NHS England

2026/27 NHS Payment Scheme – a consultation notice

Part A: policy proposals

Publication reference: PRN02097

Contents

1. About this document

1. This is the statutory consultation notice for the 2026/27 NHS Payment Scheme (NHSPS).

2. The consultation notice is in three parts:

   - Part A – policy proposals (this document). This contains:
     - an introduction that sets the context for the 2026/27 NHSPS and explains how you can respond to this consultation notice
     - a description of our proposals and our rationale for proposing them.
   - Part B – draft NHSPS. This contains a draft of the proposed NHSPS, shown as it would appear in its final form.
   - Part C – impact assessment. This describes our assessment of the likely impact of our proposals.

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

4. This document should be read in conjunction with its annexes and supporting documents. The annexes labelled with a ‘Cn’ prefix form part of this notice. Those labelled with a ‘Dp’ prefix are part of the draft NHSPS. It is proposed that ‘Dp’ annexes would form part of the 2026/27 NHSPS on publication. Supporting documents will also be updated as needed and published alongside the 2026/27 NHSPS.

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

Table 1: Annexes and supporting documents

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

2. Introduction

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

7. The proposals for the 2026/27 NHSPS follow the 10 Year Health Plan for England (10YHP) and are intended to support its aims.

8. The 10YHP commits to moving to long-term financial planning and this is reflected in the medium-term planning framework. For 2026/27, our NHSPS proposals prioritise stability and focus changes on a small number of high-priority areas, such as developing the payment approach for urgent and emergency care (UEC – see Section 6.4) and introducing additional best practice tariffs (BPTs – see Section 5.6).

9. The medium-term planning framework also commits to significantly reducing the number of routine, clinically low-value follow-up appointments, supported by GIRFT's specialty level good practice guides. We will consider whether there need to be any changes to payments for follow-up activity to support this goal. Any amendments to the 2026/27 NHSPS would be subject to consultation before being implemented.

10. While the medium-term planning framework asks organisations to develop plans for three years, we are proposing to set the 2026/27 NHSPS for one year only. We will develop proposals for the 2027 NHSPS, which are likely to include:

    - recalculating prices using more recent cost and activity data
    - using payment to help empower patient voice
    - payment mechanisms to support the provision of neighbourhood health services.

11. During 2026/27, we will work to develop and test payment approaches that support the 10YHP's commitments, particularly to shifting care away from hospital and towards neighbourhood health care settings. Our proposals for the 2026/27 NHSPS should not prevent local areas from developing and trialling payment models that support developing neighbourhood health.

12. We will also continue work to develop payment approaches for mental health and community services. As with 2025/26, guidance on the mental health and community currencies are published as supporting documents to the NHSPS. The Currency

models, support and guidance Futures workspace also contains information about currency development. The following changes have been made to the currency models for 2026/27:

- **Mental health services:** building in additional granularity to provide a better understanding of care settings and expanding guidance on additional complexity factors to help understand the wider needs of patients.
- **Community currencies:** including a wider range of community-based care, aligning with the Standardising Community Health Services programme and wider national policy objectives. We have also worked alongside the Primary Care, Communities, Screening and Vaccinations Directorate (PCCSV) Insight Unit to develop a Data Quality Improvement Framework which sets out clear goals for improving local and national data, monitoring improvement and supporting collaborative practice.

13. We are also proposing to publish non-mandatory guide prices for certain ADHD and Autism services. These would be used to support providers and commissioners to locally agree payment for these services – see Section 9.3

14. We plan to undertake extensive engagement to support the developing payment system. To keep up to date, you can join the Payment System Support Futures workspace and register for updates on payment system developments.

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

3. Responding to this consultation

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

16. The proposals for the 2026/27 NHSPS are subject to a statutory consultation process as required by Section 114C of the Health and Social Care Act 2012. The consultation allows ICBs and providers of NHS-funded services to submit objections to the proposed NHSPS, with set objection thresholds which trigger the statutory objections process. However, the consultation is open for anyone to participate in, and all responses will be carefully considered and will inform final decisions on the NHSPS. The statutory consultation period is 28 days, ending on 16 December 2025.

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

18. Please submit your feedback through the online survey. The deadline for submitting responses is midnight at the end of **16 December 2025**.

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

4. How we worked with stakeholders to develop our proposals

20. Engagement on developing our proposals for the 2026/27 NHSPS has included:

- 10YHP engagement sessions, including development of the plan's commitment to sharper incentives
- following publication of the 10YHP, discussions with provider and commissioner CEOs and CFOs, including a specific 'Sharper incentives' working group
- taking part in external events relevant to payment policy development, as well as working with colleagues across NHS England and the Department of Health and Social Care
- participating in the advisory groups including HFMA Payment and Specialised Services Group and RCP Expert Advisory Group on Commissioning
- working with clinical groups, including National Casemix Office expert working groups, to consider cost data and prices.

21. We also ran a webinar at the end of September that discussed a number of policies being considered for the 2026/27 NHSPS.

22. We intend to undertake more extensive engagement on our work as we develop the next NHSPS. In particular, on the recalculation of prices and developing policies to support 10YHP commitments.

23. To be kept informed, please register for updates. You can also join the Payment system support Futures workspace. Please contact england.pricingenquiries@nhs.net if you have any queries.

24. The rest of this document sets out our proposals for the 2026/27 NHSPS.

5. Proposals applying to all payment mechanisms

5.1 Duration

- **We propose to set the 2026/27 NHSPS for a one-year period.**

About this proposal

25. We are proposing to set the NHSPS for the period of one year – 2026/27.

Why we think this is the right thing to do

26. While there is a move to medium-term planning, we do not think it is appropriate to set the 2026/27 NHSPS for longer than one year. This is because we expect to make more substantial changes for 2027/28, including a full recalculation of prices and developing policy proposals described in the 10YHP. These proposed changes would be accompanied by guidance to explain how to apply the changes in the context of a multi-year planning period.

27. We will consider setting a longer-term NHSPS in future years.

5.2 Payment principles

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

About this proposal

28. The NHSPS contains the following payment principles that must be applied to all payment arrangements:

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

29. We propose that these principles continue to apply for the 2026/27 NHSPS. However, we would update the reference to operational planning guidance to instead relate to the medium-term planning framework.

Why we think this is the right thing to do

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

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

32. The overall objectives of payment policy have not changed. However, it will be important to ensure that chosen payment approaches appropriately reflect the shift from annual operational planning guidance to the medium-term planning framework. As such, it is appropriate to update the principle relating to planning to clearly signpost to the medium-term planning framework, but otherwise leave these principles unchanged for 2026/27.

5.3 Cost adjustment: 2026/27 cost uplift factor

- **We propose to set the cost uplift factor for 2026/27 at 2.03%.**

About this proposal

33. The cost uplift factor is a forward-looking adjustment to reflect expected cost pressures (inflation). It is applied to the prices and LVA payment values published as part of the NHSPS. Providers and commissioners must also have regard to it as part of API and local payment arrangements.

34. We have calculated the proposed 2026/27 cost uplift factor based on an assessment of cost pressures. We gathered initial estimates across several cost categories and then reviewed them to set an appropriate figure for the NHSPS, which in some instances requires an adjustment to the initial figure. Table 2 outlines the cost categories and the source for initial estimates.

Table 2: Costs included in the 2026/27 cost uplift factor

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

Unallocated CNST	Expected changes in CNST contributions that have not gone through the HRG level CNST uplifts	Internal Estimate NHS Resolution
Other	General inflation for other operating expenses	Internal data Department of Health and Social Care

35. While we have used largely the same approach as in previous years, we are proposing to use DHSC forecasts for non-pay non-drugs inflation (the 'other' cost category), rather than OBR forecasts. For more information, see Annex DpD.

36. In setting the general cost uplift factor, each cost category is assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure from published 2024/25 financial accounts. Table 3 shows the weights applied to each cost category.

37. For the cost weights, we used previous NHS Payment Scheme cost uplift factors to adjust the 2024/25 consolidated accounts data to produce a projected set of 2025/26 cost weights.

Table 3: Elements of inflation in the 2026/27 cost uplift factor

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.10%	71.31%	1.49%
Drugs	0.58%	2.37%	0.01%
Capital	1.66%	4.44%	0.07%
Unallocated CNST	0.52%	2.22%	0.01%
Other	2.20%	19.66%	0.43%
Total			**2.03%**
Note: calculations are done unrounded – only two decimal places displayed.			

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

- Purchase of healthcare from other bodies, which includes a combination of costs and cannot be discretely applied to one specific category.
- Education and training, which are not included in the NHSPS.
- High cost drugs and devices, which are not reimbursed through NHSPS prices.
- Material non-RDEL costs, such as annually managed expenditure (AME) impairments and depreciation and amortisation costs related to Government granted or donated assets.

39. We have aligned the expenditure used for calculating cost weights to that reported in the Adjusted Financial Performance (AFP) measure by NHS providers. This is an

RDEL measure and, therefore, the calculation excludes material non-RDEL costs as described in the previous paragraph. Part of the AFP calculation involves adjusting the revenue costs of private finance initiative (PFI) schemes to a UK GAAP basis. We have reviewed this adjustment and have mapped PFI revenue costs to the 'other' category for the purposes of calculating cost weights, as we consider this category to have the most appropriate uplift measure for these costs.

Why we think this is the right thing to do

40. Every year, the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. We therefore make a forward-looking adjustment to the modelled prices to reflect expected cost pressures in future years (the cost uplift factor).

41. As Table 3 shows, total indicative pay cost change is valued at 2.10% for 2026/27. This reflects a nominal 2.0% for pay currently included in 2026/27 allocations, plus 0.1% for pay drift. As presented here, the pay cost estimate explicitly does not pre-judge the outcome of the pay review body process, the outcome of which will not be known until 2026 and which we will then reflect. If further information is available prior to the publication of the final NHSPS, we will look to update the estimates of the cost uplift factor, where it is practical to do so.

42. The uplift estimates for drugs and capital expenses are reliant on an inflation assumption. Our methodology uses the Office for Budget Responsibility's March 2025 forecast GDP deflator rate for 2026/27 (1.66%).

43. Total drug uplift is estimated at 0.58% for 2026/27. This is calculated based on an assumption of unit costs for generic drugs changing by the inflation rate. The unit costs for branded medicines are assumed to be fixed, so the expected change is set at zero. These estimates are weighted based on the proportions of generic and branded medicine for drugs included in the NHSPS, which calculates the final estimate.

44. Total change in the revenue consequences of capital is estimated at 1.66%, using the GDP deflator rate for 2026/27. This estimate of change would be assumed to apply for depreciation costs.

45. Total change in unallocated CNST, which is included in the NHSPS but cannot be allocated to HRG subchapters, is estimated at 0.52%. This is based on the change in contribution rates for unallocated CNST as a proportion of the total CNST collection from NHS providers for 2026/27.

46. Total change in other operating costs (i.e. costs not covered by the above categories) is estimated at 2.20%. This reflects a figure of 2.20% inflation (not including pay or drugs), provided by DHSC. This measure includes an estimate of the weighted inflationary pressure on PFI expenditure.

5.4 Cost adjustment: 2026/27 efficiency factor

- **We propose to set the efficiency factor for 2026/27 at 2.0%.**

About this proposal

47. The cost uplift factor adjusts payments and prices up, reflecting our estimate of inflation. The efficiency factor adjusts them down.

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

49. We are proposing to set the efficiency factor for 2026/27 at 2.0%.

Why we think this is the right thing to do

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

51. The 10YHP sets the NHS a 2% productivity target. Our judgement is that it is appropriate for NHS-funded services, including those delivered by non-NHS providers, to aim to achieve this target.

52. At an aggregate level, NHS acute trusts delivered 2.7% productivity growth in 2024/25 compared to 2023/24 (see September 2025 NHS England Board papers). This indicates that the 2% is not unreasonable.

53. As such, we are proposing to set the 2026/27 efficiency factor at 2.0%.

54. We are also working to support NHS organisations' productivity and efficiency. The Productivity and Efficiency compartment on Model Health System allows organisations to benchmark themselves across a range of productivity and efficiency-related indicators and identify potential sources of improvement. The Productivity and Efficiency Improvement Hub Futures workspace also contains a range of resources and information including a workforce productivity tool. In addition, as part of the NHS planning process, we have sent organisations Productivity Opportunity Packs for

Planning. The packs quantify potential opportunities to improve productivity and efficiency performance.

5.5 Excluded items

- **We propose that certain high cost drugs, devices and listed procedures, and MedTech Funding Mandate products, continue to be excluded from core payment mechanisms.**
- **We are proposing to update the lists of excluded items for 2026/27.**

About this proposal

55. For 2026/27, we propose to continue with the established excluded items process. Several high cost drugs, devices and listed procedures, and listed innovative products (containing items covered by the MedTech Funding Mandate) are excluded from NHSPS price calculation and reimbursement. Instead, they are subject to local payment arrangements, following the excluded items pricing rule.

56. We have reviewed the lists of high cost drugs and devices for 2026/27. This has involved running a nominations process, where stakeholders can submit requests for additions or removals from the lists, as well as horizon scanning to identify new items that might come to market during 2026/27. Any NICE-approved items that come to market while the 2026/27 NHSPS is in effect would be treated as high cost exclusions.

57. We discussed the submitted nominations and findings of the horizon scanning with the NHS England High Cost Drugs Steering Group and High Cost Devices Steering Group, who provided recommendations.

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

    - Adding 47 unique drugs to the high cost drugs list (all of these were identified by the horizon scanning process). The drugs are covered by drug categories already on the list but are now available for new indications and treatments.
    - Removing 65 drugs from the list (28 of these were nominated and 37 were identified by the horizon scanning process as not currently in use with no licence expected during 2026/27).
    - Removing Sonata from the devices list. Sonata does not meet the criteria for specialised commissioning under the specialised services devices programme (SSDP), as its usage and clinical application fall outside the scope of high cost, tariff-excluded devices intended for national oversight.

- Clarifying that Radiofrequency, cryotherapy and microwave ablation probes are covered by the catheters category. The clarification brings this in line with the overarching criteria that "All devices should be used in line with NICE guidance and commissioning policy and guidance."

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

60. The funding released from the changes to the drugs list has been put back into prices. In total, we are proposing to remove £525.5m of funding from the high cost drug exclusion list. Of this, £458m would be used to adjust the unit prices for services that use the drugs that have been removed. The remaining amount is out of scope of unit prices and would be paid as part of locally agreed payment arrangements (for example, local prices for chemotherapy, SB17Z). See Annex DpA, worksheet '12b.1 HC drugs removal', for details of these proposed changes.

61. It continues to be the case that most homecare drugs 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 we are proposing moving the funding for previously excluded drugs into unit prices, and these drugs are identified as being part of prices in Annex DpA, these would 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.

62. There is also an exclusion list of innovative products covered by the MedTech Funding Mandate (MTFM). In the consultation on the 2025/26 NHSPS, we proposed removing Spectra Optia from the MTFM list but did not implement this change in the 2025/26 NHSPS Annex A. For 2026/27, we would remove Spectra Optia.

Why we think this is the right thing to do

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

64. The nominations form is intended to allow any stakeholders to submit suggested changes to the exclusion lists, providing evidence to support their nomination. This is

supplemented by the horizon-scanning work to give as full a picture as possible of items that should be considered for exclusion.

65. Our proposals do not accept all of the nominations for additions to the drugs and devices lists. This was for a range of reasons, including nominations relating to items already covered by categories on the lists. Others were not recommended for inclusion on the list either because they were not felt to be sufficiently high cost, were unlikely to be approved for use within 2026/27 or would be subject to alternative payment routes. Some nominations did not include sufficient evidence in support of their submission, meaning they could not be accepted.

66. Our reasons for proposing to remove drugs from the exclusion list are where:

- items were nominated for removal, with sufficient evidence to support the change
- there are biosimilar/generic equivalents that have been available over many years (especially in the case of infliximab, adalimumab, etanercept and rituximab)
- price reductions mean the items no longer meets the criteria of high cost
- the drug use is stable and non-volatile expenditure.

67. We are proposing to remove Spectra Optia from the MedTech Funding Mandate list as this was proposed for 2025/26 but not implemented in error.

68. Annex DpA shows our proposed high cost drugs, devices and listed procedures, and MedTech Funding Mandate products lists for 2026/27.

5.6 Best practice tariffs

- **We propose to continue to use a mix of activity and annual BPTs, expanding the scope of activity BPTs to cover UEC as well as elective services.**
- **We propose adding additional procedures to the Right Procedure Right Place (RPRP) BPT.**
- **We also propose creating new BPTs to support:**
  - **elective activity being delivered as day case rather than inpatient where appropriate**
  - **10YHP referral-to-treatment (RTT) priorities.**

About this proposal

69. Since they were first introduced in 2010/11, BPTs have been designed to incentivise quality and cost-effective care. Under the 2025/26 NHSPS, there were two types:

- elective activity BPTs, paid on an activity basis using BPT unit prices

- annual BPTs, which had funding agreed as part of the API fixed element.

70. For 2026/27, we are proposing to broaden the classification of activity BPTs so they cover both UEC and elective services. The following BPTs are either wholly or partially related to UEC and so would become activity BPTs for 2026/27:

    - acute stroke care
    - adult asthma
    - chronic obstructive pulmonary disease (COPD)
    - diabetic ketoacidosis and hypoglycaemia
    - fragility hip fracture
    - emergency laparotomy
    - heart failure
    - non-ST segment elevation myocardial infarction

71. Please note: from 2026/27 the spinal surgery BPT would be transacted wholly on an activity basis (either UEC or elective depending on the HRG). The major trauma BPT relates to UEC activity, however, its design does not support the activity BPT approach, so it would remain an annual BPT.

72. These UEC-related BPTs would form part of the UEC blended payment and operate in line with its goal of aligning payment and activity. See Section 6.4 for details on how BPTs would operate as part of the UEC blended payment.

73. BPT prices would be calculated using the process set out in Section 10.2.

74. We are also proposing to increase the number of procedures covered by the RPRP BPT and introduce new BPTs for day cases and 10YHP RTT priorities.

RPRP BPT

75. The 2025/26 NHSPS introduced the RPRP BPT as an elective activity BPT. This aligned with the GIRFT RPRP initiative, encouraging appropriate procedures to move out of traditional operating theatres and into alternative settings, such as outpatient procedure rooms.

76. For 2026/27, we are proposing to increase the number of procedures covered by the RPRP BPT, adding the following:

HRG	OPCS	Description
CA98Z: Reduction of Fracture of Nasal Bone	V092	Reduction of fracture of nasal bone NEC
CD03A: Minor Dental Procedures, 19 years and over	F202	Excision of lesion of gingiva
CD08Z: Biopsy of Gingiva	F203	Biopsy of lesion of gingiva
HN16A: Minimal Hip Procedures, 19 years and over	W903 + HIP	Injection of therapeutic substance into joint of hip
	W904 + HIP	Injection into joint NEC of hip
	T625 + HIP	Injection into bursa of hip
	T744 + HIP	Injection of therapeutic substance into tendon NEC of hip
HN26A: Minimal Knee Procedures, 19 years and over	W903 + KNEE	Injection of therapeutic substance into joint of knee
	W903 + IMAGE + KNEE	Injection of therapeutic substance into joint of knee under image control
	W904 + KNEE	Injection into joint NEC of knee
	T625 + KNEE	Injection into bursa of knee
	T744 + KNEE	Injection of therapeutic substance into tendon NEC of knee
HN36Z: Minimal Foot Procedures	W903 + FOOT	Injection of therapeutic substance into joint of foot
	W903 + IMAGE + FOOT	Injection of therapeutic substance into joint of foot under image control
	W904 + FOOT	Injection into joint NEC of foot
	T625 + FOOT	Injection into bursa of foot
	T744 + FOOT	Injection of therapeutic substance into tendon NEC of foot
HN46Z: Minimal Hand Procedures	W903 + HAND	Injection of therapeutic substance into joint of hand
	W903 + IMAGE + HAND	Injection of therapeutic substance into joint of hand under image control
	W904 + HAND	Injection into joint NEC of hand
	T625 + HAND	Injection into bursa of hand
	T744 + HAND	Injection of therapeutic substance into tendon NEC of hand
HN56Z: Minimal Shoulder Procedures	W903 + SHOULDER	Injection of therapeutic substance into joint of shoulder
	W903 + IMAGE + SHOULDER	Injection of therapeutic substance into joint of shoulder under image control
	W904 + SHOULDER	Injection into joint NEC of shoulder
	T625 + SHOULDER	Injection into bursa of shoulder
	T744 + SHOULDER	Injection of therapeutic substance into tendon NEC of shoulder
HN66Z: Minimal Elbow Procedures	W903 + ELBOW	Injection of therapeutic substance into joint of elbow
	W903 + IMAGE + ELBOW	Injection of therapeutic substance into joint of elbow under image control

HRG	OPCS	Description
	W904 + ELBOW	Injection into joint NEC of elbow
	T625 + ELBOW	Injection into bursa of elbow
	T744 + ELBOW	Injection of therapeutic substance into tendon NEC of elbow

77. Annex DpC contains details of the design and criteria of the RPRP BPT and highlights the procedures that we are proposing to add for 2026/27. The proposed RPRP BPT prices are in Annex DpA. We are not proposing to move to the next step of the transition path for the 2025/26 RPRP prices, while we collect and analyse data on performance in the first year.

78. We are also proposing to introduce two new BPT areas to support the 10YHP goals for:

- shifting activity from elective inpatients to day cases where appropriate
- elective and RTT priorities.

Day Case BPTs

79. We propose that the following 22 HRGs would have Day Case BPTs. Evidence suggests that a significant proportion of activity could be undertaken in a day case setting for these services.

HRG	Description
CA32A	Tympanoplasty, 19 years and over
CD04A	Major Surgical Removal of Tooth, 19 years and over
CD06A	Extraction of Multiple Teeth, 19 years and over
FF40B	Major Anal Procedures, 19 years and over, with CC Score 0
FF41C	Intermediate Anal Procedures, 19 years and over, with CC Score 0
FF42Z	Minor Anal Procedures
FF53A	Minor Therapeutic or Diagnostic, General Abdominal Procedures, 19 years and over
FF62D	Inguinal, Umbilical or Femoral Hernia Procedures, 19 years and over, with CC Score 0
GB06H	Intermediate Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 0-1
HN24C	Intermediate Knee Procedures for Non-Trauma, 19 years and over, with CC Score 0-1
HN34C	Intermediate Foot Procedures for Non-Trauma, 19 years and over, with CC Score 0-1
HN35A	Minor Foot Procedures for Non-Trauma, 19 years and over
JA43B	Unilateral Intermediate Breast Procedures with CC Score 0-2
JC42C	Intermediate Skin Procedures, 19 years and over
LB54A	Minor Scrotum, Testis or Vas Deferens Procedures, 19 years and over
LB55A	Minor or Intermediate, Urethra Procedures, 19 years and over
LB56A	Minor Penis Procedures, 19 years and over
MA10Z	Minor, Laparoscopic or Endoscopic, Upper Genital Tract Procedures

MA12Z	Resection or Ablation Procedures for Intrauterine Lesions
MA22Z	Minor Lower Genital Tract Procedures
YD03Z	Percutaneous Biopsy of Lesion of, Lung or Mediastinum
YG11A	Percutaneous Punch Biopsy of Lesion of Liver, 19 years and over

80. The HRGs were identified using the following criteria:

- Total activity (across elective, day case and outpatient) of at least 3,000 spells.
- Elective (overnight inpatient) spell count of at least 500.
- >80% of activity in the HRG already being performed as day case and/or outpatient.
- Mean length of stay between 0.5 to 1.5 days.

81. We have excluded activity that form part of existing BPTs, as well as gynaecology and ENT procedures that had prices uplifted for 2025/26. We have also excluded hysteroscopy procedures and those that are restricted under the evidence-based interventions principles.

82. Elective and day case prices are currently equalised for most HRGs. For the HRGs covered by the new BPT, we would adjust the day case and elective prices so there is a price differential between them. The BPT prices would then be paid for activity delivered in a day case setting.

83. The prices would be calculated based on a target day case rate, as defined by the British Association of Day Surgeons (BADS), or the top quartile of provider performance where a BADS recommendation does not exist.

84. Where current mean average performance is more than 5% from the BADS/upper quartile-based target, for 2026/27 we propose using an interim target at the mid-point between current average and target performance.

85. Where there is an outpatient procedure price that has been used for a significant proportion of the HRG's activity, we propose equalising the day case and outpatient prices. This would avoid creating a perverse incentive to move activity from outpatient to day case.

10YHP Referral to Treatment (RTT) BPTs

86. We are working with the NHS England National Elective Care Programme to understand how BPTs can support elective and RTT priorities. As part of this, for 2026/27 we are proposing to introduce 10YHP RTT BPTs for the following straight-to-test activities and services undertaken in one-stop clinics:

- **Benign prostatic hyperplasia**: reducing the time from first failed trial without catheter to transurethral resection of prostate to four weeks or fewer.
- **Sleep apnoea**: reducing the time from referral to sleep study, through to diagnosis confirmation and initiation of Continuous Positive Airway Pressure (CPAP). Initially we propose a maximum of 18 weeks. Please note the HRG and procedure code for CPAP initiation for this BPT are not yet confirmed, but they are expected to be in place before April 2026.
- **Haematuria**: relevant diagnostic testing to be undertaken at the first outpatient appointment.
- **Transnasal oesophagoscopy (TNO)**: TNO with or without biopsy for suspected cancer to be performed in an outpatient setting instead of as admitted or day cases.
- **Lower urinary tract symptoms**: relevant diagnostic testing to be undertaken at the first outpatient appointment.
- **Unilateral hearing loss/tinnitus**: relevant diagnostic testing to be undertaken at the first outpatient appointment.
- **Dysphagia**: relevant diagnostic testing to be undertaken at the first outpatient appointment.

87. For each of the services in scope of the BPTs, there would be a BPT price to be paid for activity that meets the BPT criteria, and a (lower) non-BPT price for activity that is in scope but does not meet the BPT criteria.

88. The proposed prices are set out in Annex DpA and details of the BPT design and criteria are in Annex DpC.

89. Although not an RTT BPT for 2026/27, we are encouraging, where indicated, fine needle aspiration of neck lumps on outpatient first attendance. We are working to identify specific HRGs that would be involved in this activity. We are also working towards adapting the Adult Asthma BPT to provide a similar level of support for paediatric asthma patients. We intend to include BPT proposals for these services in a future payment scheme.

Why we think this is the right thing to do

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

91. The 10YHP committed to increasing the number of BPTs year on year, starting in 2026/27. This is part of the Plan's aim to reward changes through sharper incentives, encouraging providers to focus on the most clinically and cost-effective care. The January 2025 elective reform plan, Reforming elective care for patients, also committed to introducing up to 30 BPTs in 2026/27.

92. Our proposals seek to deliver on these commitments.

93. We propose to broaden the definitions of activity BPTs to include those related to UEC services so they are consistent with the aim of the UEC blended payment, to align payment and activity for these services.

94. We propose adding more procedures to the RPRP BPT to continue to encourage a shift in appropriate procedures to less resource-intensive settings. As with the procedures covered by the 2025/26 BPT, the procedures we are proposing to add to the RPRP BPT have been discussed with GIRFT RPRP team and clinical leads, national clinical directors and the National Casemix Office.

95. The 2025/26 prices for RPRP BPT procedures based on BADS ratios were set using a transition path, with the price set at halfway between current and the target values. This was intended to reduce the risk of volatility, as well as allowing providers time to change their service models where necessary. For 2026/27, we propose maintaining this approach to give providers time to adapt to the new funding arrangements and for data on the first year's performance to be collected and analysed.

96. We will continue to monitor the impact of the RPRP BPTs, including on the procedures covered by the 2025/26 BPT, and use the findings to inform further developments.

97. The proposed Day Case BPTs would initially include 22 procedures. These have been identified using the criteria in paragraph 80, which are intended to ensure that there is potential for activity changes, the targeted procedures are suitable to be undertaken as day case, and that the activity would not routinely require an overnight stay in hospital.

98. In developing the Day Case BPTs, we have drawn on learning from the previous day case BPTs, which were retired in the 2021/22 National Tariff. This included feedback that hysteroscopies should not be routinely undertaken in a day-case or outpatient setting. Our proposals aim to ensure the procedures covered by the BPTs are suitable to be delivered as day case.

99. A focus of the RPRP and Day Case BPTs is on reducing the resources required for appropriate procedures. This has the potential to improve patient experience while also

delivering efficiencies, for example by freeing up staff time for more complex procedures.

100. The RTT BPTs aim to encourage earlier diagnosis and shorter pathways, which support RTT improvement. The services covered will reflect elective priorities and incentivise the most productive activities – this applies particularly to one-stop clinics and straight to test activity.

101. The BPTs would help address long waiting lists as money would follow the patient, with organisations that deliver the strongest performance receiving proportionally greater return.

5.7 Patient-not-present payments

- **We propose to introduce a new unit price for patient-not-present (PNP) activity which results in the stopping of an RTT clock.**

About this proposal

102. Most elective activity is currently paid for on an activity basis (either through the API variable element for NHS providers, or the activity-based payment mechanism for non-NHS providers). This means that prices are paid for each unit of activity delivered. However, this does not support patient-not-present (PNP) activity, which does not currently have a price, even though it can be productive, innovative and best for the patient.

103. PNP activity refers to necessary clinical and administrative tasks which do not involve a face-to-face or virtual appointment. PNP activity covers tasks that progress or complete care outside of a consultation without real-time patient contact. Examples include post-referral triage, validation, review of diagnostic results and setting out care plans. Much of this activity will result in the patient requiring no further intervention, stopping the RTT clock.

104. We are proposing to introduce a new unit price for PNP activity that does result in an RTT clock stop. For 2026/27, this price would not differentiate between clinical and non-clinically-led clock stops. To avoid double-payment and ensure a focus on genuine PNP clock stops this would exclude RTT status codes 30 (first definitive treatment) and 33 (DNAs).

105. In order to provide the data needed to apply the price, a new data flag would be added to the Waiting List Minimum Data Set (WLMDS). This would allow PNP activity to be recorded and monitored nationally, while keeping additional reporting requirements low.

The flag would also ensure that PNP activity is identified separately to traditional clinical activity clock stops.

106. The proposed PNP unit price for 2026/27 is £33 and is included in tab 4c of Annex DpA.

107. For PNP activity resulting in a clock stop, providers would be paid as part of the API elective variable element, or the activity-based payment mechanism.

Why we think this is the right thing to do

108. Increasing PNP activity represents a positive shift in how elective care is delivered without requiring a traditional outpatient appointment. It can include post-referral triage and clinicians reviewing diagnostic results, validating pathways and completing care plans. PNP activity reduces duplication, shortens patient journeys, reduces the requirement for patients to attend hospital unnecessarily and frees up valuable clinical time. It also aligns with the national health inequalities agenda and Core20PLUS5 by reducing unnecessary hospital attendances that create access barriers for the most disadvantaged communities.

109. Setting a unit price for PNP activity would help embed it as a core part of elective pathways, ensuring it is properly resourced and builds the foundations for stronger data capture and reporting.

110. The proposal reflects the findings from extensive engagement with policy leads, clinicians, providers, and finance colleagues. It aligns with the wider ambitions set out in the Elective Reform Plan, the 10YHP and the new Outpatient Model, which emphasises faster diagnosis, more care outside of an outpatient setting and better use of clinical time. It also delivers on the Elective Reform Plan's commitment to align payment more closely to activity that directly ends a patient's wait for care.

111. The proposal focuses on paying for RTT clock stops that are the result of PNP activity, rather than all PNP activity. This is a change from the previous non-mandatory price for non-face-to-face outpatient attendances which had been part of the National Tariff. Paying directly for clock stops resulting from PNP activity provides a clearer incentive and stronger alignment with productivity and performance improvement. This approach rewards the outcome that ends a patient's wait, rather than the PNP activity itself.

112. We have trialled the PNP payment approach (and £33 price) during the validation sprint for 2025/26, with findings suggesting that it has successfully increased the number of clock stops delivered during the trial period.

113. We are proposing to set the payment value at £33 so it is significantly below outpatient appointment costs, but is able to incentivise providers to stop RTT clocks without bringing patients back in for avoidable appointments, improving productivity and closing pathways at a lower cost.

114. We had considered introducing a higher price for clinical PNP clock stops than for non-clinical ones. While this would recognise that some PNP activity adds more value than others, it would require stronger coding quality to differentiate between types and an additional flag in WLMDS. We will consider whether differential prices would be a viable option in the future once the necessary data fields are more consistently embedded and reliably captured.

5.8 Abortion services

- **We propose that abortion services continue to be paid on an activity basis, but to clarify payment arrangements when the scan, consultation and procedure happen on the same day.**

About this proposal

115. Under the 2025/26 NHSPS, abortions (also known as termination of pregnancies) are paid for on a variable basis for both NHS and non-NHS providers. This is consistent with the NHS vision for abortion services.

116. For 2026/27, we propose to continue to apply this payment approach but to update the guidance to reflect the March 2025 abortion commissioning guidance. In particular, we would clarify reimbursement arrangements where different parts of the pathway take place on the same day (for example, consultation, scan and procedure). Providers and commissioners would be asked to set a local price for the whole pathway, based on the NHSPS prices for consultation, scan and procedure, rather than using the procedure price alone. This is applicable for both NHS and non-NHS providers.

117. Annex DpB contains the updated guidance for termination of pregnancy services.

Why we think this is the right thing to do

118. Abortion continues to be one of the most common procedures in the NHS. The payment approach was updated in 2025/26 so reimbursement was based on activity, rather than being part of the fixed payment.

119. Prices paid should promote timely access to services and not discourage the delivery of consultations, scans and procedures on the same day. As such, we are proposing to

update the guidance in Annex DpB to make clear how prices should be applied and to ensure that reimbursement is based on activity provided.

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

6.1 Scope

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

About this proposal

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

121. As with the 2025/26 NHSPS, this would mean the only NHS provider activity excluded would be:

- where there is an LVA arrangement in place (see Section 7)
- the service is a single specialised or non-acute service individually procured from an NHS provider under a separate contract.

122. Activity delivered by NHS providers that is outside the scope of API would be subject to either LVA (see Section 7) or local payment arrangements (see Section 9).

123. Activity delivered by non-NHS providers would not be in scope of API. Instead, this would either use activity-based payments (for services with NHSPS unit prices – see Section 8) or local payment arrangements (where unit prices are not available – see Section 9).

Why we think this is the right thing to do

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

125. We do not want to introduce uncertainty by changing the scope of API.

6.2 Design: fixed element

- **We propose that the fixed element covers almost all activity not covered by other API payment rules (eg elective and UEC).**
- **We propose that providers and commissioners must review their fixed payment and identify funding for individual services.**

About this proposal

126. We propose that the 2026/27 API fixed element covers funding for services including:

- an agreed level of acute activity outside the scope of the elective activity variable element (see Section 6.3) and service-specific blended payments for UEC (Section 6.4), radiotherapy (Section 6.5) and genomics (Section 6.6)
- maternity, mental health, community and ambulance services
- outpatient follow-ups
- expected achievement of annual BPTs and levels of advice and guidance delivered
- chargeable overseas visitors
- CNST contributions
- services and drugs delivered via homecare
- implementation costs of MedTech Funding Mandate products and models of care.

127. The 2025/26 NHSPS introduced a requirement for providers and commissioners to review their fixed payment each year. During summer 2025, providers and commissioners were also asked to 'deconstruct' their current fixed payments (blocks) to separately identify funding for individual services, including UEC and maternity.

128. We propose that, in setting the fixed payment for 2026/27, funding for individual services should be identified, 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.

129. For acute services commissioned by ICBs (including delegated specialised commissioning services), we propose that:

- the outcome of work to deconstruct blocks and review fixed payments should be used to inform prospective adjustments to fixed payment values, and to inform contract discussions and areas of focus in future years
- the value of any identified differences in funding should be considered when applying local efficiency requirements (including convergence), rather than immediately applied in full
- adjustments should be set at a reasonable level for the trust and an affordable level for the commissioner, and considered alongside other funding adjustments including allocations convergence, organisational deficit reduction, MFF changes, and activity growth.

130. We propose that 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, such that those funding differences are reduced. Where providers 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 providers are already expected to deliver efficiency that exceeds 2.5% NHS contract income, as a result of reduced deficit plan limits, no additional adjustments for agreed funding differences should be made. Adjustments exceeding +/- 2.5% should only be agreed in exceptional circumstances.

131. 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 income gains can be reinvested into alternative services. This approach ensures both parties are aligned in managing resources effectively while safeguarding service delivery and patient care.

132. Full details of the proposed approach to setting fixed payments, for both acute and non-acute services, are available in the supporting document *NHS provider payment mechanisms.*

133. Where adjustments to fixed payments are agreed to be actioned over time, a clear plan should be documented on what changes are expected and when they will be implemented.

Why we think this is the right thing to do

134. The fixed element covers the majority of funding for most NHS providers. This is intended to help provide financial stability and support longer-term planning and transformation. However, it is important that fixed payments reflect current activity and efficient costs – hence the requirement for providers and commissioners to review fixed payments each year.

135. We are proposing that the work on deconstructing fixed payments plays a key role in setting fixed payments for 2026/27, but that any changes implemented do not destabilise either providers and commissioners. The work should help organisations to understand the funding for individual services, as well as additional funding included in the fixed payment. This should help systems identify efficiency opportunities and appropriate distribution of resources between providers.

136. We are proposing that funding for individual services included in the fixed payment, including those not calculated on an activity basis, are separately identified. This would help systems ensure appropriate funding and identify potential productivity opportunities.

6.3 Design: variable element

- **We propose that elective services are paid on a variable basis.**
- **We propose that fixed payments are also varied based on the levels of advice and guidance delivered.**

About this proposal

137. For 2026/27, as in 2025/26, we propose that elective activity is paid for using NHSPS unit prices, with relevant market forces factor (MFF) value applied, for elective activity.

138. As described in Section 5.7, we are proposing to introduce a new patient-not-present (PNP) unit price for activity that stops an RTT clock, which would be paid via the variable element.

139. In addition, providers and commissioners should include funding for an agreed level of advice and guidance activity as part of the API fixed element. If the volume delivered is different to what was expected, the amount paid should be increased or decreased accordingly.

140. We propose to maintain the pause of the nationally mandated CQUIN scheme for 2026/27. This means there would be no variable payments relating to achievement of CQUIN criteria.

Why we think this is the right thing to do

141. We want payment arrangements to support providers to deliver as much elective activity as is affordable. Using NHSPS unit prices to pay for elective activity on a variable basis supports this intention. It also ensures an equivalent payment approach is used for NHS and non-NHS providers of elective activity.

142. Using the variable element to support advice and guidance also helps ensure the approach is supported. The 10YHP highlights the impact of advice and guidance on diverting referrals from hospitals.

143. In engagement and consultations on the NHSPS, pausing the CQUIN scheme has consistently been strongly supported. We are proposing to continue to pause the scheme for 2025/26. Non-mandatory CQUIN indicators will continue to be available on

Futures to support systems which choose to implement a CQUIN-like scheme as a variation to the API rules.

6.4 Design: urgent and emergency care

- **We propose to introduce a blended payment model for UEC, comprising a fixed payment and a variable payment for activity above or below plan and a break glass clause where activity is significantly different to plan.**

About this proposal

144. In recent years, funding for UEC services has been covered by the API fixed element. We have found that in many cases, these fixed payments are still based on the block payment arrangements introduced during the COVID pandemic, albeit with some subsequent updates. This approach has meant that fixed payments do not necessarily reflect providers' actual activity levels. In addition, while using fixed payments for UEC might incentivise providers to reduce avoidable activity or use less clinically incentive settings, it is unlikely to encourage investment in out-of-hospital care, such as virtual wards and urgent community response (UCR).

145. For 2026/27, we are proposing to introduce a blended payment model for UEC, including same day emergency care (SDEC) and other same day pathways, comprising:

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

146. This would mean that providers and commissioners 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 20% of the difference; if actual activity is lower, the amount payable would be the value of planned activity minus 20% of the difference.

147. We are proposing to set a unit price for SDEC (see Section 10.2) to help ensure that activity uses the same payment approach. The proposed price has been set based on local prices currently in use and would relate to speciality-based activity that aims to avoid a non-elective admission. Local prices should be set for other same day pathways, which should then be used for fixed and variable payments.

148. For services covered by UEC-related BPTs (see Section 5.6), 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 would 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 would 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.

149. In the longer term, we intend to introduce an incentive element to encourage providers to shift activity from overnight to same day/out of hospital and reduce length of stay. This element could be piloted in some areas during 2026/27.

150. Providers and commissioners would be required to agree a 'break-glass' clause – a floor and ceiling for activity that is significantly above or below planned activity levels. The break glass clause would 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.

151. As local circumstance will differ, the details of the break glass would be agreed locally. 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%.

152. To successfully implement the proposed 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, we propose providing a national default to both support those local conversations and act as a back stop if needed.

153. The proposed default approach is based on national 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.

154. As maturity and utilisation is variable, for 2026/27 we do not propose to set a 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.

155. The proposed unit prices for UEC are set out in Annex DpA. For more information about the proposed UEC payment approach, including guidance on setting the break glass clause, see the supporting document *NHS provider payment mechanisms*.

Why we think this is the right thing to do

156. Funding for UEC is currently included in the API fixed payment, which also covers services such as critical care, maternity and outpatient follow-ups. National analysis indicates that, in most cases, the payment is higher than would be the case if it was wholly based on price x activity. As part of the medium-term planning process, systems have been asked to compare their current contract values with the price if based on price x activity. The findings will be used to adjust contracts over a period of time, with the objective of re-aligning payment with the activity being delivered. The 10YHP committed to this deconstruction of UEC fixed payments and to realigning activity delivered with funding provided.

157. As such, the proposed UEC blended payment approach would re-establish the link between payment and activity levels. It would also ensure risk is balanced between providers and commissioners if actual activity is different to what is planned.

158. The 10YHP clearly articulates the need to move care away from hospitals and into the community and people's homes, easing UEC pressures while improving patient outcomes and experience. However, it is difficult to extract funding from the current fixed payment as there is not a link between activity and the payment level.

159. The current fixed payment may incentivise providers to reduce avoidable activity and shift activity to less clinically intensive settings, eg overnight non-electives to same day care. However, it is less likely to incentivise commissioners to invest in out of hospital services to reduce demand for acute UEC. The proposed payment model should incentivise providers to reduce costs and commissioners to reduce demand for UEC. It is intended to support commissioners to make strategic commissioning decisions about non-acute services including primary care, community and neighbourhood services by creating a clearer financial logic to shifting activity.

160. The proposed variable payment, of 20% of NHSPS prices, reflects the proportion of costs that are fully variable and therefore represent the change in costs to the provider

where activity is above or below planned levels. The variable payment would balance the volume risks between provider and commissioner. We would review the value of the variable percentage before confirming proposals for the 2027/28 NHSPS.

161. We are proposing to set a unit price for SDEC to incentivise people being treated on the same day, as this is generally best for patient experience and most productive. The price is based on local prices currently in use and would relate to speciality-based activity that aims to avoid a non-elective admission. The soon to be published Model Emergency Department will give more details of SDEC activity.

162. We propose that UEC-related BPTs form part of the variable payment as this would be consistent with the aim to align payment with activity delivered. The BPTs were initially designed to operate on a payment-by-activity basis as part of the National Tariff, so we do not expect the burden of implementing this approach to be disproportionate. The proposed approach is largely the same as the approach to BPTs included in the blended payment for emergency care as part of the 2019/20 National Tariff.

163. The break glass clause would help both providers and commissioners effectively manage any significant changes that happen during the year. We are proposing that details of the clause are agreed locally to ensure it can appropriately reflect the scale of variation between planned and actual activity levels, as well as the reasons for these differences (which may be justified by specific local operational reasons).

164. We are proposing a national default approach to setting activity plans as this would help local conversations about appropriate activity levels, as well as providing an option that could be used if agreement was not otherwise possible. The national default would support the ambition of the UEC strategy, while recognising that some systems may require more flexibility to increase capacity to enable the intended activity shifts.

6.5 Design: radiotherapy

- **We propose to introduce a blended payment model for unbundled external beam radiotherapy and Stereotactic Ablative Radiotherapy (SABR). There would be local flexibility to support providers moving to prostate SABR where appropriate.**

About this proposal

165. Unbundled external beam radiotherapy is currently funded within the API fixed element. However, another type of external beam radiotherapy, Stereotactic Ablative Radiotherapy (SABR), is paid for on a variable basis (along with other elective activity).

166. Changes in practice for radiotherapy over recent years, such as hypofractionation for breast and prostate cancer (where some patients receive more intense treatment across less appointments), have meant that the current HRG structure does not fully reflect clinical practice.

167. We are exploring options to design a long-term solution to address this, with a view to moving to a payment model based on completed episodes of care rather than based on fractions. However, for 2026/27, we want to help address the issues being caused by the current payment approach and so are proposing blended payment model for external beam radiotherapy and SABR.

168. This blended payment would comprise:

- 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.

169. This would mean that providers and commissioners 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.

170. Stereotactic radiosurgery/radiotherapy (SRS/T) and Selective internal radiation therapy (SIRT) would continue to be paid for on a variable basis, using the unit prices in Annex DpA.

171. We are proposing to set a new unit price for SABR for prostate. However, where providers and commissioners are in the process of moving to SABR for prostate and agree that a different price should be used, there would be local flexibility allowing them to use that price with no further approvals required.

172. 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.

Why we think this is the right thing to do

173. We are proposing to move to a blended payment approach for external beam radiotherapy (currently in the fixed payment) and SABR (currently in the variable payment) to ensure they are aligned. A move to a more variable approach for external beam radiotherapy will also be more aligned with other elective activity approaches, to

support an increase in activity. This blended approach balances the specific challenges a fully variable approach would cause, while supporting additional activity.

174. We are proposing a variable payment of 50% of unit prices for activity above/below planned activity to reflect estimated semi-variable and variable costs (the variable rate for the UEC blended payment is only intended to reflect fully variable costs, so we are proposing a higher variable rate for radiotherapy).

175. We are proposing to set a unit price for SABR for prostate to support activity in this area. However, providers and commissioners who are in the process of moving to SABR for prostate would have flexibility to locally agree to use different prices. This would ensure that the payment approach doesn't distort clinical practice by disincentivising the uptake of SABR.

6.6 Design: genomic testing and reporting

- **We propose to introduce a blended payment model for genomic testing and reporting services.**

About this proposal

176. Genomic testing and reporting services are currently funded via fixed payment contracts. However, NHS England is running a live procurement for these services to ensure a standardised service is in place that is contractually managed to achieve the greatest outcomes within set financial envelopes. This would ensure that a fully contracted and commissioned infrastructure is in place for 2026/27.

177. Rather than continue to use fixed payments, we propose introducing a blended payment model, which would comprise:

- a fixed payment, calculated based on planned activity x prices
- a variable payment for activity above/below plan. The value of the variable payment would be a locally agreed percentage of NHSPS unit prices
- an incentive element where a proportion of the fixed payment is dependent on improvement against some agreed metrics.

178. We are proposing to publish new unit prices for genomic testing and reporting (see Section 10.3). The proposed prices are included in tab 4b of Annex DpA.

179. This blended payment model would mean that providers and commissioners agree the value of planned activity as the fixed payment, multiplying planned activity by the unit prices. They would also need to locally agree the percentage value of the variable

element that would apply for activity above or below plane (for example, this could be 20% of prices to reflect fully variable costs). The total value of planned activity would need 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.

180. 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.

181. The incentive element would link 2% of the value of the fixed payment to achieving improvement in the following areas:

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

182. The level of required improvement and the specific metrics would be agreed locally, referring to guidance in *NHS provider payment mechanisms*.

Why we think this is the right thing to do

183. Analysis suggests that the current fixed payment approach for genomic testing may not be incentivising activity and productivity. The proposed blended payment model would do so more effectively by re-aligning payment with activity being delivered.

184. The proposed fixed element would be based on a forward-looking assessment of activity required, rather than the previous year's fixed payment. We are proposing that differences between values calculated on a price x activity basis and previous payment levels are considered as part of setting the fixed payment to ensure that services are not destabilised.

185. As different providers will have different local situations, we are proposing that the variable element should be locally agreed, rather than having a nationally set rate. This would allow local areas to effectively balance their risks of activity above or below plan between providers and commissioners.

186. We are keen to support further developments in genomic testing and the incentive element of the payment model would help to support particular types of test or efficient practice. We are proposing to set the incentive amount at 2% of the fixed payment so that it is enough to incentivise improvement, but does not introduce too much uncertainty for providers.

187. We are proposing to introduce the blended payment model in time to support the reprocurement of genomic testing services for 2026/27.

6.7 Design: specialised services

- **We propose that specialist top-up funding continues to form part of specialised service providers' fixed payment.**
- **We propose to continue to specify that treatment costs relating to NICE decisions are subject to local payment arrangements.**

About this proposal

188. In the 2025/26 NHSPS, top-ups for specialised service providers became part of the API fixed payment, rather than being paid on a variable basis. Top-ups were funded by NHS England commissioners on a host provider basis, with payments made to providers on this basis. We propose that the 2026/27 NHSPS continues to set the total top-up amount, which commissioners then pay as part of the fixed payment.

189. Under the 2025/26 API payment rules, Rule 4 states that genomic testing services and treatment costs relating to NICE decisions are exceptions to the main API rules, with providers and commissioners locally agreeing payment arrangements.

190. For 2026/27, we are proposing to introduce a blended payment model for genomic testing, which would mean it is no longer an exception to API (see Section 6.6). Treatment costs relating to NICE decisions would continue to be an exception to the API rules and subject to local payment arrangements.

Why we think this is the right thing to do

191. We moved to setting specialist top-ups as part of the fixed payment in 2025/26 as it was an effective way to support delivery of specialised services, recognising their uncommon nature, and the delegation of commissioning. Guaranteeing the amount each provider would receive supported allowed them to plan effectively.

192. We are proposing to continue to pay top-ups as part of the fixed payment to avoid the risk of potential volatility as a result of changes.

193. We are proposing to continue to exclude treatment costs relating to NICE decisions from the main API rules, as local payment arrangements are likely to be most appropriate for these services.

6.8 Variations from API design

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

About this proposal

194. For 2026/27, we propose to continue to allow providers and commissioners to vary API payment arrangements on condition that:

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

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

Why we think this is the right thing to do

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

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

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

7.1 Scope

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

About this proposal

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

199. In 2025/26, we set this threshold at £1.5m and also included the following criteria to be considered when deciding whether to set an LVA for a provider/commissioner relationship:

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

200. For 2026/27, we are proposing to keep this threshold unchanged but are proposing to expand the criteria to include consideration of whether an LVA was previously in place. We want relationships to continue to be covered by LVA unless there are significant changes in circumstances. We are proposing to set LVA values based on the proposed statutory configuration of ICBs for 1 April 2026 (noting that several ICBs are currently undergoing merger and boundary-change processes).

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

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

Why we think this is the right thing to do

202. The purpose of the LVA approach is to reduce the number of transactions for relatively small amounts of money. This reduces the administrative burden of processing these transactions.

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

204. When considering where to set the LVA threshold, it is our intention that around 90% of provider/commissioner relationships are in scope of LVA. We feel that this strikes the appropriate balance between capturing large numbers of transactions and retaining appropriate levels of control.

205. Having a set of criteria to consider, in addition to the threshold, when deciding whether to set an LVA allows flexibility to better manage the list of LVA relationships and reduce the likelihood of relationships that are close to the threshold frequently moving in and out of API arrangements. We are proposing to expand the criteria to also consider whether an LVA was previously in place would support the intention to ensure stability in payment arrangements. This would also help manage the transition to new ICB footprints, where applicable, from April 2026.

7.2 Design

- **We propose to adjust the values ICBs pay providers to reflect the 2026/27 cost uplift and efficiency requirements, with an additional uplift to reflect estimated average historic activity growth.**

About this proposal

206. Section 7.1 describes where LVA arrangements apply. For each provider/ commissioner relationship with an LVA, ICBs must pay each provider identified on the 2026/27 LVA payments schedule the calculated amount. The LVA payments schedule is published in tab 15 of Annex DpA.

207. The values in the LVA payment schedule are made up of:

- core ICB services (including non-acute)
- secondary dental services
- delegated specialised services (where applicable).

208. We are proposing to calculate the 2026/27 LVA payments schedule values by applying the proposed 2026/27 cost uplift and efficiency factors (see Sections 5.3 and 5.4) to the 2025/26 LVA values for each of these components. We would remove 2025/26 MFF values and then apply the 2026/27 values, alongside the compensating increase of 0.42% the MFF quantum neutrality factor (Section 10.4). We would then combine these updated values and apply an uplift of 8.5% to reflect estimated average activity growth. This uplift is intended to capture overall activity increases and is applied uniformly across all areas. The calculation was based on HES episodes reflecting activity increases from 2019/20, 2022/23 and 2023/24 (the reference years used in core ICB values calculation), bringing them to 2024/25 levels.

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

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

Why we think this is the right thing to do

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

212. For 2026/27, we want to ensure the amount paid via LVA is predictable and sustainable, prioritising stability. As such, we are proposing to set 2026/27 LVA values by uplifting the 2025/26 values. This would be consistent with the proposed approach to setting 2026/27 NHSPS prices (see Section 10.2).

213. Since introducing LVA, we have frequently received feedback raising concerns that values underestimate the latest activity growth and exclude costs from services not captured in SUS. We will continue to investigate these issues. We are aware that the uplift in A+E and non-elective payment introduced in 2025/26 generally increased LVA payment values, and this would continue to be reflected in the values for 2026/27. In addition, for 2026/27, we are proposing to uplift LVA values by 8.5% to reflect estimated average activity growth between the reference years used to calculate LVA

values and 2024/25. This recognises financial pressures as a result of the time taken for increases in activity to be reflected in the LVA values, whilst continuing to prioritise stability.

214. Overall, we believe prioritising stability for 2026/27 is appropriate. In future years, we would expect to recalculate the payment values using a more recent three-years average for the acute sector and consider options how best to set non-acute values to reflect more recent activity growth and service changes. We would also review the LVA design to consider whether other changes could be proposed.

8. Payment mechanism: activity-based payment

8.1 Scope

- **We propose that activity-based payment continues to be used for all services with an NHSPS unit price that are delivered by non-NHS providers.**

About this proposal

215. We propose that activity-based payment continues to apply to all services with NHSPS unit prices delivered by non-NHS providers. For 2026/27, this would include the patient-not-present (PNP) services described in Section 5.7.

Why we think this is the right thing to do

216. This proposal would mean that non-NHS providers and NHS providers are both paid 100% of unit prices for elective activity. For 2026/27, this would include the PNP services, supporting PNP activity that stops the RTT clock.

217. We recognise that the cost base and casemix of NHS and non-NHS providers can vary, while NHSPS prices are calculated based on NHS cost and activity data alone (see Section 10.2). However, cost data is not available for non-NHS providers. We also feel that using the same prices as the API elective variable element (described in Section 6.3) is consistent with the Elective reform plan, as well as facilitating patient choice and allowing funding to follow the patient.

8.2 Design

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

About this proposal

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

219. Providers and commissioners would be able to agree to vary away from published prices where appropriate. They would need to submit details of the variation to NHS England. Provider and commissioner would be required to consider the NHSPS payment principles when agreeing any variation to the published prices.

220. The MFF value for non-NHS providers should be that of the NHS trust or foundation trust nearest to the location where the services are being provided (see Section 10.4 and *A guide to the market forces factor*).

Why we think this is the right thing to do

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

222. As in previous years, we propose that MFF values apply whenever NHSPS prices are used. This offsets the financial implications of unavoidable cost differences between healthcare providers (see Section 10.4).

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

9. Payment mechanism: local payment arrangements

9.1 Scope

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

About this proposal

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

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

Why we think this is the right thing to do

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

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

9.2 Design

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

About this proposal

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

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

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

Why we think this is the right thing to do

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

9.3 Attention-Deficit/Hyperactivity Disorder (ADHD) and Autism

- **We propose to introduce non-mandatory guide prices for certain ADHD and Autism services.**
- **We propose implementing a first iteration of a currency model for ADHD and Autism services.**

About this proposal

231. For both ADHD and autism services, there are currently no national service specification or prices, leading to significant variation in the prices being paid, and specifications used, for the services delivered and little information on the cost of delivering the services.

232. For 2026/27, we are proposing to set non-mandatory guide prices for these services. These guide prices are intended to help providers and commissioners agree local prices to be used for commissioning services paid for on an activity basis.

233. The proposed guide prices will cover the following.

- **ADHD**
  - Adult - ADHD Assessment – Face-to-Face
  - Adult - ADHD Assessment – Virtual
  - Adult - Titration Pathway
  - Adult - Annual Review with Shared Care
  - Adult - Annual Review without Shared Care
  - Children and young people - ADHD Assessment – Face-to-Face
  - Children and young people - Titration Pathway
  - Children and young people – Review with Shared Care

  - Children and young people – Review without Shared Care
- **Autism**
  - Adult – Autism Assessment – Face-to-Face
  - Children and young people – Autism Assessment – Face-to-Face
- **Combined ADHD and Autism**
  - Adult – Combined ADHD/Autism Assessment – Face-to-Face
  - Children and young people – Combined ADHD/Autism Assessment – Face-to-Face

234. We are not proposing prices for virtual assessments for autism, or for ADHD for children and young people. ICBs should commission autism assessments in line with NHS England's National Framework and Operational Guidance for Autism Assessment Services. However, where virtual services currently exist a local price should be agreed.

235. The guide prices are published in tab 8 of Annex DpA and in the supporting document, *ADHD and Autism payment guidance*. The guidance document also provides more information about the proposed payment approach.

236. In addition, we have developed a first iteration of a currency model for ADHD and Autism services, to be implemented in 2026/27. The currency model uses national data set information to populate standardised units and improve an understanding of care provision. Further information is included in Annex DpB, the supporting documents, and on the Currency models, support and guidance Futures workspace. This includes how providers can derive the currency units from local data to aid service planning, benchmarking and commissioning discussions.

237. We will continue to work with the NHS England and DHSC policy teams and wider stakeholders to further develop currencies and consider appropriate payment options for ADHD and Autism services. If you would be interested in getting involved, please contact england.pricingenquiries@nhs.net.

Why we think this is the right thing to do

238. Patient choice has resulted in a significant expansion of ADHD and Autism assessment providers. There is significant variation in the prices being paid, and specifications used, for the services delivered, with little information on the cost of delivering the services. This has led to wide variation in service delivery and local care models.

239. There are currently no national service specifications for either ADHD or Autism. For ADHD services, NICE guidance is the only national reference point for local payment

arrangements. For Autism, NHS England has previously published a National Framework and Operational Guidance for Autism Assessment Services.

240. This lack of standardisation and understanding of treatment costs has resulted in opaque and variable pricing, and inconsistent service quality which leads to disruption to care pathways and unequal access to care across different areas.

241. For 2026/27, we propose introducing guide prices for ADHD services and Autism assessments. Introducing these as non-mandatory would allow providers and commissioners to consider how best to use them, ensuring that they do not destabilise effective service delivery. We welcome feedback, and will engage stakeholders on future development plans.

242. The recently published reports of the ADHD taskforce make significant recommendations for change in relation to ADHD service provision. We will take this into account in the development of this work.

243. In the longer term, currency models would help to improve understanding of activity and costs. This could support the development of payment options to support equitable funding, transparency and sustainability across the system.

10. Prices: role, calculation and related adjustments

10.1 The role of prices

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

About this proposal

244. Under the 2012 Act, the NHSPS rules can specify prices. As in previous years, we are proposing to publish two categories of price for 2026/27:

- Unit prices – to be used for API elective variable element and activity-based payment. The proposed UEC payment approach (see Section 6.4) requires API fixed payments to be set based on NHSPS price x planned activity. As such, UEC prices would become unit rather than guide prices. BPT prices are a type of unit price.
- Guide prices – to be used as benchmark information and to support local payment arrangements.

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

Why we think this is the right thing to do

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

247. The change in categorisation of UEC prices, from guide to unit prices, supports the proposed payment approach discussed in Section 6.4.

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

10.2 Calculating 2026/27 prices

- **We propose that 2026/27 prices are calculated by updating 2025/26 NHSPS pay award prices for inflation and efficiency.**
- **We propose to set new unit prices for same-day emergency care (SDEC), patient-not-present activity and the Day Case, RTT and RPRP BPTs as well as direct access services, SABR for prostate and genomic testing services. We would also set guide prices for ADHD/Autism.**

About this proposal

249. We propose to calculate NHSPS prices for 2026/27 by updating the 2025/26 NHSPS prices that were published with adjustments for pay awards (2025/26 pay award prices). For 2026/27, we would adjust these prices for inflation and efficiency (the cost uplift and efficiency factors – see Sections 5.3 and 5.4).

250. This would mean that prices continue to be based on 2018/19 cost and activity data. It would also mean that the following aspects of the 2025/26 NHSPS price calculation are rolled over:

- Currency specification (see Annex DpB for guidance on certain currencies).
- Manual adjustments used for prices since 2022/23, including the uplift of prices for accident and emergency, maternity and non-elective services implemented in 2025/26.
- Top-slice for specialist top-ups (see Section 6.4 for details of how the specialist top-ups would be applied).
- Adjustments for high cost drugs and devices (see Annex DpA and DpD for details).

251. The currencies used to set prices for admitted care and some outpatient procedures are Healthcare Resource Groups (HRGs), while outpatient attendances use Treatment Function Codes (TFCs). HRGs are based on OPCS-4 (procedures) and ICD-10 (diagnoses). For this consultation, we have used the 2025/26 local payment grouper. OPCS-4.10, will be updated to OPCS-4.11 from April 2026. The National Casemix Office have advised that some OPCS-4 codes used in HRGs may change. New codes will be matched to the most suitable ('best fit') HRG. When it is published, the 2026/27 payment grouper will reflect the new OPCS codes.

252. We propose to set the prices cost base in largely the same way as in previous years. The cost base is the level of cost that the NHSPS would allow providers to recover (if prices were used), before adjustments are made for cost uplifts and the efficiency factor is applied. We are proposing to set the initial prices cost base by equalising it to that which was set in the previous year, adjusted for activity and scope changes (see Annex DpD for details).

253. The 2025/26 NHSPS prices were initially calculated with a 4.15% cost uplift factor and 2.0% efficiency factor. However, following the 2025/26 pay awards, a revised set of prices was published in June 2025. This increased the cost uplift factor to 4.83%. The proposed prices for 2026/27 would be calculated by updating these NHSPS pay award prices.

254. The proposed 2026/27 prices would be calculated using largely the same method as previous NHSPS and National Tariff prices. This is described in detail in Annex DpD. In summary, this would involve the following steps:

- Setting draft price relativities – for 2026/27, these would be the 2025/26 NHSPS pay award prices published in June 2025.
- Making manual adjustments to the price relativities (see Section 10.3 for details of the proposed manual adjustments).
- Scaling prices to the cost base.
- Adjusting prices for inflation and efficiency (see Sections 5.3 and 5.4) and changes in MFF values (see Section 10.4).

255. We are proposing to set the prices for the procedures being added to the RPRP BPT using a combination of the methodology used for the 2025/26 RPRP BPT, which set prices based on British Association of Day Surgery (BADS) targets where applicable, data on current levels of delivery, and views from clinical experts. We are not proposing to move to the second step of the glidepath for RPRP BPT prices that were introduced in 2025/26. Instead, these would just be adjusted for inflation, efficiency and MFF changes.

256. For the new Day Case BPTs, we propose to introduce a price differential, so the day-case price is higher than the elective price. The differential has been calculated based on a target day case rate as defined by BADS, or the top quartile of provider performance where a BADS recommendation does not exist. For 2026/27 the prices are set at the midpoint between current and target performance. Where there is a high proportion of outpatient activity in the targeted procedure, the outpatient procedure price would be equalised with the BPT day case price.

257. For the new RTT BPTs, we propose following the standard BPT price setting approach. This aims to create an approximate 10% differential between the BPT and non-BPT price, maintaining overall quantum neutrality (ie not changing the overall amount of funding) based on current levels of delivery.

258. We are also proposing to introduce unit prices for direct access interventions used to assess patients with breathlessness and other respiratory issues. These unit prices would be used for activity accessed directly from primary care. The procedures are:

- DZ36Z Bronchial Challenge Studies
- DZ38Z Oxygen Assessment and Monitoring
- DZ46Z Respiratory Muscle Strength Studies

- DZ60Z Hypoxic (Altitude) or Hyperoxic (Shunt) Assessment.

259. For DZ57Z Oximetry or Blood Gas Studies, we propose the CDC price being used for direct access.

260. We are also proposing setting unit prices to support blended payment models. For the UEC blended payment, non-elective prices would become unit prices rather than guide prices (see Section 5.6), although they would still use the calculation method summarised above. We would also set prices for:

- Patient-not-present payments (see Section 5.7)
- Same-day emergency care (SDEC) (see Section 6.4)
- SABR for prostate (see Section 6.5)
- Genomic testing services (see Section 6.6).

261. As described in Section 5.7, the patient-not-present price would apply to clinical and administrative tasks which do not involve an appointment but result in an RTT clock stop. The price would be set to be lower than outpatient appointment costs, but at a level that would provide an appropriate incentive. The £33 price was tested during 2025, with stakeholders supporting the proposed price.

262. The SDEC price would cover speciality-based activity that aims to avoid a non-elective admission and would be set based on local prices currently in use.

263. The SABR for prostate price would be set based on the combination of the SC41Z unit price for the number of planning treatments per patients and the SC31Z unit price for the average number of fractions per patient. This unit price would be adjusted for the cost uplift and efficiency factors and MFF changes for 2026/27.

264. The prices for genomic testing and reporting services would be calculated based on efficient provider costs.

265. Guide prices are non-mandatory but can be used to inform local payment arrangements. We are proposing to introduce guide prices for ADHD/Autism (see Section 9.3). These prices would be set based on information about the prices currently paid by ICBs (for ADHD) and engagement with the ADHD/autism policy/clinical advisors and ICBs.

266. All proposed prices are set out in Annex DpA.

Why we think this is the right thing to do

267. 2018/19 cost and activity data (patient-level costs – PLICS – and hospital episode statistics – HES) have been used to set National Tariff and NHSPS prices since the 2022/23 National Tariff.

268. We considered using more recent data to calculate a new set of prices. However, final 2023/24 National Cost Collection PLICS data was not available in sufficient time for it to be used for a full price calculation and we did not think it was helpful to use less recent cost data.

269. Rolling over the 2025/26 price relativities requires the rolling over of the currency design used for the prices. It also means that manual adjustments and other price changes, such as the top-slice of prices for specialist top-ups and uplift of the prices for UEC and maternity services, introduced in previous years continue to be reflected in the proposed prices.

270. The proposed approach to setting new BPT prices is consistent with the aims of the BPTs, as set out in Section 5.6. We proposed using BADS ratios for RPRP and Day Case BPTs as they highlight expected best practice. Using the standard BPT price-setting approach for the RTT BPT, creating a 10% price differential, would ensure an appropriate incentive is established. We are not proposing to move to the second step of the glidepath for the RPRP BPTs introduced in 2025/26 as we want to review evidence of impact before deciding if it is appropriate to make the change.

271. The proposed direct access prices are for interventions that do not currently have prices and aim to support more rapid access to diagnostic testing.

272. The proposed patient-not present price is intended to help embed this activity in elective pathways, reducing duplication, shortening patient journeys and freeing up clinical time. During testing, the proposed price was found to successfully increase the number of clock stops delivered during the trial period (see Section 5.7 for more details).

273. The proposed SDEC price would be an important part of the UEC blended payment approach set out in Section 6.4, ensuring that SDEC activity is included in plans and appropriately reimbursed. We are proposing to base the price on local prices currently in use as appropriate cost data is not available so local prices would provide a reasonable reflection of the activity being delivered.

274. The SABR for prostate and genomic testing and reporting prices would play a key role in the blended payment models discussed in Sections 6.5 and 6.6. The proposed calculation approaches draw on relevant cost and price information and are intended to produce to support activity and commissioning of these services.

275. The proposed guide prices should provide a starting point for providers and commissioners to discuss appropriate local payment arrangements. They would support other payment approaches (such as the UEC blended payment) and provide useful benchmarks for commissioning conversations. The proposed methods used to set guide prices draw on available information and stakeholder feedback and are intended to be consistent with other work in these areas.

10.3 Price adjustments

- **We propose to make manual adjustments to price relativities for:**
  - **changes to the list of high cost drugs**
  - **ophthalmology services**
  - **stroke and pneumonia non-elective services.**

About this proposal

276. As set out in Section 10.2, the proposed prices for 2026/27 would be calculated using 2025/26 NHSPS pay award prices as initial price relativities, which would then be updated by applying the cost uplift and efficiency factors.

277. For 2026/27, we are proposing to make changes to price relativities for changes to the high cost drugs list, ophthalmology and stroke and pneumonia non-elective services.

High cost drugs list changes

278. As described in Section 5.5, we are proposing to make changes to the high cost drugs and devices lists, including removing a number of drugs and returning the funding into prices. We are proposing to remove £525.5m of funding from the high cost drug exclusion list and using £458m to adjust the unit prices for services that use the drugs that have been removed. The remaining amount is out of scope of unit prices and would be paid as part of locally agreed payment arrangements. See Annex DpA, worksheet ‘12b.1 HC drugs removal’, for details of these proposed changes.

Ophthalmology

279. During 2025/26, we ran a consultation on amending the 2025/26 NHSPS to change the prices for these services (reducing the prices for the main cataract HRGs and using the funding to increase prices for all other ophthalmology services). Having considered the

feedback from the consultation, we decided not to implement the changes mid-way through the financial year.

280. For 2026/27, we are proposing to make the similar changes to the price relativities for ophthalmology services to those in the proposed amendment to the 2025/26 NHSPS. We are proposing to:

- reducing the prices for main cataract services (BZ31*, BZ32* and BZ34*) by 20%
- removing the price differential for complex cataracts with and without complications (BZ31A and BZ31B)
- increasing the other prices for BZ***, using the funding from the changes above.

281. The 2025/26 amendment consultation proposed applying a uniform uplift across all non-cataract ophthalmology prices. However, following consideration of the feedback to the consultation, for 2026/27 we are proposing to focus price increases on more complex activity. As such, we propose that prices for minor elective procedures would receive a 5% uplift, but prices for all other procedures, including non-elective activity, would receive an uplift of around 19%.

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

Stroke and pneumonia

283. We are proposing to update the non-elective prices for stroke and pneumonia services, calculating new prices based on 2023/24 costs to reflect latest costs and coding practices. These are among the most commonly delivered non-elective services so the prices have a material affect on funding available for other UEC services.

284. For 2026/27, it estimated that making these price adjustments would reduce payments for these services by around £300m (reducing payments for stroke by around 6% and pneumonia by around 3%).

Why we think this is the right thing to do

High cost drugs list changes

285. As described in Section 5.5, the proposed removal of items from the high cost drugs list is intended to ensure that use of biosimilar/generic drugs that have been available over many years will be encouraged, as well as the list accurately reflecting most recent evidence and costs. Increasing the prices for HRGs that involve using the drugs

removed from the excluded items list would ensure that the services are appropriately funded.

Ophthalmology

286. We are proposing to make these manual adjustments to ophthalmology prices to address concerns that cataract activity has been increasing faster than other ophthalmology services. In many areas, there are relatively short waiting lists for cataracts, but longer waits for other services. Analysis of NCDR SUS+ data shows the following:

- In 2017/18, 384,000 ophthalmology episodes (HRG codes BZ*) were recorded. By 2023/24, this had increased to 704,845.
- Cataract activity (BZ31*, BZ32* and BZ34*) was a significant part of this, increasing from 224,204 in 2017/18 to 456,306 in 2023/24.
- This means that, as a proportion of all of ophthalmology activity, BZ31*, BZ32* and BZ34* increased from 58% in 2017/18 to 65% in 2023/24.

287. This growth in activity has meant more resources going into cataracts, resulting in fewer resources for other services, including those with longer waits.

288. We consulted on proposals to changing ophthalmology prices during 2025/26, as an amendment to the 2025/26 NHSPS. While there was a lot of support for the proposals to change the prices, there were concerns about introducing the changes during the year, after plans for the year and contracts had been agreed. There were also concerns about unintended consequences of uplifting all non-cataract prices, potentially incentivising activity inappropriately.

289. Following consideration of the feedback to the amendment consultation, we decided not to implement the change to ophthalmology prices during 2025/26, but instead propose to make the changes for 2026/27. We have also worked to ensure that our proposed uplift of prices, using the funding from reducing the cataract prices, is targeted at the more complex activity where the changes will have the most significant impact.

Stroke and pneumonia

290. We are proposing to reduce the non-elective prices for stroke and pneumonia as activity reporting and coding practice has changed significantly in recent years, with a much higher proportion of activity now coded to the most complex HRGs. Analysis and discussion with clinicians suggest that, rather than this being the result of a change in

patient casemix, this is likely to be due to providers being better able to identify patient co-morbidities.

291. This has resulted in the current prices not representing the latest cost relativities. As prices for these services will be important for the UEC blended payment (which we propose sets fixed payment based on price x activity and then uses prices for variable payments – see Section 6.4), we propose setting new prices based on 2023/24 costs. These more recent costs would better reflect current costs, coding and accurate reporting of clinical activities.

292. The proposed prices would result in a difference between the results of the work to deconstruct fixed payments (see Section 6.2) and 2026/27 prices, which should be considered when agreeing 2026/27 fixed payment values.

10.4 Market forces factor

- **We propose that the market forces factor (MFF) continues to be applied to prices.**
- **We propose to move to the second step of the two-step transition path introduced following the update of the data used to set MFF values in 2025/26.**

About this proposal

293. The market forces factor (MFF) is a measure of unavoidable cost differences between healthcare providers, and a means of offsetting the financial implications of these cost differences. Each NHS provider is assigned an individual MFF value. This is used to adjust commissioner allocations and is applied wherever prices are used (so the total amount paid is price x MFF value).

294. In the 2025/26 NHSPS, we updated the underlying data used to calculate MFF values, meaning all NHS providers received new MFF values. The changes were introduced using a two-step transition path to introduce the new values, limiting the absolute change in annual MFF values.

295. For 2026/27, we are proposing to move to the second step of this transition path.

296. Annex DpA contains the proposed MFF values for 2026/27.

297. The proposed change in MFF values would reduce the total amount paid through the MFF, compared to using 2025/26 MFF values, if all activity was reimbursed using unit

prices. There is therefore a compensating increase in the proposed 2026/27 prices of 0.42%.

298. For more information, see *A guide to the market forces factor*.

Why we think this is the right thing to do

299. In 2025/26, we updated the data used to calculate MFF values as we did not want to leave it so long between updates that the changes led to significant shifts in MFF values (such as those following the 2019/20 update, when the underlying data had not been updated for almost 10 years).

300. To limit volatility, we decided to use a two-step transition path to introduce the new values, moving to the first step in 2025/26. For 2026/27, we are proposing to move to the second step of this transition path. This would ensure the MFF values fully reflect the more recent data.