Classification: Official

NHS England

2026/27 NHS Payment Scheme

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Contents

1. Introduction

1. This document specifies the NHS Payment Scheme for the NHS in England for 2026/27. The NHSPS sets rules for determining the amount payable by a commissioner for the provision of NHS health care services and some public health services.

2. This document is published in exercise of functions conferred on NHS England by section 114A of the Health and Social Care Act 2012 (the 2012 Act), as amended by the Health and Care Act 2022.

3. This 2026/27 NHSPS has effect for the period beginning on 1 April 2026 and until the next scheme comes into effect (anticipated 1 April 2027).

4. **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).

5. The NHSPS allows different payment mechanisms to be used in different circumstances – although there are some things that must be considered regardless of the payment mechanism used (see Section 3).

6. Table 1 summarises the payment mechanisms:

Table 1: Payment mechanisms

Payment mechanism	Applies to
Aligned payment and incentives (API)	Almost all NHS provider relationships with • NHS England for any directly commissioned services; and • any ICB where the relationship is not covered by LVA arrangements
Low volume activity (LVA) block payments	Almost all NHS provider and ICB relationships for which NHS England has mandated an LVA block payment (this will normally be those with an expected value of annual activity of £1.5m or less)
Activity-based payment	Services with NHSPS unit prices delivered by non-NHS providers
Local agreement	Activity not covered by another payment mechanism (including non-NHS provider services without NHSPS unit prices and NHS provider activity excluded from API and LVA)

7. The document is split into the following sections:

   - Section 2: the scope of the payment scheme
   - Section 3: overarching policies – payment principles and cost adjustments
   - Section 4: aligned payment and incentive rules
   - Section 5: rules for LVA block payments
   - Section 6: activity-based payment rules
   - Section 7: rules for local payment arrangements
   - Section 8: prices and related adjustments
   - Section 9: rules for making payments.

8. In summary, Section 3 covers policies that apply to all payment mechanisms, while Sections 4-7 set out the rules for each payment mechanism. Section 8 gives details of the NHSPS prices, and adjustments to those prices.

9. There are four annexes:

- Annex A: NHSPS prices workbook
- Annex B: Guidance on currencies
- Annex C: Guidance on best practice tariffs
- Annex D: Prices and cost adjustments

10. The NHSPS is also supported by documents containing guidance and other information:

    - NHS provider payment mechanisms: Guidance on aligned payment and incentive and low volume activity (LVA) block payments
    - A guide to the market forces factor
    - Mental health and neurodevelopment resource groups guidance
    - Community currency models guidance
    - Attention deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) payment guidance

11. All annexes and supporting materials for the 2026/27 NHSPS can be downloaded from the NHS England website.

12. Additional information and support can be found on the Payment System Support Futures workspace.

13. The NHSPS forms part of a set of materials that inform planning and payment of healthcare services. Related materials include the Medium-term planning framework and the NHS Standard Contract.

14. From 1 April 2026, a new edition (v4.11) of OPCS procedure codes will be introduced. The national reimbursement system will be updated to reflect these new codes. A table of coding equivalence (TOCE) will be made available to providers and commissioners, who can use it in conjunction with the HRG4+ 2025/26 Local Payment Grouper. However, this may not take into account changes in coding practice. Where there is a significant impact as a result, changes should be neutralised using the counting and coding provisions in the NHS Standard Contract. NHS England will issue separate guidance on the treatment of ungrouped activity arising from OPCS-4.11 codes prior to the TOCE being available for reimbursement purposes.

2. Scope of the NHS Payment Scheme

15. As set out in the amended 2012 Act, the NHSPS covers the pricing of healthcare services provided for the purposes of the NHS.

16. Other than the exclusions described in Sections 2.1-2.8, this covers all forms of NHS healthcare provided to individuals, whether relating to physical or mental health and whether commissioned by integrated care boards (ICBs), NHS England, ICBs exercising functions delegated to them by NHS England, or local authorities acting on behalf of NHS commissioners under partnership arrangements.

17. Various healthcare services are, however, outside the scope of the NHSPS. The rest of this section explains these exclusions.

2.1 Public health services

18. The NHS payment scheme does not apply to public health services that are:

    - provided or commissioned by local authorities or United Kingdom Health Security Agency
    - commissioned by NHS England or an ICB on behalf of a local authority pursuant to a partnership agreement under section 75 of the National Health Service Act 2006 (the 2006 Act).

19. Public health services commissioned by local authorities include local open access sexual health services and universal health visitor reviews.

20. The Health and Care Act 2022 removed the prohibition on setting national payment rules for services commissioned by NHS England or an ICB in exercise of the Secretary of State's public health functions (as set out in section 7A or 7B of the National Health Service Act 2006). These services are subject to the NHSPS payment rules.

2.2 Primary care services

21. The NHS payment scheme does not apply to primary care services (general practice, community pharmacy, general dental practice and community optometry) where payment for the services is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the 2006 Act. (See Parts 4 to 7 of the 2006 Act and related instruments: for example, the Statement of Financial Entitlements for GMS GP Services, and the drug tariff for community pharmaceutical services.)

22. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act then the 2026/27 NHSPS rules on local payment arrangements apply (see Section 7). For instance, minor surgical procedures performed by GPs and commissioned by ICBs would be subject to local payment arrangements.

2.3 Personal health budgets

23. A personal health budget (PHB) is a set amount of money to support the identified health and wellbeing needs of a particular patient, planned and agreed between that patient and their local NHS.

24. There are three types of PHB:

- **Notional budget; no money changes hands:** the patient and their NHS commissioner agree how to spend the money; the NHS will then arrange the agreed care.
- **Real budget held by a third party:** an organisation legally independent of the patient and their NHS commissioner will hold the budget and pay for the care in the agreed care plan.
- **Direct payment for healthcare:** the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.

25. If an ICB uses a notional budget to pay providers of NHS services, this is in the scope of the 2026/27 NHSPS. Payment will be governed by the rules applicable to the services in question.

26. A notional budget may also be used to buy integrated health and social care services to facilitate more personalised care planning. Where these services and products are not NHS services, the 2026/27 NHSPS does not apply.

27. If a PHB takes the form of a direct payment to the patient or budget held by a third party, the payments for health and care services agreed in the care plan and funded from the PHB are not in the scope of the 2026/27 NHSPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act (see National Health Service (Direct Payments) Regulations 2013 (SI 2013/1617, as amended)).

28. The following are not in the scope of the 2026/27 NHSPS, as they do not involve paying for provision of NHS healthcare services:

- Payment for assessing an individual's needs to determine a PHB.
- Payment for advocacy (advice to individuals and their carers about how to use their PHB).
- Payment for the use of a third party to manage an individual's PHB on their behalf.

29. More information about PHBs can be found on the NHS Personal Health Budgets page.

2.4 Integrated health and social care

30. Section 75 of the 2006 Act provides for the delegation of a local authority's health-related functions (statutory powers or duties) to its NHS partner, and vice versa, to help meet partnership objectives and create joint funding arrangements.

31. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain in the scope of the 2026/27 NHSPS even if commissioned by a local authority. This also applies to NHS services commissioned by local authorities under arrangements made under section 65Z5 (joint working and delegation arrangements) of the Health and Care Act 2022.

32. Payment to providers of NHS services that are jointly commissioned are governed by the rules applicable to those services, as set out in this document.

33. Local authority social care or public health services commissioned under joint commissioning arrangements are outside the scope of the 2026/27 NHSPS.

2.5 Contractual sanctions

34. The NHS Standard Contract includes certain provisions under which commissioners may withhold payment from providers. Where these contractual provisions are used and change the amount paid for the provision of an NHS service, this is permitted under the rules relating to the making of payments to providers (see Section 9).

2.6 Devolved administrations

35. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, the 2026/27 NHSPS applies in some but not all circumstances.

36. Table 4 summarises how the 2026/27 NHSPS applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

Table 4: How the 2026/27 NHSPS applies to devolved administrations

Scenario	NHSPS applies to provider	NHSPS applies to commissioner	Examples
DA patient treated in England and paid for by commissioner in England	Yes	Yes	A Scottish patient attends A&E in England
DA patient treated in England and paid for by DA commissioner	No	No	A Welsh patient, who is the responsibility of a local health board in Wales, has elective surgery in England which is commissioned and paid for by that local health board
English patient treated in DA and paid for by DA commissioner	No	No	An English patient, who is the responsibility of an ICB, attends A&E in Scotland
English patient treated in DA and paid for by commissioner in England	No	Yes	An English patient has surgery in Scotland which is commissioned and paid for by their ICB in England

37. In the final scenario above, the commissioner in England must follow the 2026/27 NHSPS rules. However, there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally in the country in question, or use a different currency from that specified by the NHSPS. In such cases, the commissioner must follow the rules for local payment arrangements (see Section 7).

38. Providers and commissioners should also be aware of guidance relating to cross-border payment responsibility. The England/Wales cross border healthcare services: statement of values and principles sets out the values and principles agreed between the NHS in Wales and the NHS in England to ensure smooth and efficient interaction between NHS organisations for patients along the England-Wales border.

39. NHS England's Who Pays? document provides comprehensive rules on determining the responsible NHS commissioner in England. For queries, contact england.responsiblecommissioner@nhs.net

40. The payment responsibility rules set out in these documents should be applied as well as any applicable provisions of the 2026/27 NHSPS. The scope of the 2026/27 NHSPS does not cover the payment responsibility rules.

2.7 Overseas visitors

41. Overseas visitors who are liable to pay a charge under the relevant regulations are NHS patients where the cost of treatment is to be recovered from the individual. As such, where they receive treatment that falls within the scope of the NHSPS, they should be charged based on commissioned prices determined in accordance with the NHSPS. The charges will either be 100% of the commissioned price (for those patients who hold a European Settlement Scheme Status), or 150% of the price for all others.

42. For more details, please see the DHSC guidance on Charging overseas visitors in England.

43. It is important to be aware of exemptions from charges. This may be services (for example accident and emergency or family planning services) or individuals (including vulnerable people such as refugees or asylum seekers). Please see Chapter 1 of Charging overseas visitors in England for details of exempt services and individuals.

44. It should be noted that the episodic risk-share charging rules for chargeable overseas visitors (COV) were replaced in 2023/24 by the shared risk of non-payment being set on an annual basis through the fixed element of API contracts. When agreeing the arrangements of their shared risk of non-payment, trusts and commissioners should consider the level of funding within their prior year fixed payment, the historical rate of non-recovery of patient charges and an agreed rate of income recovery improvement.

45. For more details, see the supporting document, *NHS provider payment mechanisms.* You can also contact england.overseascostimprovement@nhs.net if you have any questions about this area.

2.8 Commercial research

46. The National contract value review (NCVR) is a standardised, national approach to costing for commercial contract research. It is underpinned in England by the NHS Standard Contract and the National directive on commercial research studies.

47. The NCVR focuses on agreeing the resources and price needed to set up commercial research studies within NHS providers. These research studies, and related costs, are outside of the scope of the NHSPS.

3. Overarching policies

48. Under the NHSPS, some overarching policies apply regardless of the payment mechanism used. All payment arrangements must apply the NHSPS payment principles and have regard to the cost uplift and efficiency factors.

49. Where providers and commissioners are not able to agree a payment arrangement, they should speak to their NHS England regional team or, if there is no applicable regional team, the NHS England Pricing team (england.pricingenquiries@nhs.net), who will work with them to find a resolution.

3.1 Payment principles

50. Commissioners and providers must apply the following principles when agreeing any payment approach:

- 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 medium-term planning framework objectives.

51. These principles are explained in more detail in Sections 3.1.1 to 3.1.5 and are additional to other legal obligations on commissioners and providers. These obligations include other rules set out in the NHSPS, and the requirements of competition law, procurement regulations under section 12ZB of the 2006 Act, and the NHS provider licence.

3.1.1 Best interest of patients

52. Payment arrangements must be in the best interests of patients today and in the future. Commissioners and providers must therefore consider the following factors:

- **Quality**: how will the agreement maintain or improve the clinical effectiveness, patient experience, timeliness of access and safety of healthcare today and in the future?

- **Cost-effectiveness**: how will the agreement make healthcare more cost effective, without reducing quality, to enable more effective use of resources for patients today and in the future?
- **Innovation**: how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interests of patients today and in the future?
- **Allocation of risk**: how will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

53. The extent to which, and way in which, these factors need to be considered will differ according to the characteristics of the services and the circumstances of the agreement.

54. To have considered a relevant factor properly, we would expect providers and commissioners to have:

- obtained sufficient information
- used appropriately qualified/experienced individuals to assess the information
- followed an appropriate process to arrive at a conclusion.

55. It is up to providers and commissioners to determine how to consider the factors set out above based on the matter in hand.

56. Where activity can be better delivered in a less resource intensive healthcare setting, and this is in the best interests of patients, providers and commissioners should consider the financial implications of such a movement of activity. For example, activity identified by the GIRFT Right Procedure Right Place (RPRP) programme may involve activity switching from an admitted or day case setting to outpatients. The financial effect of this should be explicitly considered. The RPRP best practice tariffs (BPTs) support a shift of activity to less resource intensive settings. Similarly, the day case BPTs support the shift of activity from elective admission to day cases – see Annex C for details.

3.1.2 Transparency and data quality

57. Payment arrangements must be transparent. Increased transparency will make commissioners and providers more accountable to each other, patients, the general public and other interested stakeholders. Transparent agreements also mean that best practice examples and innovation in service delivery models or payment approaches

can be shared more widely. Commissioners and providers must therefore consider the following factors:

- **Accountability**: how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the public and other stakeholders?
- **Sharing best practice**: how will innovations in service delivery or payment approaches be shared in a way that spreads best practice?

58. Ensuring good data quality is also vital for effective payment arrangements. Both provider(s) and commissioner(s) must ensure they have confidence the underlying patient level data (including the coded clinical information) submitted is accurate, complete and fit for the purposes of payment under the NHSPS.

3.1.3 Constructive engagement

59. Where payment arrangements require provider and commissioner agreement of the level and mix of activity to be delivered within the payment specified, they must engage constructively with each other to decide on the mix of services and delivery model that delivers the best value for patients in their local area. This process should involve clinicians, patient groups and other relevant stakeholders where possible. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time. Constructive engagement is intended to support better and more informed decision making in both the short and long term.

60. Commissioners and providers must therefore consider the following factors:

- **Framework for negotiations (where appropriate)**: Have the parties agreed a framework for negotiations that is consistent with the existing guidelines in the NHS Standard Contract and procurement law (as applicable)?
- **Information sharing**: Are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?
- **Involvement of relevant clinicians and other stakeholders**: Are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
- **Short- and long-term objectives**: Are clearly defined short- and long-term strategic objectives for service improvement and development agreed before starting price negotiations?

3.1.4 Health inequalities

61. Addressing health inequalities is a key priority for the NHS and, following the 2022 Act, a statutory obligation. When agreeing payment arrangements, commissioners and providers must ask how the agreement could facilitate equitable access, excellent experience and optimal outcomes for seldom heard population cohorts. This should be underpinned by analysis of suitably disaggregated data, where available.

62. The agreement must not adversely affect other national and local initiatives which seek to tackle health inequalities. Where all or part of the agreement is specifically tailored to enhance equality of healthcare provision, commissioners and providers must jointly recognise both the expected cost of this and the anticipated benefit. This should be reflected in the locally determined price.

63. In agreeing payment arrangements, it is recommended commissioners and providers visit the NHS Equality and Health Inequalities Hub to consider their legal duties with regard to health inequalities and to learn more on how the NHS aims to reduce health inequalities. Providers and commissioners should also consider using the Core20PLUS5 approach to achieve better, more sustainable outcomes and reduce healthcare inequalities.

3.1.5 Medium-term planning framework

64. The medium-term planning framework and associated materials set out detailed guidance on what commissioners and providers are expected to deliver. Providers and commissioners should carefully consider this guidance and use it to inform their priorities as they are agreeing payment arrangements.

3.2 Cost uplifts

65. 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 set a forward-looking adjustment to reflect expected cost changes in future years deemed outside providers' control. We refer to this as the cost uplift factor.

66. The cost uplift factor for 2026/27 is 2.03%. All payment arrangements must have regard to this figure.

67. Table 3 shows the categories of cost pressure considered in setting the cost uplift factor, and the weight each cost category is assigned (reflecting the proportion of total expenditure). For more details of the cost uplift calculation, see Annex D.

68. The following costs are excluded from the calculation of 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 costs relating to placements which have been funded directly by Health Education England (trainee salaries are included within pay costs).
- High cost drugs, which are not reimbursed through NHSPS prices.
- Material non-RDEL costs, such as AME impairments and depreciation and amortisation related to Government granted and donated assets.

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

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.

69. Please note: Table 3 shows total indicative pay cost change is valued at 2.10% for 2026/27. This reflects a nominal 2.0% for pay included in 2026/27 allocations, and then allows a 0.1% increase for pay drift. As presented here, the pay cost estimate explicitly does not pre-judge the outcome of the pay review body process. Once pay awards for 2026/27 are confirmed (including agenda for change and DDRB – Doctors' and Dentists' Remuneration), we will update the cost uplift factor and reissue Annex A with revised prices that reflect the new value. Once issued, the revised cost uplift factor and prices should be applied from 1 April 2026.

3.3 Efficiency

70. Payments are adjusted up by the cost uplift factor (see Section 3.2), reflecting our estimate of inflation, and down by the efficiency factor. 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.

71. The efficiency factor for 2026/27 is 2.0%. All payment arrangements must have regard to this figure. For more information on the efficiency factor, see Annex D.

3.4 Excluded items

72. Several high cost drugs, devices and listed procedures, and MedTech Funding Mandate products are unbundled and excluded from prices. These items are listed on tabs 12a, 12b and 12c of Annex A and are subject to local payment arrangements, with commissioners deciding whether, and how, they should be paid for. High cost drug excluded items under NHS England Specialised Commissioning are either eligible for block or cost and volume payments (see the Specialised Commissioning drugs list). Where items are categorised as block, a fixed amount will be agreed by the commissioner and provider at the start of the year.

73. For items that are not on the exclusion lists and are part of a priced treatment or service, the cost of the drug, device or listed procedure is covered by the NHSPS unit price, or under the API arrangements.

74. While the 2026/27 NHSPS is in effect, any newly introduced items that are funded by commissioners and available for use by providers are excluded from core payment mechanisms and should be paid for separately.

75. Almost all homecare services (drugs, devices and their related costs) are excluded from core payment mechanisms and prices, and local funding arrangements must be agreed by the commissioner and provider. From 2026/27, a number of drugs often delivered as homecare have been removed from the high cost exclusion list, with all funding for these drugs moved into prices, including the cost of the drugs when delivered as homecare. These drugs are listed in *NHS provider payment mechanisms*. Providers and commissioners should ensure that homecare delivery that is clinically appropriate and in the patient's best interest is supported, using payment mechanism rules for locally agreed adjustments where necessary. Additional information about the high cost drugs moved into prices is available on the Payment system support Futures workspace.

76. For some high cost drugs, a reference price is set at a level to incentivise provider uptake of that drug.

77. A number of high cost devices are directly commissioned by NHS England. Providers will be reimbursed directly for any purchases made via the NHS England Central Procurement process with NHS Supply Chain (the Visible Cost Model). Any device categories or specific products not available via NHS Supply Chain will be reimbursed directly based on the Device Patient Level Contract Monitoring (DePLCM) template. Trusts will not be reimbursed for expenditure reported on the DePLCM which should have been ordered via NHS Supply Chain.

78. Annex A, tab 12c, contains a list of MedTech Funding Mandate products, which are also excluded from core payment mechanisms. These products should be commissioned by ICBs and reimbursed following the excluded items pricing rule set out below. As part of these arrangements, the NHS England Innovation team may publish 'reference prices' for some listed products.

79. Under the rules for low volume activity (LVA), the LVA payment value covers all services delivered by an NHS provider for an ICB where, historically, there has not been a written contract. No invoicing should take place outside of this payment (other than where the LVA rules specify particular exceptions), so the excluded items pricing rule does not apply for LVA arrangements.

Excluded items pricing rule

a) This rule applies to high cost drugs, devices and listed products and MedTech Funding Mandate products which are listed in Annex A and which:

   i. are used in the delivery of services commissioned by either NHS England or an ICB; or
   ii. are being commissioned as part of a service to which API does not apply (see rules 1(c), 4 and 5 in Section 4),

   and should be read alongside Service Condition 39 of the NHS Standard Contract (Procurement of Goods and Services).

b) A commissioner and provider must agree the price to be paid for a high cost drug, device or listed procedure or MedTech Funding Mandate product to which this rule applies. However, the price for that item must be adjusted to reflect any part of the cost already captured by an NHSPS unit price or API fixed element.

c) The price agreed should reflect:

   i. in the case of a high cost drug for which a reference price has been set at a level to incentivise provider uptake of that drug, that reference price;
   ii. in the case of a MedTech Funding Mandate product for which a reference price has been set, that reference price;
   iii. in all other cases, the actual cost to the provider, or the nominated supply cost, or any other applicable reference price, whichever is lowest.

d) As the price agreed should reflect either the actual cost, or the nominated supply cost, or a reference price, the requirement to have regard to the efficiency factor and cost uplift factor (see Sections 3.2 and 3.3) does not apply.

e) The 'nominated supply cost' is the cost which would be payable by the provider if the high cost device, high cost drug or MedTech Funding Mandate product was purchased via an NHS Medicines Framework Agreement or via NHS Supply Chain (as appropriate) as required in accordance with Service Condition 39 of the NHS Standard Contract (Procurement of Goods and Services). The reference prices are set by NHS England and are based on the current best procured price achieved for a product or group of products by the NHS, or set at a level to incentivise provider uptake of a particular drug.

3.5 Terms used in payment mechanism rules

80. In the NHSPS rules set out in Sections 4-7, the following terms have the meanings defined here:

- "Community diagnostic activity" means diagnostic activity delivered both in community diagnostic centres (CDCs) and non-CDC locations.
- "Elective activity" means the number of elective spells, first outpatient attendances, outpatient procedures which group to a non-WF HRG with a published HRG price, chemotherapy delivery and unbundled diagnostic imaging and nuclear medicine activity.
- "Emergency care services" means:
  - all emergency admission spells (admission method code 21-25, 28, 2A-2D);
  - emergency admission excess bed days;
  - A&E attendances at Type 1, 2 and 3 A&E facilities, including urgent treatment centres where they are classified as a Type 3 A&E service;
  - all ambulatory/same day emergency care activity, including speciality based activity that aims to avoid a non-elective admission.
- "Emergency care services" do not include, in particular:
  - all other admission method codes;
  - all unbundled elements, such as critical care spells associated with emergency admissions and high cost drugs and devices.
- "Expected annual contract value" means:
  - the amount agreed by the commissioner and provider as the expected value of the contract between them for the provision of secondary care services for the relevant financial year, or
  - if no such contract has been agreed but the commissioner and provider accept that such services are to be provided by the provider (for the benefit of persons for which the commissioner is responsible) during some or all of that year, the amount agreed by the commissioner and provider as the expected amount to be

paid for provision of those services if a contract was agreed, calculated on the same basis as referred to in the payment mechanism rules.

- “Secondary care services” means health care services provided for the purposes of the NHS, including hospital, community, mental health and ambulance services, but excluding services provided pursuant to the public health functions of local authorities or the Secretary of State. It does not include primary care services where the payments made to providers of those services are determined by, or in accordance with, regulations or directions, and related instruments, made under the primary care provisions of the National Health Act 2006 (Parts 4 to 7).
- “Specialty same day emergency care (SDEC)” means activity that is designed to stop people being admitted. It does not include follows-ups. Other same day emergency care pathways could include Extended emergency medicine ambulatory care (EEMAC), which would cover people who are unlikely to need to be admitted.

4. Payment mechanism: aligned payment and incentive

81. This section sets out the aligned payment and incentive (API) rules for 2026/27. These rules apply only to services provided by NHS providers (ie NHS trusts and NHS foundation trusts). Almost all contractual relationships between a commissioner and an NHS provider with an expected annual value of activity above £1.5m are subject to API rules. Section 3.5 defines the meanings of some terms used in these rules.

82. NHS providers and commissioners must apply the rules set out here to agree the amounts payable for the specified services, subject to certain exceptions.

83. The API approach does not change the requirements to report activity data (see Section 9.2).

Rule 1 (general rule)

a) Commissioners and NHS providers (ie NHS trusts and NHS foundation trusts) must determine the prices payable for the provision of all secondary care services, except elective activity, in accordance with this rule, rules 2 to 6 below, and having regard to the overarching policies set out in Section 3 and guidance published by NHS England in relation to the pricing of those services.

b) Elective and community diagnostic activity will be reimbursed in accordance with rule 2 (e)(i) below. Emergency care services will be reimbursed in accordance with rule 2(e)(iii). External beam radiotherapy or Stereotactic Ablative Radiotherapy (SABR) will be reimbursed in accordance with rule 2(e)(iv). Genomic testing will be reimbursed in accordance with rule 2(e)(v).

c) Subject to rules 4 and 5 (exceptions), rule 2, and the aligned payment and incentive specified in that rule, applies to all secondary care services where the provider of the service is an NHS provider.

Rule 2 (agreeing the aligned payment and incentive)

a) Where this rule applies, the price payable by a commissioner to a provider for the provision of secondary care services shall be a single payment for the financial year, calculated in accordance with the following paragraphs. The supporting document *NHS provider payment mechanisms* provides more detail on calculating this payment.

b) The provider and commissioner must agree a fixed element, applying the payment principles specified in Section 3.1. The fixed element represents funding for the provision of secondary care services, except for elective and community diagnostic activity,

emergency care, genomic testing and external beam or SABR radiotherapy services, for the financial year. The fixed element should be based on a forward-looking assessment of activity and an agreed plan. The fixed payment should be split by broad service category. Commissioners and providers must review their fixed payments each year. The *NHS provider payment mechanisms* document sets out a methodology to support providers and commissioners with this. Providers and commissioners must also have regard to the cost uplift and efficiency factors for the financial year (as set out in Sections 3.2 and 3.3). This should also include agreed funding for CNST contributions, having regard to the subchapter costs, particularly for maternity services, shown in Section 2.3 of Annex D, and the implementation costs of the MedTech Funding Mandate products in Annex A, tab 12c.

c) High cost drugs, devices and listed procedures, and MedTech Funding Mandate products in Annex A (tabs 12a, 12b and 12c), as well as homecare services (drugs, devices and their related costs), will be reimbursed in accordance with excluded items pricing rule (see Section 3.4)

d) The provider and commissioner must also agree:

   i. for the annual best practice tariffs (BPTs), the expected level of BPT criteria attainment which the provider will achieve in delivering those services
   ii. the expected level of advice and guidance activity for the financial year which is intended to be reflected in the fixed element

e) Subject to rule 3, the price payable shall be the fixed payment, varied as set out below:

   i. Where the provider delivers elective or community diagnostic activity, the amount payable for this activity must be added to the fixed payment. The amount payable must be calculated by reference to the volume of elective and community diagnostic activity, priced using the unit prices set out in Annex A. Any elective activity BPT payment and the relevant market forces factor (MFF – see Section 8.2) should be applied. A locally agreed price should be used where no unit price is published. The amount payable for patient-not-present activity should be calculated for relevant activity and implemented by 1 July 2026 (see Section 3.5 of Annex B).
   ii. If the level of advice and guidance activity is different to that agreed pursuant to paragraph (d) above, the fixed payment should be increased or decreased as agreed by the commissioner and provider in accordance with guidance issued by NHS England.
   iii. Where the provider delivers emergency care services:
      a. The amount payable for this activity must be added to the fixed payment.

b. The amount payable must be calculated using planned activity and prices for the expected casemix to establish the value of planned activity. Prices should be unit prices, published in Annex A, and locally agreed prices for specialty same day emergency care (SDEC) activity and other same day pathways. Annex A contains a guide price that can inform a locally agreed price for specialty SDEC activity. See Annex B for more information.
c. The value of actual activity must also be calculated using unit prices, local specialty SDEC and other same day pathway prices and casemix. If the value of actual activity is more than the value of planned activity, the price payable will be the value of planned activity plus 20% of the difference between the two values. If the value of actual activity is less than the value of planned activity, the price payable will be the value of planned activity minus 20% of the difference between the two values.
d. For services covered by UEC-related BPTs, providers and commissioners must agree activity levels for services which attract BPTs as part of the fixed payment. This should be valued using the base or non-BPT price. Where providers achieve best practice (as set out in the rules for each BPT), they should receive the difference between the BPT price and the base price as an additional payment.
e. Providers and commissioners must agree a 'break glass' clause which contains a trigger point where actual activity is above or below the planned level and a set of binding arrangements which will apply if the trigger point is reached.

iv. Where the provider delivers unbundled external beam radiotherapy services or SABR:
a. The amount payable for this activity must be added to the fixed payment.
b. The amount payable must be calculated using planned activity and unit prices for the expected casemix to establish the value of planned activity.
c. The value of actual activity must also be calculated using unit prices and casemix. If the value of actual activity is more than the value of planned activity, the price payable will be the value of planned activity plus 50% of the difference between the two values. If the value of actual activity is less than the value of planned activity, the price payable will be the value of planned activity minus 50% of the difference between the two values.
d. Where providers would be significantly affected by the move to blended payment, providers and commissioners can locally agree to retain the payment arrangements used in 2025/26 for 2026/27, without reference to rule 3 or requiring approval from NHS England.

v. Where the provider delivers genomic testing services:
a. The amount payable for this activity must be added to the fixed payment.

b. The amount payable must be calculated using planned activity and unit prices for the expected casemix, plus a consideration of previous payment levels and necessary management costs, to establish the value of planned activity and delivery.
c. The value of planned activity and delivery must be reduced by 2% to establish the adjusted value of planned activity and delivery, which is subject to paragraphs d and e.
d. The value of actual activity must also be calculated using unit prices and casemix. If the value of actual activity is more than the adjusted value of planned activity and delivery, the price payable will be the adjusted value of planned activity and delivery plus a locally agreed percentage of the difference between the two values. If the value of actual activity is less than the adjusted value of planned activity and delivery, the price payable will be the value of planned activity minus a locally agreed percentage of the difference between the two values.
e. Providers can earn the difference between the value of planned activity and delivery and the adjusted value of planned activity and delivery (2%, as described in paragraph c) by demonstrating improvements. The metrics and required improvements will be locally agreed, based on guidance in *NHS provider payment mechanisms*.

Rule 3 (locally agreed adjustments)

a) The commissioner and provider may agree an adjustment to the price payable under rule 2, including a change as to how the fixed payment is calculated or a variation to the fixed payment other than as provided for in rule 2(e), provided that:

i. they comply with paragraphs (b) to (e) of this rule 3; and
ii. the agreement is approved by NHS England following an application by the commissioner and provider.

b) The commissioner and provider must apply the local pricing principles in Section 3.1.

c) Once approved by NHS England, the agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers the services in question.

d) The commissioner must maintain and publish a written statement of the agreement, using an approved template provided by NHS England, within 30 days of the relevant contract being signed, or in the case of an agreement during the term of an existing contract, the date of the agreement.

e) The commissioner must submit the written statement to NHS England.

Rule 4 (exceptions – services in scope of the aligned payment and incentive)

a) Rules 2 and 3 do not apply for treatment costs relating to NICE decisions (such as CAR-T).

b) For these services, the provider and commissioner must apply the payment principles specified in Section 3.1, and have regard to the cost uplift and efficiency factors for 2026/27 (as set out in Sections 3.2 and 3.3). They must locally agree payment arrangements, having regard to NHS England Specialised Commissioning guidance.

Rule 5 (exceptions – services outside the aligned payment and incentive)

a) Rules 2 and 3 do not apply where:

i. there is an LVA arrangement in place
ii. there is an individually procured service for a clinical area identified by NHS England Specialised Commissioning
iii. there is a single non-acute service procured by an ICB from an NHS provider.

b) In those cases, the prices payable for the provision of secondary care services for the financial year must be determined as follows:

i. in cases falling within paragraph (a)(i):

a. The value set out in the LVA payments schedule in Annex A

or

ii. in cases falling within paragraph (a)(ii) or (a)(iii) (whether or not also falling within paragraph (a)(i)), the unit prices set out in Annex A (to the extent those prices apply to the services – where no unit price exists for the service, a local price must be agreed), subject to the relevant market forces factor.
iii. the payment mechanism as detailed in the original procurement invitation and subsequent contract awarded.

5. Payment mechanism: low volume activity block payments

84. This section sets out the low volume activity (LVA) rules for 2026/27. Almost all activity delivered by NHS providers with an expected annual value below £1.5m is subject to LVA rules. Section 3.5 defines the meanings of some terms used in these rules. The *NHS provider payment mechanisms* document provides more guidance on the LVA.

85. The LVA arrangements do not change the requirements to report activity data (see Section 9.2).

Rule 1 (general rule)

a) Commissioners and providers must determine the prices payable for the provision of secondary care services in accordance with this rule, and rules 2 to 3 below, and having regard to guidance published by NHS England in relation to the pricing of those services.

b) Subject to rule 3 (exceptions), rule 2 and the low volume activity specified in that rule applies to all secondary care services where:

   i. the annual activity between a commissioner and NHS provider is expected to have a value of less than £1.5 million, and
   ii. NHS England judges an LVA is appropriate, following consideration of:
      a. proximity of the provider to the commissioner
      b. value of the LVA payment compared to the trust's overall income
      c. whether the provider delivers specialised services
      d. whether an LVA was previously in place.

Rule 2 (LVA payment)

a) For any LVA arrangement identified in the LVA payment schedule, published in Annex A, the commissioner must pay the provider the amount specified in the schedule once any in-year updates have been made to reflect the impact of any agreed pay award or by the end of quarter two, whichever is sooner. Where LVA payments are made prior to the impact of any pay award, any required additional payments should be made in the month after the updated LVA schedule is published.

b) No invoicing should take place outside of this payment.

Rule 3 (exceptions)

a) The LVA arrangements cover all clinical services (acute, mental health and community) provided by NHS providers, with four exceptions:

   i. Services provided by ambulance trusts, including patient transport services.
   ii. Non-emergency inpatient out-of-area placements into mental health services where these are directly requested by the patient's commissioner.
   iii. Elective care commissioned by an ICB where there is no contractual relationship to allow meaningful choice for patients, including making use of alternative providers if people have been waiting a long time for treatment.
   iv. Mental health lead provider collaborative contracts are out of scope of the LVA arrangements and are excluded from LVA payment values.

b) Where both parties agree to do so, providers and commissioners can choose to enter into a contract in place of the LVA arrangements. This contract would be subject to the NHSPS local payment arrangement rules in Section 7.

6. Payment mechanism: activity-based payment

86. This section sets out the activity-based payment rules for 2026/27. Almost all activity delivered by non-NHS providers for services where there are NHSPS unit prices are subject to these rules. Section 3.5 defines the meanings of some terms used in these rules.

87. Providers and commissioners must apply the rules set out here to agree the amounts payable for the specified services.

88. The activity-based payment approach does not change the requirements to report activity data (see Section 9.2).

89. Almost all activity delivered by NHS providers (trusts and foundation trusts) would be subject to either API or LVA rules (see Sections 4 and 5), although some exceptions are subject to local payment arrangements (see Section 7). The rules here apply only to non-NHS providers.

Rule 1 (general rule)

a) Commissioners and providers must determine the prices payable for the provision of secondary care services in accordance with rules 2 and 3 where the following conditions apply:

   i. the provider is not an NHS trust or an NHS foundation trust, and
   ii. the service has an NHSPS unit price, published in Annex A.

Rule 2 (the activity-based payment)

a) The price payable by a commissioner to a provider for the provision of secondary care services shall be a payment for each unit of activity delivered, calculated in accordance with the following paragraphs.

   i. The NHSPS unit price for the service, published in Annex A, must be paid for each unit of activity delivered.
   ii. Where the criteria set out in Annex C are achieved, best practice tariff (BPT) unit prices should be paid for elective activity BPTs.
   iii. The amount paid should be the NHSPS unit price after the application of the relevant market forces factor (MFF – see Section 8.2).

Rule 3 (locally agreed adjustments)

a) The commissioner and provider may agree an adjustment to the price payable under rule 2, provided that they comply with paragraphs (b) to (e) of this Rule 3.

b) The commissioner and provider must apply the local pricing principles in Section 3.1.

c) The agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers the services in question.

d) The commissioner must maintain and publish a written statement of the agreement, using the template and guidance provided by NHS England, within 30 days of the relevant contract being signed, or in the case of an agreement during the term of an existing contract, the date of the agreement.

e) The commissioner must submit the written statement to NHS England.

7. Payment mechanism: local payment arrangements

90. This section sets out the local payment arrangement rules for 2026/27. Where one of the payment mechanisms set out in Sections 4 to 6 does not apply, local payment arrangement rules should be used. Section 3.5 defines the meanings of some terms used in these rules.

91. Where payment arrangements are determined locally, it is the responsibility of commissioners to have regard to relevant factors, including opportunities for efficiency and the actual costs reported by their providers. Providers and commissioners should also bear in mind the requirements set out in the NHS Standard Contract, such as in relation to counting and coding.

92. Rule 2 requires commissioners and providers to have regard to NHSPS cost uplift and efficiency factors. In effect they should be used as a benchmark to inform local negotiations. However, these are not the only factors that should be considered. Other relevant factors may include, but are not restricted to:

- commissioners agreeing to fund service development improvements
- additional costs incurred as part of any agreed service transformation
- funding of initiatives to address health inequalities
- taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
- comparative information (eg benchmarking) about provider costs and opportunities for local efficiency gains
- differences in costs incurred by different types of provider.

93. Where a commissioner and provider cannot agree a local payment arrangement, they should speak to their NHS England regional team to help resolve the situation.

Rule 1 (general rule)

a) Where the payment rules set out in Sections 4 to 6 do not apply, a provider and commissioner may agree the price payable for services.

b) Providers and commissioners must apply the payment principles in Section 3.1 when agreeing the amount payable for services.

Rule 2 (cost adjustments)

a) Commissioners and providers must have regard to the cost uplift and efficiency factors for the relevant financial year (as described in Sections 3.2 and 3.3), and CQUIN funding transferred into the National Tariff in 2021/22, when agreeing local payment arrangements.

8. Prices and related adjustments

94. Our aim in setting prices is to support the highest quality patient care, delivered in the most efficient way.

95. Annex A contains the 2026/27 NHSPS prices.

96. In the NHSPS there are two types of price:

- **unit price**: unit prices should be used for all services within scope of an activity-based payment mechanism, for the API variable elements for elective and emergency care services.
- **guide price**: guide prices can be used to support local payment arrangements and as a source of benchmarking data.

97. Whenever prices are used, the relevant market forces factor (MFF – see Section 8.2) should be applied to calculate the final price.

98. The LVA payments schedule is also published in Annex A. This sets out the amounts to be paid under the LVA arrangements set out in Section 5.

8.1 Calculating prices

99. We calculated almost all NHSPS prices for 2026/27 by updating 2025/26 NHSPS pay award prices (published in June 2025) for inflation and efficiency (see Sections 3.2 and 3.3). This means the prices are based on 2018/19 cost and activity data and we have used the same currency design as 2025/26 (the currency design used for 2018/19 reference costs), with the healthcare resource group HRG4+ phase 3 as the basis for prices for many services, including admitted patient care and outpatient procedures.

100. Annex D contains a step-by-step description of the calculation method, but it is briefly summarised here:

- Set draft price relativities (the 2025/26 pay award prices, published in June 2025).
- Make manual adjustments to the price relativities (details in Annex D).
- Scale to the 2026/27 prices cost base, described in Section 2.6 of Annex D.
- Adjust prices for 2026/27 inflation and efficiency (see Sections 3.2 and 3.3) and change in MFF values (see Section 8.2).

8.2 The market forces factor

101. The purpose of the market forces factor (MFF) is to compensate providers for unavoidable cost differences in providing healthcare services. Unavoidable costs include variations in capital and building costs, business rates and labour costs.

102. The MFF takes the form of an index. This allows a provider's location-specific costs to be compared with every other organisation. The index is constructed so that it always has a minimum value of 1.00. The MFF payment index operates as a multiplier to each unit of activity.

103. MFF values for all NHS trusts and foundation trusts are available in Annex A, tab 11.

104. For 2026/27, we are continuing to implement the update of data used to calculate MFF values, which started in 2025/26, moving to the second step of the transition path introduced in 2025/26. This change in MFF values reduces the total amount of money that would have been paid through the MFF (if all activity was reimbursed using unit prices), with compensating increases in the prices. The resulting increase in 2026/27 prices, compared to using 2025/26 MFF values, is 0.42%.

105. Changes in MFF should not immediately translate into a change to API fixed payment values. However, it should be considered when applying local efficiency requirements, including convergence or deficit reduction, activity growth and changes in MFF. Such requirements should be considered in aggregate; for example, convergence may moderate the impact of MFF changes for a commissioner. Where adjustments in API fixed payment are agreed to be actioned over time, a clear plan should be documented on what changes are expected and when they will be actioned. For elective services, providers are paid 100% of NHSPS unit prices with relevant MFF value applied.

106. The MFF value for independent sector providers is the MFF value of the NHS trust or foundation trust nearest to the location where the services are being provided. The supporting document, *A guide to the market forces factor*, provides more detail as well as guidance on MFFs for remote/virtual services.

107. Providers should notify NHS England of any planned changes that might affect their MFF value. This includes organisations merging or undergoing other organisational restructuring after the publication of the 2026/27 NHSPS. Please contact england.pricingenquiries@nhs.net.

108. Further information on the calculation and application of the MFF – including for remote/virtual services – is provided in the supporting document, *A guide to the market forces factor*.

8.3 PSS top-up payments

109. NHSPS prices are calculated on the basis of average costs. This means they do not take account of cost differences between providers, even though some providers serve patients with more complex needs. Only a few providers are commissioned to deliver such care, based on the prescribed specialised services (PSS) definitions provided by NHS England Specialised Commissioning team.

110. The purpose of PSS top-up payments is to recognise these cost differences and to improve the extent to which prices reflect the actual costs of providing specialised healthcare when this is not sufficiently differentiated in the HRG design.

111. When calculating prices, we make an adjustment (a top-slice) to the total amount of money allocated to unit prices and reallocate this money to eligible providers of specialised services using top-up payments.

112. The amounts paid and the providers that are eligible are based on the PSS definitions and the list of eligible providers is contained within the PSS operational tool.

113. PSS top-up payments are only made for inpatient care where prices are used. A list of the services eligible for PSS top-ups, the adjustments and their flags can be found in Annex A, tab 13.

114. Each eligible provider will receive specialist top-up payment from commissioners as part of the API fixed element.

8.4 Calculating LVA payment values

115. Section 5 sets out where LVA arrangements apply. The LVA payments schedule, which gives the value of LVA payments, is in Annex A.

116. The 2026/27 LVA payments schedule values were calculated by updating the 2025/26 LVA values for inflation and efficiency (see Sections 3.2 and 3.3). An activity growth factor of 8.5% was then applied to reflect estimated average activity growth between the reference years used for the LVA values (2019/20, 2022/23 and 2023/24) and 2024/25 levels.

9. Rules for making payments

117. Section 114A(8) of the 2012 Act allows for the setting of rules relating to the making of payments to providers where health services have been provided for the purposes of the NHS (in England).

9.1 Billing and payment

118. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS Standard Contract. Application of provisions within the NHS Standard Contract may lead to payments to providers being reduced or withheld.

9.2 Activity reporting

119. For NHS activity where there is no NHSPS price, providers must adhere to any reporting requirements set out in the NHS Standard Contract.

120. For services with NHSPS prices, providers must submit data as required under SUS guidance.

121. We will publish the dates for reporting activity and making the reports available.

122. NHS England has approval from the Secretary of State to allow ICBs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online about these conditions and sets the actions that ICBs, CSUs and providers must take to ensure they act lawfully.