity and outpatient follow-ups are not included and should be funded by the fixed element (see Section 3).

83. The payment model is intended to support appropriate investment in out-of-hospital care, such as virtual wards and urgent community response (UCR).

84. The UEC blended payment model comprises two elements:

- a fixed payment, calculated based on NHSPS prices x planned activity
- a variable payment of 20% of NHSPS prices for activity above or below the planned level.

85. For services covered by UEC-related BPTs (see Section 2.4), providers and commissioners should agree activity levels for services which attract BPTs as part of the fixed payment. This should be valued using the base or non-BPT price. Where providers achieve best practice (as set out in the rules for each BPT), they should receive the difference between the best practice price and the base price as an additional payment. Where actual activity is above the level agreed in the fixed element, this should be paid at 20% of the non-BPT price. Where the provider achieves best practice on this extra activity, they would be eligible to receive all of the difference between the BPT and non-BPT price.

86. The model requires providers and commissioners to locally agree a break glass clause which adjusts the value of the variable payment in response to actual activity being significantly above or below plan. This would share utilisation risk between provider and commissioner for levels of activity which are very different to those planned.

87. The break glass arrangements should have two components:

- a trigger point (%) where actual priced activity is above or below the planned level
- a set of binding arrangements which will apply if the trigger point is reached.

88. The details of the break glass clause need to be locally agreed but it is recommended that it sets out changes to the variable rate which will apply at different levels beyond

the break glass threshold. For example, it could consist of an agreement to change the percentage of the variable payment in response to unexpected deviations from the system plan so that:

- if overnight non-elective activity rises over 10% above plan, the marginal rate increases to 50%;
- if it rises over 20% above plan, the marginal rate increases to 80%.

89. For 2026/27, we have set a unit price for SDEC, which should be used for the blended payment. The SDEC price covers speciality-based activity that aims to avoid a non-elective admission. Providers and commissioners can also choose to use a local price for SDEC, subject to the API variations process (see Section 2.10).

90. To successfully implement the payment model, providers and commissioners will need to agree planned levels of UEC activity, including overnight non-elective, SDEC and A&E. The most appropriate level for this decision to take place is likely to be at system level. However, the following national default can both support those local conversations and act as a back stop if needed.

91. The default approach is based on the 2025 Spending Review assumptions for underlying non-elective and A&E growth. After the impact of left-shift investments, these are 2.6% for non-electives and 1.8% for A&E. We propose using these figures as the national defaults. To avoid double counting of productivity savings, an additional shift from overnights to same day should not be factored into the blended payment calculation.

92. As maturity and utilisation is variable, there is no national default for SDEC activity or out-of-hospital activities such as UCR and virtual wards. However, providers and commissioners should consider how these approaches can help support appropriate activity shifts.

93. The unit prices for UEC are set out in Annex DpA.

5.2 Radiotherapy: External beam radiotherapy and SABR

94. The payment model for unbundled external beam radiotherapy and Stereotactic Ablative Radiotherapy (SABR) services is a blended payment comprising:

- a fixed payment based on planned activity x prices
- a variable payment for activity above/below plan of 50% of NHSPS unit prices
- local flexibility to protect providers moving to SABR for prostate.

95. This means that providers and commissioners need to agree the value of planned activity as the fixed payment, then compare that with the value of actual activity delivered. If the value of actual activity is higher than planned, the amount payable would be the value of planned activity plus 50% of the difference; if actual activity is lower, the amount payable would be the value of planned activity minus 50% of the difference. Stereotactic Radiosurgery/Radiotherapy (SRS/T) and Selective Internal Radiation Therapy (SIRT) will continue to be paid for on a variable basis.

96. We have set a unit price for SABR for prostate. Where providers and commissioners are in the process of moving to SABR for prostate and agree that a different price should be used, there is local flexibility allowing them to use that price with no further approvals required. This would ensure that the payment approach doesn't distort clinical practice by disincentivising the uptake of SABR.

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

98. The unit prices for unbundled external beam radiotherapy are set out on tab 3 of Annex DpA, while the prices for SABR are on tab 4b.

5.3 Genomic testing and reporting

99. The payment model for genomic testing and reporting services is a blended payment comprising:

- a fixed payment based on planned activity x prices, plus amounts to help transition from previous payment levels and to cover necessary management costs where applicable
- a variable payment for activity above/below plan. The value of the variable payment would be a locally agreed percentage of unit prices
- an incentive element where a proportion of the fixed payment is dependent on improvement against some agreed metrics.

100. This blended payment model means that providers and commissioners need to agree the value of planned activity as the fixed payment, multiplying planned activity by the unit prices for genomic testing services. Where there is a significant difference between the fixed payment value calculated on a price x activity basis and previous payment levels, the provider and commissioner should agree an affordable and sustainable transition. The fixed payment should also contain funding for necessary management costs to help support the service where required.

101. Once the initial fixed payment has been calculated, up to 2% should be removed. Providers would be able to earn this by demonstrating improvements in key areas. The metrics and levels of improvement required would be locally agreed, but could include:

    - reductions in testing turnaround times
    - use of specific technologies
    - evidence generation of equity in genomic testing
    - increases of testing in areas such as ethnicity.

102. A variable payment applies for activity above or below plan. The value of the variable payment would be a locally agreed percentage of unit prices (for example, this could be 20% of prices to reflect fully variable costs). The total value of planned activity needs to be compared with the value of actual activity delivered (again, calculated using unit prices). If the value of actual activity is higher than planned, the amount payable would be the value of planned activity plus the agreed percentage of the difference; if actual activity is lower, the amount payable would be the value of planned activity minus the agreed percentage of the difference.

103. Annex DpA contains the unit prices for genomic testing.

6. Low volume activity block payments

104. Payments for low volume activity (LVA) have formed part of the payment scheme since 2023/24.

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

6.1 LVA – scope

106. 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
- whether an LVA was previously in place.

107. For 2026/27, we have set LVA values based on the proposed statutory configuration of 36 ICBs for 1 April 2026 (noting that several ICBs are currently undergoing merger and boundary-change processes). Around 90% of provider-commissioner relationships operate on an LVA basis.

108. The LVA arrangements cover all clinical services (acute, mental health and community), with four 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 to allow meaningful choice, including making use of alternative providers if people have been waiting a long time for treatment.
- Mental health lead provider collaborative contracts are out of scope of the LVA arrangements and are excluded from LVA payment values.

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

110. For those relationships not included on the LVA payments schedule, commissioners and providers must agree and sign a written contract (either using the API or local

payment arrangement rules). To minimise administrative workload, use of a collaborative contracting approach across ICBs is very strongly recommended; see Standard Contract Technical Guidance for details.

111. 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 99 above.

6.2 LVA payment schedule

112. The LVA payments schedule is published in Annex DpA. The 2026/27 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.

113. For 2026/27, 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 and 2026/27 cost uplift and efficiency factors applied.
- Mental health and community services – update the 2024/25 LVA values with the 2025/26 and 2026/27 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 and 2026/27 cost uplift and efficiency factors applied.
- Specialised services – update the 2024/25 LVA values with the 2025/26 and 2026/27 cost uplift and efficiency factors and add newly-delegated services.

114. We have then applied an uplift of 8.5% to the LVA values, reflecting estimated average activity growth. This uplift reflects increases in activity from the reference years used for the LVA values (2019/20, 2022/23 and 2023/24) to 2024/25 levels. This recognises financial pressures and the fact that it takes time for increases in activity to be reflected in the LVA values whilst continuing to prioritise stability.

115. 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.

116. Where LVA applies, no further payments or amounts should be transacted during 2026/27, 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 2026/27

Providers and commissioners are advised to consider the following guidelines in establishing their 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: • **2025/26 fixed payment value** – this value should not include the value of services on variable terms as defined in the 2025/26 NHS Payment Scheme (NHSPS). It should be adjusted for any non-recurrent and full-year effect items • **2025/26 full variable value** – this value should include the relevant proportion of the 2025/26 elective activity, which was incorporated into 2025/26 baselines, plus the 2025/26 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 2025/26, as well as those that are newly in scope for delegation from 2026/27. High-cost exclusions and the 2025/26 value of SDF should not be included.
Service changes from 1 April 2026	The cost of service changes from the point of setting the opening 2026/27 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 2026/27 baseline for relevant intra-system, inter-system and NHS England API arrangements.

Inflation net of general efficiency	By default, commissioners and trusts should adjust the opening 2026/27 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 2026/27 revenue and finance contracting guidance.
Adjustments for identified differences in funding	Additional adjustments for identified differences in funding should be informed by work to deconstruct blocks and review fixed payments (see Section 3.2). **This then sets the overall envelope for 2026/27**
Adjustment to remove the variable and blended payment elements	• The payment value should then be adjusted to remove the 2026/27 planned variable and blended payment elements, comprising planned elective activity x price (including planned value of delivering chemotherapy, unbundled diagnostic imaging and nuclear medicine) • planned value of delivering Urgent and Emergency (UEC) services, radiotherapy (external beam and SABR) and genomics.
Service development funding (SDF)	Having removed the 2025/26 value of SDF to form the opening baseline value, the API fixed payment should now be adjusted to include the confirmed level of 2026/27 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	2025/26 fixed payment = £180m 2025/26 SDF to be removed = - £25m 2025/26 elective activity payment = £45m 2025/26 planned chemotherapy = £2m 2025/26 planned unbundled diagnostic imaging = £3m = £180m – £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 +2.03% General efficiency factor of -2.0% Appropriate growth in CNST between 2025/26 and 2026/27. The change for each individual trust will reflect its relative risk factors.	+£0.6m (0.03% 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 2026/27 revenue and finance contracting guidance.	+£5.0m
Net adjustments for identified differences in funding	Sum of additional efficiency requirements and potential funding gaps identified through deconstructing blocks and review of fixed payment of -1.2%.	-£2.5m (1.2% of £210.1m)
Variable and blended payment adjustment	Planned electivity activity payment: **£52m.** Planned blended elements (UEC, radiotherapy and genomics): **(£80m)**	-£132.0m
Service development funding (SDF)	Add confirmed 2026/27 SDF values to the fixed payment (a value of £26m used for the purpose of this example)	+26.0m

Total fixed payment for 2025/26 = £180m

Total fixed payment for 2026/27 (with blended payments, including UEC removed) = £101.6m