Classification: Official

2026/27 NHS Payment Scheme – a consultation notice

Part C: Impact assessment

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Contents

1. Impact assessment

1.1 Purpose

1. This document presents our assessment of a likely impact of implementing NHS England's proposals for the 2026/27 NHS Payment Scheme (NHSPS). It should be read alongside Part A of the *2026/27 NHS Payment Scheme – a consultation notice* which provides full details of our proposals. The aim of this document is to help providers, integrated care boards (ICBs) and other consultees understand the likely impact of our policy proposals. This should support planning and help inform responses to the consultation on the proposed 2026/27 NHSPS.

2. For the 2026/27 NHSPS, we are proposing to continue with the four payment mechanisms introduced in the 2023/25 NHSPS that cover the provision of NHS-funded secondary healthcare services.

3. In Part A of the consultation notice we present the details of each of our policy proposals, explaining why we think this is the right thing to do. In this document, our aim is to provide an overall qualitative assessment of the 2026/27 NHSPS proposals and a quantitative assessment of the estimated aggregate impact of the NHSPS prices under two simplified scenarios.

4. In detail, this document covers:

    - a qualitative assessment of the proposed 2026/27 NHSPS and the likely impact on patient choice (Section 2)
    - our estimated aggregate financial impact of the proposed 2026/27 NHSPS prices on provider revenue and commissioner expenditure under two complementary scenarios (Section 3)
    - the likely impact of the 2026/27 NHSPS proposals on equality (Section 4)

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

1.2 Scope of the analysis

6. We propose that the 2026/27 NHSPS contains rules for four different payment mechanisms:

Aligned payment and incentives (API)	Fixed element, with variable element paying 100% of NHSPS prices for elective activity (inc. unbundled diagnostic imaging and chemotherapy delivery), with blended payments for urgent and emergency care, radiotherapy (external beam and SABR) and genomic testing	Almost all NHS provider relationships with • NHS England for any directly commissioned services; and • with any ICB not covered by LVA arrangements
LVA block payments (for low volume activity)	Nationally set payment amounts to cover entire provider/commissioner relationship	Almost all NHS Trust or NHS Foundation Trust and ICB relationships for which NHS England has mandated an LVA block payment (this will normally be those with an expected value of annual activity of £1.5m or less, inclusive of any services delegated by NHS England)
Activity-based payment	NHSPS unit prices paid for each unit of activity	Services with NHSPS unit prices delivered by non-NHS providers
Local agreement	Providers and commissioners agree appropriate approach	Activity not covered by another payment mechanism

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

8. A financial impact of the 2026/27 NHSPS values compared to the equivalent 2025/26 values is presented under two scenarios, using the approach described below in section 1.3. This analysis is intended to help providers and commissioners understand a likely impact of our proposals.

9. The quantitative assessment is based on contract information data received in the 2025/26 planning template submissions, Hospital Episode Statistics (HES) data and

proposed 2026/27 prices which can be found in Annex DpA. For more information on proposed price changes, see Section 11 of Part A of the consultation notice.

1.3 Our assessment approach

1.3.1 Appraisals overview

10. We have structured our assessment into two appraisals:

- **Appraisal A**: A brief overall qualitative assessment of the proposals for the 2026/27 NHSPS. See Section 2.
- **Appraisal B**: A quantitative assessment of the impact on provider income and commissioner expenditure for 2026/27, under two complementary scenarios. For our quantitative assessment, we combine Hospital Episode Statistics (HES) data with the contract information data received in 2025/26 planning templates to create the fixed and variable payments for NHS providers.
    - Under our first scenario, the fixed element is set by using data from the commissioner submissions and the variable element is set by reference to the proposed 2026/27 prices and equivalent 2025/26 pay award prices. This scenario includes NHS providers only. Recognising data limitations and potential data quality issues with planning submissions data, we also introduce a second scenario.
    - In our second scenario, we have included both NHS and independent sector providers to make a simplifying assumption that both fixed and variable elements are set by reference to the proposed 2026/27 prices and equivalent prices in 2025/26. Our objective here is to present an isolated impact of the proposed changes to provider revenue and commissioner expenditure under a constant level of activity (2024/25 activity as published in HES).

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

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

1.3.2 Approach to the qualitative assessment

13. In Appraisal A, we consider the overall direction of the proposed 2026/27 NHSPS against the ambitions set out in the 10 Year Health Plan (10YHP) and the medium-term planning framework, providing an overall qualitative assessment of our proposals, including the likely impact on patients and the sector.

1.3.3 Approach to the quantitative assessment

14. In Appraisal B, we present a quantitative impact on NHSPS revenue and expenditure, for providers and ICBs under two complementary scenarios. To measure the effect of the proposed 2026/27 NHSPS on provider revenue, under both scenarios of Appraisal B, we compare provider NHSPS revenue using the proposed 2026/27 prices against the equivalent 2025/26 prices. The 2025/26 prices used are the pay award prices published in June 2025, which reflected agreed 2025/26 pay awards.

15. Under our first scenario, for NHS providers only, we combined HES data with the contract information data received in the commissioner submitted planning templates. In this scenario, the fixed element is estimated using the submitted contract values data and the variable element is calculated using NHS prices. For our analysis, the fixed payment is derived from the submitted data for 2025/26 and 2026/27 values is calculated adjusting for the impact of the net cost uplift and efficiency factors, the MFF quantum neutrality adjustment factor and the 2026/27 MFF values. For the variable payment for elective activity, we used NHSPS prices under a constant level of activity for both years (2024/25 activity as published in HES).

16. Under our second scenario, we use a simplifying assumption that the API fixed element is calculated using the NHS prices. For the proposed blended payments for UEC, radiotherapy and genomics, we have assumed that activity is delivered as planned and the variable elements are not used. We believe this to be appropriate as the focus of this assessment is to present an isolated impact of our proposed price changes into provider revenue and commissioner expenditure. We cannot predict at a national level how actual activity levels may differ from planned.

17. For this scenario, we estimate provider revenue and commissioner expenditure using the proposed 2026/27 prices against the equivalent 2025/26 prices for both fixed and variable elements. As in scenario 1, we use a constant level of activity for both years (2024/25 activity as published in HES).

18. Under both scenarios, we assessed the aggregate impact of the 2026/27 NHSPS proposals on NHS providers by type (acute, specialist, teaching and non-acute providers), independent sector providers and on ICBs and NHS England

commissioners. As the transition to greater integration in specialised services commissioning arrangements is still ongoing, and to avoid changes in commissioning responsibility complicating the analysis, for the purposes of our quantitative assessment, we assume responsibility of specialised services activities remains with NHS England as they were prior to delegation.

19. Finally, in Section 4, we have assessed the likely impact of the proposed 2026/27 NHSPS on patients. We have also given due regard to our public sector equality duty, under the Equality Act 2010,[1] to eliminate discrimination and advance equality of opportunity for groups with protected characteristics and foster good relations between people who share a relevant protected characteristic and persons who do not share it.

20. This aspect of our analysis, under the simplified assumptions of our second scenario, looks at how the financial impact of our proposals on providers and commissioners are likely to impact on the services provided and how the proposed 2026/27 NHSPS is likely to impact on access to services and the quality of care provided. We also consider our proposals' likely impact on patient choice. See Sections 2 and 4.

1.3.4 Quantitative assessment: limitations and assumptions

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

22. In addition, we do not quantitatively assess how the API fixed element is going to be set in practice and how the blended payments for UEC, radiotherapy and genomic testing will be determined and varied locally. We calculate a likely scenario using submitted data under our first quantitative scenario for NHS providers and in our second scenario we assess the likely impact using the simplifying assumption that NHSPS prices are a reasonable way of estimating or indicating that likely impact. Similar to previous years, we will continue working with stakeholders to understand how systems are implementing the API payment mechanism. We will also continue

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

looking at ways to monitor the implementation of our proposals without adding a burden on the sector.

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

- **Duration** – We have assumed the NHSPS is in effect for a full financial year.
- **Activity levels** – Our baseline run uses 2024/25 activity levels and casemix. We consider this to be useful as our aim is to present the isolated impact of our proposed price changes under a given casemix. We recognise that actual 2026/27 activity data could be different to the activity levels and casemix used in our baseline. As a result, the final quantitative impact of our proposals on NHSPS revenue and commissioner expenditure could differ from the impacts presented in this document. Note that the impact of OPCS – 4.11, mandated from 1 April, 2026 will see changes to HRG labels, logic, and contents. This cannot be modelled at this stage.
- **Level of use** – Our modelled scenarios assume that providers and commissioners use the NHSPS prices for the API elements. Particularly, in our scenario 2, which is equivalent of setting the fixed and variable elements of our proposed API mechanism using NHSPS prices and activity. This assumption allows a comparison of our proposals on prices and the associated impacts on providers and commissioners. However, the more the elements of the agreed API approach differ from our assumptions, the greater the difference between the impact of our quantitative findings and the local impact on systems. Also, we assume that the inflation and efficiency factors set out in Part A of the consultation notice are achieved.

1.3.5 Summary of quantitative findings

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

- We anticipate an increase in NHSPS payment revenue under both of our scenarios. With total payments in our first scenario increasing by +£596m (+0.82%) in 2026/27 from 2025/26. And anticipated payments in our second scenario increasing by +£475m (+0.85%).
- The main drivers of this are: i) the net effect of the cost uplift and efficiency factors, ii) uplift of prices due to CNST changes and iii) adjustments to price relativities in services areas like Ophthalmology, Stroke, Pneumonia, High-cost drugs removals from exclusion list into scope of prices, new BPTs and RPRP BPTs.

- We do not expect the 2026/27 NHSPS proposal to have a disproportionate impact on patients based on different age groups, race, or ethnicity.

1.4 Document structure

25. The rest of this document supports Part A of the statutory consultation notice on the proposed 2026/27 NHSPS. It is structured as follows:

- **Section 2** provides an overall qualitative assessment of the proposed 2026/27 NHSPS.
- **Section 3** presents the estimated aggregate financial impact of the 2026/27 NHSPS proposals on provider revenue and commissioner expenditure, under two complementary scenarios.
- **Section 4** considers the likely impact of our proposals in relation to the protected characteristics as described in the Equality Act 2010.

2. Appraisal A – Qualitative assessment

2.1 The proposed 2026/27 NHS Payment Scheme

26. For 2026/27, we are proposing to set the NHSPS for one year, focusing on changes in a small number of priority areas, like the new payment approach for urgent and emergency care (UEC), high-cost drugs and devices exclusion list and BPTs.

27. We will continue with our four payment mechanisms as set out in the NHS payment scheme, however, with some key design changes to ensure that fixed payments better reflect current activity levels and support the 10YHP ambition to shift care away from hospitals.

28. We are proposing to calculate 2026/27 prices by adjusting 2025/26 pay award prices for the 2026/27 cost uplift factor (CUF), general efficiency requirement, changes in MFF values and other targeted changes in best-practice tariffs and adjustments for high-cost drugs and devices. In following years, we intend to recalculate prices using more recent cost and activity data to ensure prices remain linked to the costs of delivering each unit of activity.

29. We continue to maintain the same core payment principles[2] that must be applied to all payment arrangements. This is anticipated to provide stability in planning while ensuring that available resources are used as effectively and efficiently as possible.

2.1.1 Payment mechanisms

Aligned payment and incentive (API)

30. Almost all activity delivered by NHS providers would either be delivered by API blended payments or low volume activity (LVA) block payments. The API payment mechanism applies to almost all services, including acute, community, mental health and ambulance services. LVA applies to most provider-commissioner relationships with an annual value below £1.5m. Under 2026/27 API arrangements, elective care is paid for via a variable element (using unit prices), with a fixed payment to cover other services.

31. For 2026/27, we are proposing to introduce blended payment approaches for UEC[3], radiotherapy (external beam and SABR)[4] and genomic testing[5] services. For these, fixed payments will be required, with variable elements to increase or decrease

2 See Section 5.2 of the consultation notice.
3 The UEC blended payment model would cover all urgent and emergency care, including same day emergency care (SDEC) and other same day pathways. See section 6.4 of consultation notice
4 See Section 6.5 of the consultation notice.
5 See Section 6.6 of the consultation notice.

payment where activity differs from plan. These blended payments would more closely align payment with activity (with fixed payments calculated on a price x activity basis). This would ensure greater clarity of what activity is being paid for and highlight potential opportunities to target resources where they will have the greatest impact. Any changes to payment levels between years should be carefully considered to ensure stability of service provision.

32. In summer 2025, systems were asked to deconstruct fixed payments (blocks), using analysis of what funding would have been received were services paid for on a price x activity basis. Our analysis of system planning data received through this work has shown that in most cases the current fixed payments (typically introduced during Covid and carried over with annual adjustments since) don't reflect current activity levels. The proposed blended payments are intended to re-align funding closer to the actual activity delivered and encourage providers and commissioners to review pathways. This approach will support providers and commissioners identify areas where efficiencies can be delivered and re-design pathways at a system level in a way that delivers the best outcomes for the local population.

33. There could be cases where the new blended payments, in combination with the exercise to deconstruct fixed payments, could increase provider financial risk. To mitigate this risk, the supporting document *NHS provider payment mechanisms* gives details of how findings from the deconstruction of fixed payments should be applied and changes in contract values managed over time to avoid destabilising commissioners or providers, with a recommended limit of 2.5% except for in exceptional circumstances.

34. For UEC, in particular, the blended payment would support the 10YHP goals to reduce avoidable attendances and support the shift to out-of-hospital care. The UEC blended payment model includes a break-glass clause, which would apply where actual activity is significantly above or below planned levels. This is intended to allow systems to manage any significant changes, for example due to coding inflation locally, and to balance the risk between provider and commissioners, ensuring appropriate service provision.

35. The proposals mean that prices have a more significant role in 2026/27 (as fixed payments should be informed by price x activity). Unit prices will also continue to be used for the API variable elements, where activity is above or below the level planned for in the fixed elements, as well as the activity-based payment mechanism.

36. As mentioned above, fixed elements should be calculated based on price x planned activity, with any funding in excess of the unit price value of activity also identified. We would not expect significant changes in payments overall, but the additional clarity would help systems identify potential opportunities to use resources as efficiently as possible. In addition, the operation of the variable elements and, for UEC, the break glass clause, would help mitigate activity that are different to plan.

37. Overall, we expect the API payment mechanism proposals for 2026/27 to support the delivery of NHS's key priority areas and implementation of the medium-term planning framework. The move to align payments more closely with activity will help support planning in future years, ensuring resources are used effectively and services are delivered for patients appropriately.

Low volume activity (LVA) block payments

38. We propose to continue with the LVA payment mechanism, applicable to NHS provider/ICB relationships, maintaining the same scope. We propose updating the qualifying criteria to include consideration of whether an LVA has previously been in place. For 2026/27, we will be updating the payment values to reflect the 2026/27 cost uplift and efficiency requirements.

39. We propose to amend the LVA schedule to reflect proposed changes to ICB footprints from April 2026, reducing the total number of ICBs from 42 to 36. These changes would also reduce the total number of relationships between NHS providers and ICBs (whether LVA or API) from 8190 to 7020.

40. Additionally, feedback received regarding the LVA policy highlighted concerns that the current values take too long to reflect activity growth and as a result underfund providers. We are proposing for 2026/27 to apply an activity growth factor of 8.5% to the baseline value. Total LVA payments are currently at £703m. It is anticipated that applying a growth would increase the LVA payment by an estimated value of £60m. However, the ICB changes noted above may result in some LVA relationships converting to API and no longer being counted as part of the overall LVA quantum.

41. From April 2026, the statutory number of ICBs are proposed to reduce to 36 as mentioned above. We propose to publish the LVA payment values aligned to this footprint, maintaining an API relationship where previously one existed in one of the pre-mergers ICBs. As a result, the number of LVA relationships decreases, with the proportion of provider/commissioner relationships in scope of LVA at 88%. Proposed total LVA payments for 2026/27 will be at £705m compared to £703m in 2025/26.

42. Since its introduction the LVA payment mechanism has achieved its objective to minimise the low volume transactions between providers and ICBs and maintains supports from both commissioners and providers. We will continue reviewing feedback received and carry on an evaluation of the total payments transacted through the LVA arrangements. This will inform our decision-making to ensure LVA payments remain at an appropriate level.

43. For 2026/27, we believe the balanced approach proposed supports financial stability in provider and commissioner finances, avoiding significant year-on-year variations while reflecting some activity growth that has contributed to financial pressures in providers. For more information on our LVA policy proposals and why we think this is the right thing to do see section 7 Part A of the consultation notice.

Activity-based payments

44. For non-NHS providers, we propose to continue with an activity-based payment mechanism for all services with an NHSPS unit price. This would reimburse providers for each unit of activity delivered and similar treatment between NHS and non-NHS providers for elective services. We expect this to continue supporting patient choice and improved efficiency, by directly linking provider income to activity delivered. However, this could also result in financial risk to commissioners in cases of unplanned activity growth. Commissioners and providers will need to manage these risks including through the activity management provisions of the NHS Standard Contract.

45. Overall, the proposals set out in the 2026/27 NHSPS are expected to have a negative impact on non-NHS providers' income, using prices for elective care services. This is primarily due to the proposed changes to ophthalmology prices, which would increase funding for more complex activity, while independent sector providers mainly deliver less complex services. For more details, see the quantitative appraisal in Section 3. The reduction in income (around £45m) is less than that expected from the changes to ophthalmology prices proposed as an amendment to the 2025/26 NHSPS in summer 2025 (which was estimated to reduce independent sector provider income by around £60m).

Local payment arrangements

46. There is also a local payment arrangement mechanism, which would apply to any activity not covered by another payment mechanism (for example services delivered by non-NHS providers that do not have an NHSPS unit price).

47. The NHSPS includes guide prices to help inform local payment arrangements, including the prices for ADHD and autism services that are proposed for 2026/27. Guide prices are intended to support local negotiation, minimising complex contract negotiations and reducing transaction costs. In setting guide prices, we take into consideration NHS England's duties, such as addressing health inequalities.

48. However, by definition, local payment arrangements are dependent on the local situation. As such, it is not possible to centrally assess the likely impact of these arrangements. They are therefore out of scope of this assessment.

2.1.2 Other policy proposals

Excluded items - High-cost drugs and devices

49. The cost of drugs and devices are captured in the scope of prices by default for the treatment of patients. The exclusions list works on the premise that the prices cannot cover the cost of the drug or device under a set of certain criteria and in which case, it is removed from the underlying prices and put onto the exclusions list.

50. Like previous Payment Schemes, we are proposing to review the list of high-cost drugs and devices. For 2026/27, we propose to continue with the established excluded items process. For more information see Section 5.5 of the consultation notice.

51. The updated high-cost drugs and devices list will set out the items that are reimbursed outside of NHSPS prices, ensuring appropriate funding for providers and better access to new drugs and devices for patients.

52. For 2026/27, following the advice of the steering groups and colleagues from Specialised Commissioning, we are proposing to add some drugs identified through the horizon scanning, removing some drugs from the list and put funding into prices where they no longer meet the high-cost criteria or where there are biosimilar/generic equivalents that have been in use over many years. We have made some other clarifications and adjustments to the drugs and devices lists.

53. The majority of funding for drugs removed from the high cost list has been put into prices (see Section 3). However, there are some costs that mapped to specialities that we do not have prices for. These HRGs / TFCs should still be reimbursed locally in line with NICE guidance and commissioning policy and guidance.

54. Moving funding for drugs into prices should not have an adverse impact on those with protected characteristic or health inequalities (see Section 4). The addition of this quantum into prices mainly affects paediatrics, musculoskeletal systems, infectious

diseases and immune disorders, chemotherapy, digestive system and outpatients but this does not impact the protected characteristics adversely. Full details of the funding being moved into prices as a result of drugs being removed from the exclusion list can be found in Annex A, worksheet '12b.1 HC drugs removal' and the cash in/cash out table in Annex DpD.

Best practice tariffs (BPTs)

55. Since their introduction BPTs have supported improvements in patient care, incentivising high-quality and promoting cost-effective care. BPTs are designed to flow money to providers to reflect actual performance, reinforcing the financial incentive to maintain or improve quality in these priority areas.

56. For 2026/27, we propose introducing new BPTs to support 10YHP goals, increasing the number of procedures on the Right Procedure Right Place (RPRP) BPTs and introducing new Day Case and RTT BPTs. We are also proposing that UEC-related BPTs become activity-based, to reflect the UEC blended payment. 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. Detailed information of our proposals and why we believe this is the right thing to do can be found in the main consultation notice.

57. We propose adding more procedures to the RPRP BPT to continue to encourage a shift in appropriate procedures to less resource-intensive settings. The introduction of the additional RPRP prices changes resulted in excess quantum of £12.1 million which has been recycled into the prices of the respective medical speciality subchapters (see Annex DpD, Appendix 2 for details). The proposed Day Case BPTs include 22 procedures which have potential for activity changes, are suitable to be undertaken as day case, and would not routinely require an overnight stay in hospital. These BPTs would support reducing the resources required for appropriate procedures. They would improve patient experience while also delivering efficiencies, for example by freeing up staff time for more complex procedures, and improving clinical standard of care.

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

Ophthalmology prices

59. In July 2025, we consulted on amending the 2025/26 NHSPS by reducing simple cataract prices and using the funding to increase all other ophthalmology prices. Following consideration of feedback, we decided not to implement this change during 2025/26. Instead, we are proposing to make changes to ophthalmology prices as part of the 2026/27 Payment Scheme.

60. The proposal is to reduce the prices for the main cataract services and uplift other ophthalmology prices, with prices for minor elective procedures increasing by 5% and all other procedures (including non-elective admissions) increasing by around 19%. This would incentivise providers to focus on the more complex activity and improved patient care.

61. For 2026/27, the overall impact of this policy proposal is expected to be quantum neutral for ophthalmology services and funding. However, our assessment suggests that NHS providers are expected to receive an increase in payment income, while independent sector providers are expected to receive a small decrease in payment income (see Section 3). This is because of the higher proportion of complex activity undertaken by NHS providers compared to independent sector providers.

Stroke and pneumonia prices

62. Activity reporting and coding practices have changed significantly for some non-elective conditions, especially stroke and pneumonia, where a much higher proportion of activity is now coded to the most complex HRGs. This is likely to be due to providers being able to better identify patient complexities and co-morbidities. As a result, current prices do not represent the latest cost relativities from the changes in coding.

63. This becomes important in 2026/27 as the prices will be used as the basis for the calculating of the UEC fixed and variable payments. As stroke and pneumonia are among most common non-elective services, having unduly high prices would risk resources being diverted away from other UEC services. We have calculated new prices based on 2023/24 costs and propose to replace the existing prices with the updated prices. It is therefore proposed to adjust the stroke and pneumonia prices to reflect latest costs and coding practice and accurate reporting of clinical activities.

64. 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%). Whilst these prices are reduced, since they are based on latest coding practices and latest costs data, we do not expect these prices to impact on service provision.

Attention Deficit/Hyperactivity Disorder (ADHD) and Autism

65. Recognising the significant variation that exists into how ADHD and Autism services are paid, we are proposing to introduce non-mandatory guide prices and supporting guidance.

66. These are expected to act as benchmarks for providers and commissioners to minimise variation in service delivery and payments. While their non-mandatory basis would still allow local systems to arrange services according to their needs. We expect this to result in more consistent service delivery and improved patient care.

Genomic testing and reporting

67. Genomic testing and reporting services are currently funded via fixed payment contracts. However, NHS England is currently 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.

68. For 2026/27 NHS payment scheme, we propose introducing a blended payment model, which would comprise: 1) a fixed payment, calculated based on planned activity x prices; 2) a variable payment for activity above/below plan, the value of which would be a locally agreed percentage of NHSPS unit prices; 3) an incentive element where a proportion of the fixed element is dependent on improvement against some key metrics.

69. The proposed fixed element would be based on a forward-looking assessment of activity required, rather the previous year's fixed payment. The methodology for calculating the NHSPS unit prices for genomic testing and reporting prices for 2026/27 is different to the standard NHSPS methodology.

70. The proposed method for calculating prices is not based on average cost submitted by providers, but rather on the lowest cost of efficient providers. For more information on the calculation method, see Annex DpD. Our impact assessment suggests that providers' payment income from genomic testing and reporting would decrease by 19.5%. This is mainly due to the implicit efficiency assumption from using lowest cost providers to set the prices, and the fact that we do not recycle the quantum of savings into other prices. In practice, we are expecting a transition to the use of the prices to set the fixed payment. 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 will need to agree an affordable and sustainable transition.

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

2.2 Impact on patient choice

72. The proposals for the 2026/27 NHSPS are intended to support the 10YHP ambitions, improved performance on elective and UEC care while maintaining our focus on financial stability.

73. Our payment proposals, underpinned by our payment principles, make no distinction as to which providers should be commissioned to undertake patient care. The proposed four payment mechanisms are designed to support local decision making where suitable under the same payment rules and allow for different payment approaches as appropriate considering the different contracts values and providers who hold these.

74. In addition, this year we have requested systems to review how they have constructed their fixed elements and introduced a new blended payment for UEC services. These proposals are expected to re-align funding closer to actual activity delivered and support re-designing pathways in a way that works best for patients. Through our API variable element systems are allowed to adjust provider utilisation (choice) against assumptions in the system plan, while LVA arrangements reduce the transactional burden for small values of activity allowing providers to focus on delivering patient care.

75. The proposed changes to ophthalmology prices are intended to address an imbalance in the length of waiting lists for services, with short waiting times reported for cataract activity and longer waits for more complex services. If providers decide to reduce service provision as a result of the change in prices, patients may have fewer options to choose from. However, we have considered this risk and feel that supporting more complex activity is appropriate for the full casemix for ophthalmology services.

76. Under the proposals , funding and payment will continue to follow patients, with NHSPS prices used for API arrangements and all services where the activity-based payment mechanism is applicable.

2.3 Impact of activity growth

77. We have set out previously that one of our limiting assumptions was that activity levels would remain constant at 2024/25 levels. Activity levels have, however, changed during 2025/26 (for example, due to the introduction of new contractual changes) and would very likely continue to change in 2026/27. Furthermore, the aligned payment and incentive proposals, proposals to align payment with activity more closely, and proposed changes in services such as neighbourhood service models may further

change activity within and across providers. We have not sought to make a forecast of these changes as part of this assessment.

2.4 Engagement with the sector

78. Every year we work with providers, commissioners, representative bodies, and other appropriate stakeholders throughout the development of our proposals for the next NHSPS. Due to the tighter timescales necessary this year to publish the consultation at an earlier point, we undertook a more targeted engagement this year, through external events, engagement sessions following the 10YHP publication and discussions with provider and commissioner CEOs and CFOs. We also receive regular feedback through our pricing mailbox and regular discussions with stakeholders and clinical groups. At the end of September, we ran a webinar discussing a number of policies considered for the 2026/27 NHSPS.

79. Feedback and comments received have been considered throughout the development of our proposed policies and we invite consultees to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts of our proposals.

80. In Section 4 of Part A of the consultation notice we explain in more detail how we have worked with stakeholders to develop our proposals.

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

3.1 Introduction

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

3.2 Scenario 1 – Anticipated aggregate impact of 2026/27 proposals on provider income

82. In our first scenario, we combine HES data with the fixed element contract information received in the commissioner submitted planning templates. As such, this appraisal is focused on NHS providers only. In this analysis, the fixed element is set using the submitted information for 2025/26, with the previous year's MFF component removed. For 2026/27 we adjust the submitted values for the impact of the net cost uplift and efficiency factors and the MFF adjustment neutrality factor. The assessment includes the blended payments and assumes that activity is delivered as planned. The elective variable element is calculated using the NHSPS unit prices for both years under a constant level of activity (2024/25 HES). We have also used the most recently published provider accounts (2023/24) to estimate the impact on income.

83. The findings presented include the following price-affecting changes proposed for 2026/27 (See Section 11 of the consultation notice Part A):

- Updating the market forces factor (MFF) values by moving to year 2 of the planned glidepath to the new MFF values.
- Changes in the Clinical Negligence Scheme for Trusts (CNST) payments put through the NHSPS and allocated across clinical areas (HRG Subchapters).
- Expansion of prices for the Right Procedure, Right Place (RPRP) BPT to encourage activity to move from day cases to outpatient procedures or elective inpatients to outpatients, new BPTs to incentivise the shift in activity elective inpatients to day cases and well as to support elective and RTT priorities by linking payment to efficient pathways.
- Adjustments based on the changes to ophthalmology prices.
- Adjusting prices for cost uplift and efficiency factors.
- Continue the uplift of various prices introduced in previous year (including A&E, maternity, Automated Red Cell Exchange, non-elective and some gynaecology

and ENT procedures with the largest waiting list prices to ensure prices more accurately reflect current costs).

- Changes to the high-cost drugs removal items and moving the quantum into the scope of prices.
- Updating unit prices for Stroke and Pneumonia treatments by adjusting certain HRGs.
- Setting unit prices for direct access HRGs.

84. More details on how we propose to calculate 2026/27 prices are available in Annex DpD - Prices and cost adjustments.

85. Figure 1 shows the combined impact of our proposals for 2026/27 on NHSPS provider revenue under scenario one – ie it shows the difference between what each type of provider would receive in 2026/27 compared to 2025/26 based on the 2024/25 level of activity.

Figure 1: Total 2026/27 NHSPS difference by NHS provider type

Provider Type	Total Payment NHSPS Income (£'m) - 2025/26	Total Payment NHSPS Income (£'m) - 2026/27	Total Payment NHSPS Income Difference (£'m)	Percentage Difference (NHSPS Income)
Acute - Large	£14,312.13	£14,430.40	£118.27	0.83%
Acute - Medium	£8,194.26	£8,259.10	£64.85	0.79%
Acute - Multi-Service	£2,605.12	£2,629.79	£24.67	0.95%
Acute - Small	£5,467.12	£5,511.80	£44.67	0.82%
Acute - Specialist	£2,566.74	£2,590.32	£23.58	0.92%
Acute - Teaching	£39,533.61	£39,852.23	£318.61	0.81%
Non-Acute	£66.44	£68.09	£1.65	2.49%
Total	**£72,745.41**	**£73,341.72**	**£596.31**	**0.82%**

86. This scenario shows the total NHSPS revenue for NHS providers increasing from £72.7 billion to £73.3 billion, an increase of +£0.596 billion (+0.82%) in 2026/27 from 2025/26. The main driver of this change are: a) the net effect of the cost uplift factor for inflation and efficiency, and b) specific adjustment to price relativities such as changes to the high-cost drugs removal items and moving the quantum into the scope of prices for the variable payment element.

87. The expected percentage increase in NHSPS revenue across NHS acute provider types between 2025/26 and 2026/27 ranges from +0.79% to +0.95% (Figure 1).

Anticipated aggregate impact of 2026/27 proposals by provider type

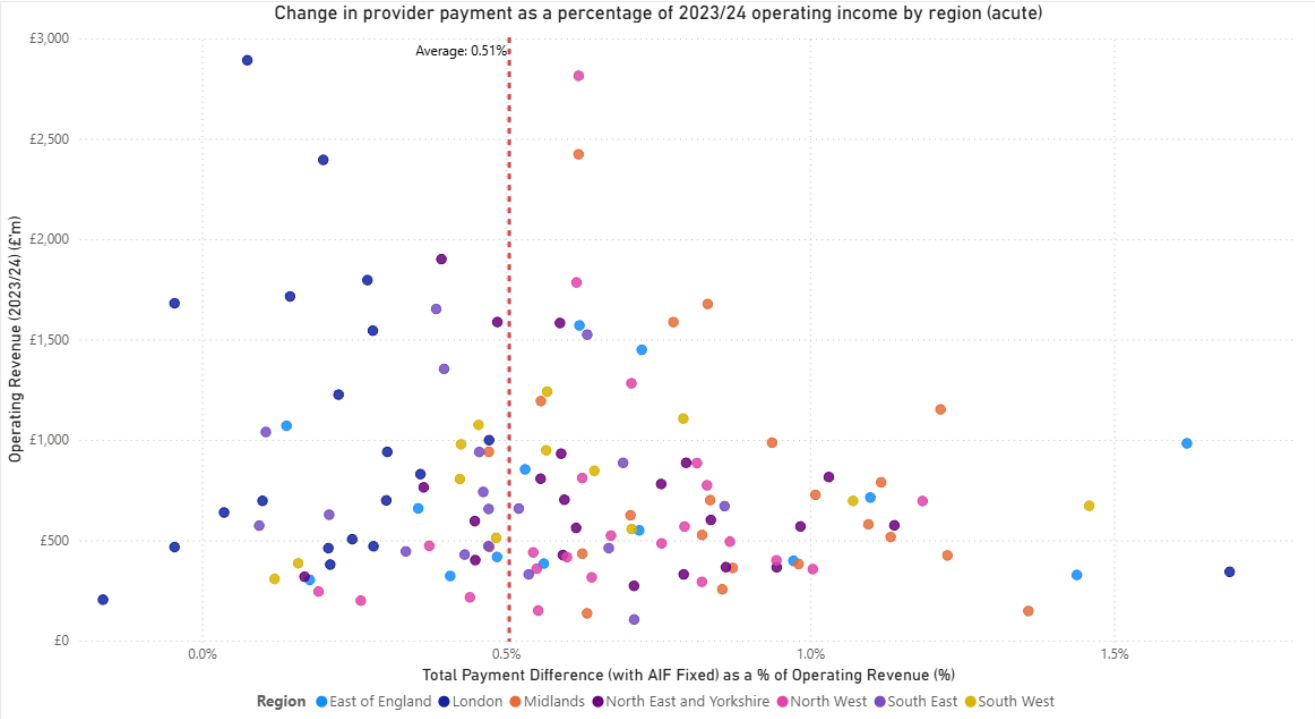
88. We expect that most acute providers will receive an increased income from our proposals in 2026/27. They represent the largest proportion of overall NHSPS revenue and therefore receive a greater share of the overall increase in NHSPS revenue resulting from the adjustment for cost uplift net of efficiency. Figure 2 shows that 70 out of 135 NHS providers will have an above average increase in NHSPS priced revenue.

Figure 2: Number of NHS providers, excluding non-acute, that are above or below the average change in NHSPS revenue in 2026/27

Provider Type	Above Average	Below Average	Number of Providers
Acute - Large	11	12	23
Acute - Medium	10	10	20
Acute - Multi-Service	2	5	7
Acute - Small	13	6	19
Acute - Specialist	5	11	16
Acute - Teaching	29	21	50
Total	**70**	**65**	**135**

89. Figure 3 shows that most acute providers are anticipated to see an increase in NHSPS income expressed as a proportion of their 2023/24 operating revenue, with an average increase of 0.51%. Acute NHS providers are anticipated to see changes ranging between -0.16% and 1.69%. About 10% of NHS providers are expected to see a decrease in payment. Changes in MFF payments contribute to these changes.

Figure 3: Overall impact of NHSPS proposals on NHSPS payment as % of operating revenue for NHS providers, excluding non-acute, in 2026/27



90. The cluster distribution observed in Figure 3 above reflects underlying variations in casemix and exposure to the policy changes proposed in 2026/27. Whilst the average increase in expected funding is 0.51%, provider level impacts will vary depending upon their individual activity and casemix. The impact will be particularly influenced by factors such as the RPRP, ophthalmology and high-cost drugs proposals. On a more global level, the graph demonstrates the regional differences that arise due to changes in MFF values.

91. Smaller and more specialist providers show greater volatility in percentage terms, reflecting their concentrated service mix and sensitivity to specific policy changes. In contrast, larger and teaching trusts remain close to the overall average, supported by a more diversified case mix that moderates the financial impact of individual pricing adjustments

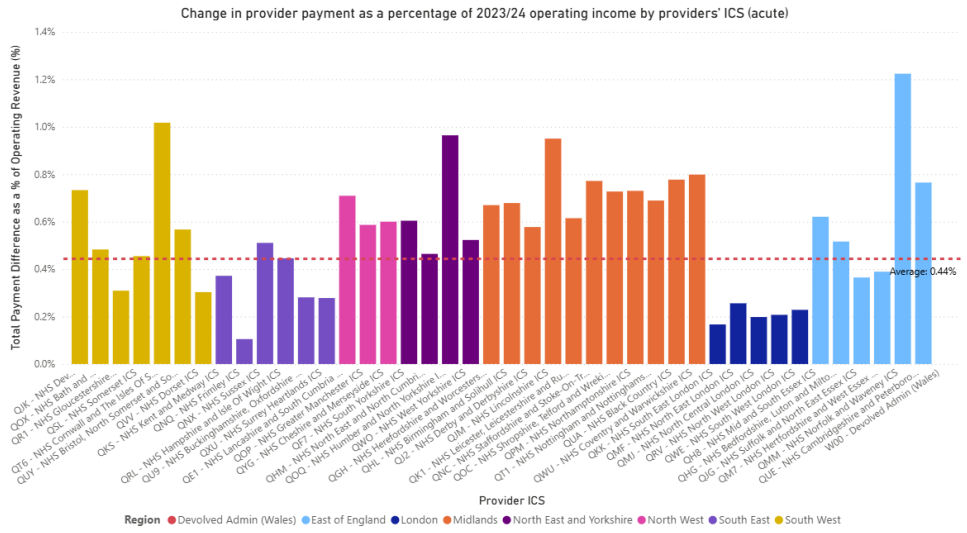
Anticipated aggregate impact of all 2026/27 proposals by ICBs

92. The expected impact of the 2026/27 NHSPS proposal on commissioner spending is presented in the figure 4 below.

    Figure 4 shows the aggregate impact of our proposals for 2026/27 at ICB and regional levels. On average, it is expected that ICBs' overall spending will increase by 0.44%. There is measurable variation at ICS level and these range from small reductions to increases close to +1%. ICBs in the Midlands, South West, and North West see above average uplifts. This is due to greater exposure to ophthalmology and RPRP HRGs, positive CNST adjustments, and gains from High Cost Drug (HCD) cash in changes. In

contrast, London and South East ICBs remain closer to or below average which is attributable to the MFF glide-path step-down and a lower share of incentivised activity. Some ICBs in the East of England show a distinct uplift driven by larger HCD movements.

Figure 4: Change in NHSPS spending in 2026/27 as a percentage of 2023/24 operating income by ICB



3.3 Scenario 2 – Anticipated aggregate impact of 2026/27 proposals on NHSPS income (Variable payment and Fixed payment using NHSPS prices)

93. Scenario 2 models the impact of the proposed 2026/27 prices by assuming that all activity is reimbursed using national NHSPS prices, effectively treating both the fixed and variable elements as covering 100% of activity. This approach isolates our assessment of the price effect of our proposed changes, allowing a pure assessment of how the 2026/27 prices influence provider revenue and commissioner expenditure, independent of local payment variations and the impact of policy on how fixed payments are set.

94. The following graphs highlight the impact across all acute NHS and Independent provider types. The analysis then moves on to show the impact from a point of delivery (POD) perspective.

95. Figure 5 shows the total payment difference for acute providers as a percentage of their operating income. The chart illustrates that, on average, acute providers are

expected to experience a +0.51% increase in total payments under the 2026/27 NHSPS prices and activity assumption.

96. The majority of providers cluster closely around the average, which reflects that the proposed policy changes remain broadly quantum neutral at an aggregate level. There is some variation between provider type. Our assessment demonstrates that teaching and large trusts cluster around the average reflecting a balanced exposure to both positive and neutral policy drivers. Medium and multi-service providers display a slightly wider range of results, with some experiencing modest gains and others small reductions. This variation reflects differences in their service mix and local cost structures; for example, trusts with more elective or outpatient activity benefit from policy uplifts in 2026/27, while those with higher proportions of emergency activity see smaller or neutral changes. Specialist and smaller acute trusts show the greatest variation in percentage terms. This is a result of the narrower range of services they provide, which means that a small price change can result in a bigger impact on their overall income in 2026/27.

Figure 5: Change in provider payment in 2026/27 as a percentage of 2023/24 operating income

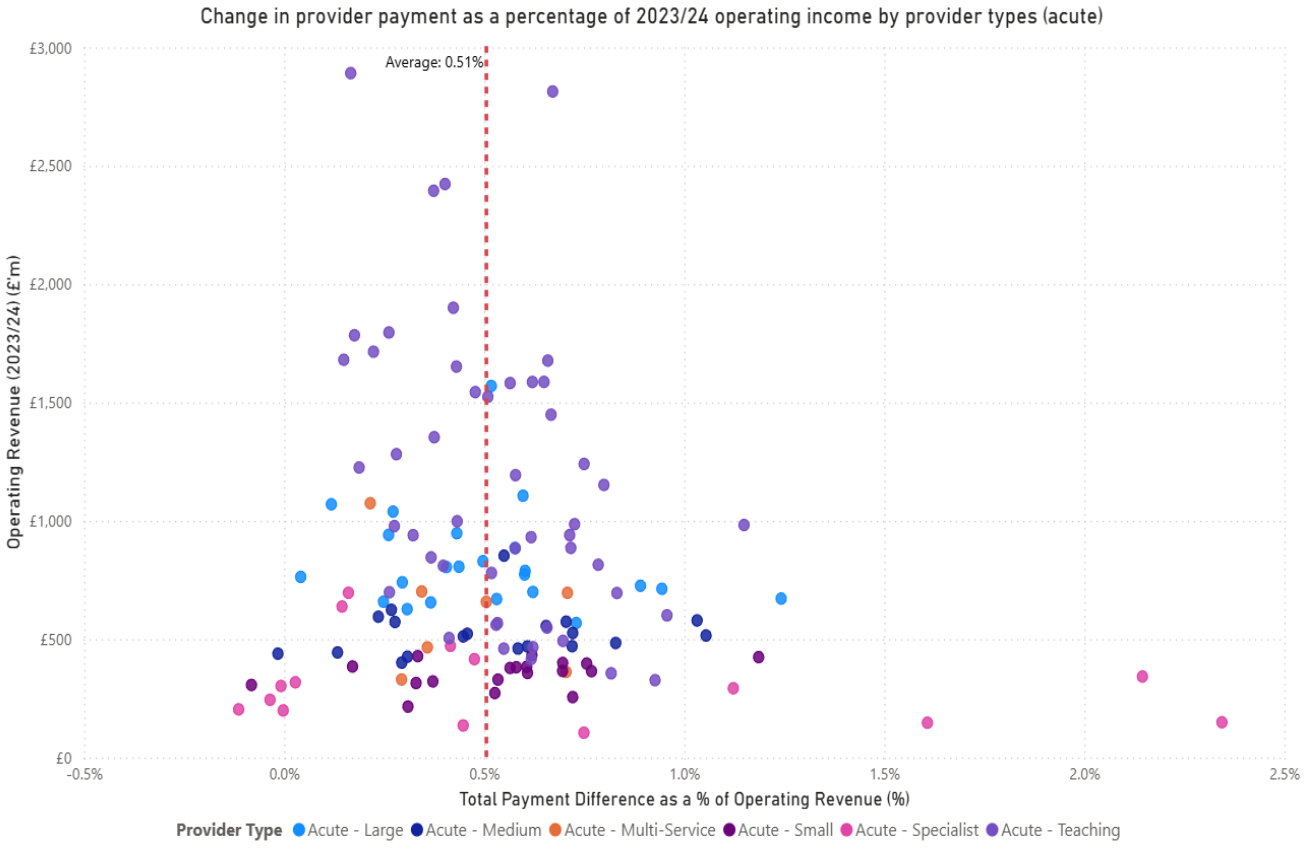


Figure 6: Change in provider payment in 2026/27 by Point of Delivery

Payment Type	Point of Delivery	Total Payment (£'m) - 2025/26	Total Payment (£'m) - 2026/27	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
Blended Fixed	Accident & Emergency	£5,355.91	£5,367.39	£11.48	0.21%
	Non elective	£22,321.80	£22,140.50	-£181.30	-0.81%
	Radiotherapy	£351.82	£351.87	£0.05	0.02%
Fixed - Other	Maternity	£3,592.75	£3,805.16	£212.41	5.91%
	Outpatient Follow-Up Attendance	£2,452.09	£2,592.62	£140.53	5.73%
Total		**£34,073.95**	**£34,257.12**	**£183.17**	**0.54%**

Payment Type	Point of Delivery	Total Payment (£'m) - 2025/26	Total Payment (£'m) - 2026/27	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
Variable	Daycase	£7,708.51	£7,716.92	£8.41	0.11%
	Elective	£6,493.25	£6,524.53	£31.28	0.48%
	Non elective	£54.28	£55.03	£0.76	1.39%
	Outpatient First Attendance	£3,070.94	£3,227.67	£156.72	5.10%
	Outpatient Procedure	£2,757.83	£2,831.42	£73.59	2.67%
	Unbundled	£1,983.29	£2,005.11	£21.83	1.10%
Total		**£22,068.10**	**£22,360.68**	**£292.58**	**1.33%**

97. Figure 6 above shows that the introduction of the 2026/27 prices results in an overall +0.54% increase in total payments for the services in scope of the fixed element, and a +1.33% increase for those in scope of variable payments, when applied to constant 2024/25 activity. This indicates a small national uplift, which is consistent with the intention of maintaining affordability whilst still ensuring prices align with the latest costing data and policy adjustments. Within the fixed component, changes vary across point of delivery.

98. Maternity and Outpatient follow ups present the largest uplifts of +5.91% and +5.73% respectively. The increase observed in Maternity is driven by CNST changes affecting delivery HRGs. Increases in outpatient follow up payments are the result of increased prices because of high-cost drugs which have moved from the exclusion list and into the scope of prices. Non-elective payments see a decrease due to adjustments in prices for stroke and pneumonia to offset changes in coding practice and activity reporting. Proposals for 2026/27 have been implemented to reduce the non-elective prices for stroke and pneumonia as coding practice has changed significantly in recent years, with a much higher proportion of activity now coded to the most complex HRGs.

99. The variable payment for activity experiences a slightly higher anticipated overall uplift of +1.33%, reflecting policy intent to better reward activity growth and cost pressures in procedural outpatient-based care. The main policies driving the expected increased income in outpatients are increases in prices for ophthalmology services and high-cost drug being moved from the exclusion list into prices.

100. We assess that overall payments to the independent sector will reduce somewhat. This is primarily the result of changes to ophthalmology prices, where prices for simple cataract procedures are being reduced, and prices for more complex HRGs increase.

Figure 7: 2026/27 Total payment difference by provider type

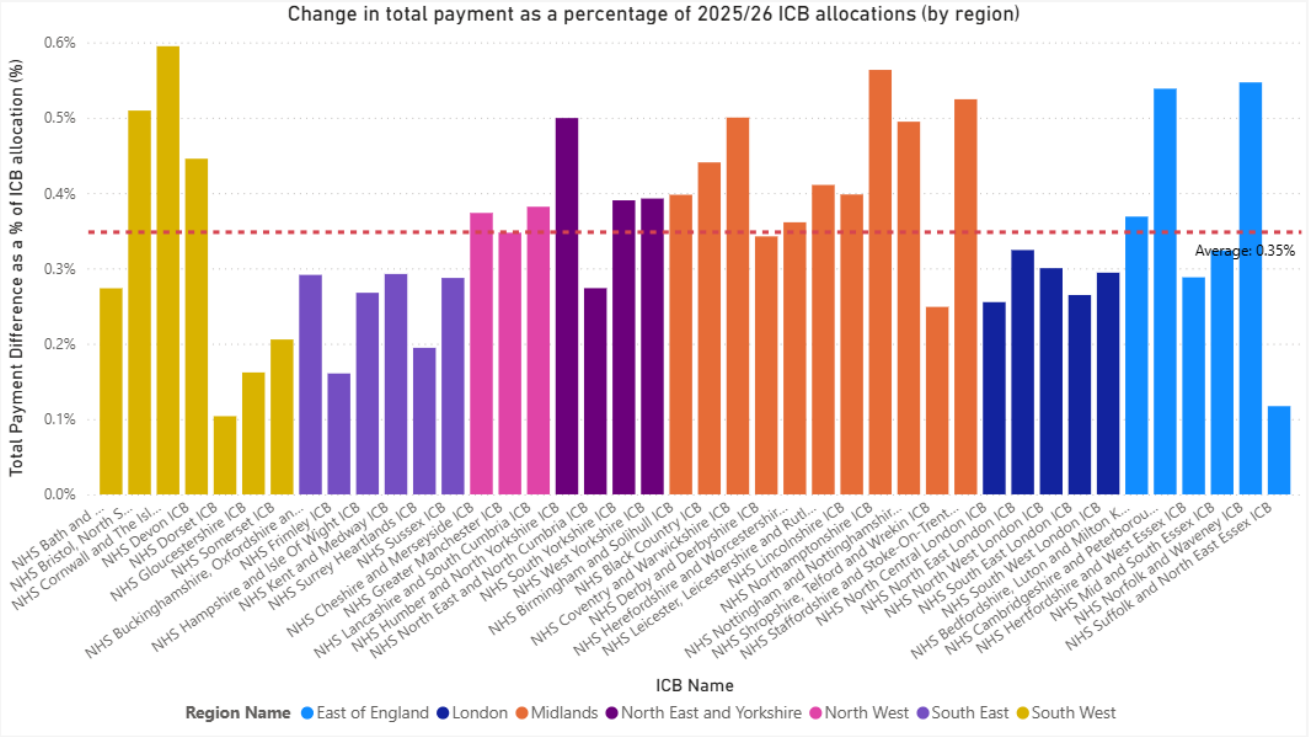
Provider Type	Total Payment NHSPS Income (£'m) - 2025/26	Total Payment NHSPS Income (£'m) - 2026/27	Total Payment NHSPS Income Difference (£'m)	Percentage Difference (NHSPS Income)
Acute - Large	£10,833.45	£10,926.30	£92.84	0.86%
Acute - Medium	£6,089.54	£6,144.41	£54.87	0.90%
Acute - Multi-Service	£1,830.62	£1,848.78	£18.16	0.99%
Acute - Small	£3,910.00	£3,947.48	£37.48	0.96%
Acute - Specialist	£1,696.16	£1,724.80	£28.64	1.69%
Acute - Teaching	£28,912.06	£29,198.97	£286.91	0.99%
Independent Provider	£2,561.07	£2,516.14	-£44.93	-1.75%
Non-Acute	£309.15	£310.93	£1.78	0.58%
Total	**£56,142.46**	**£56,618.22**	**£475.76**	**0.85%**

b)

Provider Type	Total Payment (£'m) - 2025/26	Total Payment (£'m) - 2026/27	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
Independent Providers	£2,561.07	£2,516.14	-£44.93	-1.75%
NHS Providers	£53,581.39	£54,102.08	£520.68	0.97%
Total	**£56,142.46**	**£56,618.22**	**£475.76**	**0.85%**

101. Our assessment demonstrates that in 2026/27, prices have an overall +0.85% increase in total income across all provider types, equivalent to around +£0.475 billion nationally. This outcome aligns with design intent of the 2026/27 tariff to maintain quantum neutrality nationally while updating prices to reflect cost data for stroke and pneumonia, and other policy adjustments as mentioned in earlier paragraphs.

Figure 8: Change in NHSPS priced spending in 2026/27 as a percentage of ICB 2025/26 allocations by ICB



102. Figure 8 illustrates an average increase of +0.35% in provider payments as a share of 2025/26 ICB allocations. This indicates a broadly neutral financial effect nationally, with moderate regional variation reflecting differences in activity mix, service configuration, and exposure to policy adjustments such as MFF rebalancing, RPRP changes, and other uplifts.

103. Midlands ICBs consistently show above average uplifts, with several ICBs around +0.5% to +0.6%. This reflects increased income in elective and outpatient activity where both areas that have seen higher price uplifts and limited downward pressure from MFF adjustments. South West ICBs also show positive impacts typically between +0.3% to +0.5%. London ICBs generally sits at the lower end of the distribution, with most between +0.15% and +0.3% This is consistent with smaller uplifts for London due to the stabilisation of the Market Forces Factor (MFF) glide path and less exposure to price increasing areas such as outpatient and maternity care.

4 Impacts relating to equality

4.1 Overview

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

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

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

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

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

107. It is important to note that there is a significant amount of funding associated with categories where the protected characteristics of age, ethnicity or gender are either unknown or not identified. Strengthening accountability for incomplete demographic data is being explored as part of implementing the Ethnicity Recording Improvement Plan. NHS England and DHSC will continue to undertake work to improve data quality.

4.2 Methodology

108. We present the impact of proposed price changes on the variable element and fixed payment where activity is paid for using NHS prices under our second scenario outlined in paragraph 10, acknowledging that not all the fixed element is necessarily constructed using NHSPS prices. The NHSPS may impact people differently based on their characteristics if HRGs with different price uplifts are utilised disproportionality by people with a given characteristic, leading to an unequally distributed growth in funding for care. For the purposes of this impact assessment, we have considered the impact of our proposals on activity performed using unit prices for payment on the nine protected characteristics listed above. The Index of Multiple Deprivation (IMD) is also used to consider inequality by deprivation.

109. Patient age, race, gender and IMD are recorded in the 2024/25 HES data set and are independently quality assured within NHS England. The use of HES data therefore enables analysis of how the proposed 2026/27 NHSPS prices would affect spending on patients with different recorded age, race, gender and IMD, applying the same assumptions set out in Section 1 of this impact assessment. For some records in HES, these patient variables have not been recorded or have been excluded following quality assurance. We have assessed growth in prices aggregated by these patient variables and individual ICB and clinical areas (as determined by HRG subchapter categorisation).

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

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

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

4.3 Assessment

4.3.1 Age

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

114. Figure 9 shows the anticipated change in spending for the different age groups, where the age field was populated in HES. Based on our assessment, we estimate the proposed NHSPS prices would impact spending on activity performed under the NHSPS prices for all age groups by between -1.55% to 3.11%. Age groups 20-29 and 30-39 have a higher growth rate due to an increase in obstetric prices because of CNST liabilities in this area. The anticipated negative changes for age groups 70+ are driven by the proposed stroke and pneumonia services prices. Whilst these prices are reduced, since they are based on latest coding practices and costs, we do not expect these prices to impact on service provision. Overall, we do not expect the 2026/27 NHSPS proposals to have a material disproportionate impact on patients based on age.

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

Age_band_10_yrs	Total Payment (£'m) - 2025/26	Total Payment (£'m) - 2026/27	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
0-9	£3,080.44	£3,096.38	£15.94	0.52%
10-19	£2,328.68	£2,376.04	£47.36	2.03%
20-29	£3,782.39	£3,900.11	£117.72	3.11%
30-39	£5,392.23	£5,559.16	£166.93	3.10%
40-49	£4,132.11	£4,195.78	£63.67	1.54%
50-59	£6,067.67	£6,129.78	£62.11	1.02%
60-69	£8,210.92	£8,257.40	£46.48	0.57%
70-79	£10,063.75	£10,059.18	-£4.58	-0.05%
80-89	£7,931.87	£7,880.58	-£51.29	-0.65%
90-99	£2,158.45	£2,135.27	-£23.19	-1.07%
100 and above	£48.41	£47.66	-£0.75	-1.55%
Unknown	£2,945.53	£2,980.88	£35.35	1.20%
Total	**£56,142.46**	**£56,618.22**	**£475.76**	**0.85%**

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

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

116. Based on our assessment, the proposed NHSPS prices in scenario 2 would increase spending by between 0.53% and 1.66% for all ethnic groups, as illustrated in Figure 10 below. Black and ethnic minority patients are anticipated to receive a higher share of the increase as a result of our proposals.

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

118. We do not expect the 2026/27 NHSPS proposals to have a disproportionate impact on patients belonging to other ethnic categories represented in Figure 10.

Figure 10: Anticipated changes in NHSPS priced payment in 2026/27, by ethnicity

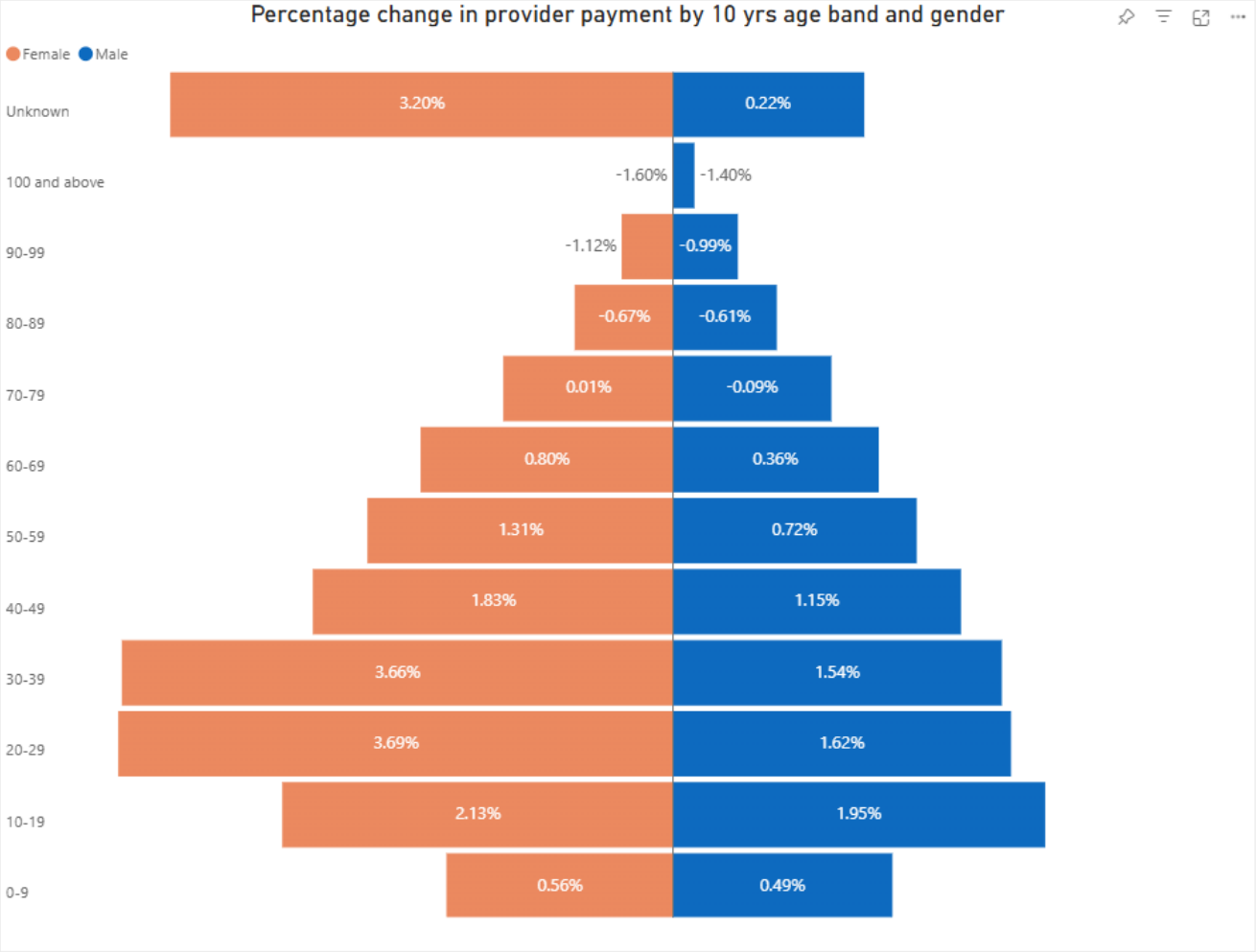
Ethnic Category	Total Payment (£'m) - 2025/26	Total Payment (£'m) - 2026/27	Total Payment Difference (£'m)	Percentage Difference
Asian or Asian British	£3,832.50	£3,896.08	£63.58	1.66%
Black or Black British	£1,927.46	£1,950.63	£23.17	1.20%
Mixed	£732.13	£743.92	£11.79	1.61%
Not known/stated	£9,981.06	£10,033.53	£52.47	0.53%
Other ethnic groups	£1,330.52	£1,345.23	£14.71	1.11%
White	£38,338.78	£38,648.83	£310.04	0.81%
Total	**£56,142.46**	**£56,618.22**	**£475.76**	**0.85%**

4.3.3 Gender

119. Certain procedures are, by their nature, specific to male and female patients and there are HRG chapters with gender-specific procedures. Based on assessment of the available data, we estimate that the proposed NHSPS prices would increase spending by gender slightly more for female patients (Figure 11). In particular, the higher growth observed in female patients within the age range 20-39 is due to the increases in obstetric prices because of increased CNST liabilities mentioned previously.

120. The reduction in the distribution of funding observed from age 70 and above is primarily due to the changes in stroke and pneumonia prices. As mentioned previously, since these new prices are based on latest costs, we do not expect prices to impact on service provision. Overall, given the small percentage changes we do not expect the 2026/27 NHSPS proposals to have a disproportionate impact on men or women.

Figure 11: Anticipated changes in NHSPS priced payment in 2026/27, by gender.



Gender Description	Total Payment (£'m) - 2025/26	Total Payment (£'m) - 2026/27	Total Payment Difference (£'m)	Percentage Difference (Total Payment)
Female	£29,189.90	£29,554.66	£364.77	1.25%
Male	£24,293.16	£24,382.63	£89.47	0.37%
Not known	£241.03	£239.84	-£1.19	-0.49%
Not specified	£2,418.38	£2,441.09	£22.71	0.94%
Total	**£56,142.46**	**£56,618.22**	**£475.76**	**0.85%**

4.3.4 Pregnancy and maternity

121. Maternity services will continue to be paid and funded as part of the API fixed element of the NHSPS. However, to support better benchmarking and service reviews based on prices, the 2026/27 NHSPS proposals would increase the guide prices for maternity services. Maternity prices will also increase to take account of higher CNST costs.

122. To help address the increasing demand and declining capacity associated with the timely delivery of termination of pregnancy (TOPs) services, for 2026/27 we will continue the proposal introduced last year and maintain the variable payment mechanism for this service. This would remove a potential financial barrier for NHS providers, where increasing activity could result in unfunded costs. The proposal would also ensure that providers who deliver less than the planned level of activity are not inappropriately compensated.

123. Overall, the proposals set out in the 2026/27 NHSPS are expected to have a positive impact on patients using maternity and pregnancy services.

4.3.5 Sexual orientation

124. The NHSPS does not distinguish between patients on the basis on their sexual orientation. We do not hold statistics on the sexual orientation of patients and are not aware of any information that would suggest that the 2026/27 NHSPS proposals would have a disproportionate impact on patients by sexual orientation.

4.3.6 Marriage and civil partnership

125. The NHSPS does not distinguish between patients based on their marital or civil partnership status. We are not aware of any information that would suggest that the 2026/27 NHSPS proposals would have a disproportionate impact on patients by marriage or civil partnership status.

4.3.7 Gender reassignment

126. Gender reassignment is a specialised service provided by the NHS. The NHSPS does not distinguish between patients based on gender reassignment, and we do not currently have data available that would allow us to quantify any such impact. We are not aware of any other information that would suggest that the 2026/27 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.8 Disability

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

2026/27 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.9 Religion or belief (including lack of belief)

128. The NHSPS does not distinguish between patients based on their religion, belief, or lack thereof. We are not aware of any information that would suggest that the 2026/27 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.10 Deprivation

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

Figure 12: Anticipated changes in NHSPS priced payment in 2026/27, by deprivation decile

IMD04 Decile Description	Total Payment (£'m) - 2025/26	Total Payment (£'m) - 2026/27	Total Payment Difference (£'m)	Total Payment Difference (%)
Most deprived 10%	£5,717.35	£5,771.23	£53.89	0.94%
More deprived 10-20%	£5,550.80	£5,598.10	£47.31	0.85%
More deprived 20-30%	£5,440.53	£5,486.88	£46.36	0.85%
More deprived 30-40%	£5,350.02	£5,395.04	£45.02	0.84%
More deprived 40-50%	£5,232.11	£5,274.68	£42.56	0.81%
Less deprived 40-50%	£5,210.70	£5,253.80	£43.10	0.83%
Less deprived 30-40%	£5,057.68	£5,098.82	£41.14	0.81%
Less deprived 20-30%	£5,000.16	£5,040.05	£39.89	0.80%
Less deprived 10-20%	£4,865.56	£4,903.39	£37.83	0.78%
Least deprived 10%	£4,605.98	£4,642.32	£36.34	0.79%
Unknown	£4,111.59	£4,153.91	£42.32	1.03%
Total	**£56,142.46**	**£56,618.22**	**£475.76**	**0.85%**

4.3.11 Other considerations

130. While we do not anticipate the 2026/27 NHSPS proposals to have a disproportionate impact on patients with protected characteristics, we acknowledge that the extent of services offered to patients are determined by both local and national commissioners, who are themselves expected to commission services that address the needs of their local populations (with a duty to actively promote advancement of equalities and the reduction of health inequalities). We expect providers and commissioners to take any

necessary steps to ensure unintended consequences are mitigated and compliance with the equality duty maintained when designing and/or commissioning services.