Classification: Official

Publication reference: PR2123

2023/25 NHS Payment Scheme – a consultation notice

Part A: Policy proposals

23 December 2022

This is part of the consultation notice for the 2023/25 NHS Payment Scheme. The consultation notice has three parts:

- **Part A – Policy proposals.**
- Part B – Draft NHS Payment Scheme.
- Part C – Impact assessment.

The consultation notice documents, as well as annexes and supporting documents, are available from: www.england.nhs.uk/publication/2023-25-nhsps-consultation/

Contents

1. About this document

1. This is the statutory consultation notice for the 2023/25 NHS Payment Scheme (NHSPS).

2. The consultation notice is in three parts:

   - Part A – policy proposals. This contains:
     - an introduction that sets the context for the 2023/25 NHSPS and explains how you can respond to this consultation notice
     - a summary of how we have engaged with stakeholders in developing the proposals in this notice
     - a description of our proposals and our rationale for proposing them.
   - Part B – draft NHSPS. This contains a draft of the proposed NHSPS, shown as it would appear in its final form.
   - Part C – impact assessment. This describes our assessment of a likely impact of our proposals.

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

4. This document should be read in conjunction with its annexes and supporting documents. The annexes labelled with a ‘Cn’ prefix form part of this notice. Those labelled with a ‘Dp’ prefix are part of the draft NHSPS. It is proposed that ‘Dp’ annexes would form part of the 2023/25 NHSPS on publication.

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

Table 1: Annexes and supporting documents[1]

Document type	Document
Cn	Annex CnA: How to respond to this consultation and the statutory objection process
Draft NHS Payment Scheme (Dp)	Annex DpA: NHS Payment Scheme prices workbook
Dp	Annex DpB: Guidance on currencies
Dp	Annex DpC: Guidance on best practice tariffs
Dp	Annex DpD: Prices and cost adjustments
SD	NHS provider payment mechanisms: Guidance on aligned payment and incentive and low volume activity (LVA) block payments
SD	A guide to the market forces factor

[1] All materials are available from: www.england.nhs.uk/publication/2023-25-nhsps-consultation/

2. Introduction

6. The Health and Social Care Act 2012 (as amended by the Health and Care Act 2022) (the 2012 Act) will replace the National Tariff Payment System with the NHS Payment Scheme (NHSPS). The relevant amended provisions are due to come into force on 1 April 2023. We are therefore consulting on the basis that the amendments will be effective on 1 April 2023 when the proposed NHSPS is due to commence. For this reason, this document includes references to the provisions of the 2012 Act as amended by the Health and Care Act 2022.[2]

7. As with the National Tariff, the NHSPS governs transactions between providers and commissioners of NHS-funded care. The amended 2012 Act states that the NHSPS must set rules for determining the amount payable by a commissioner for NHS health care services.[3] This includes acute, ambulance, community and mental health services. However, the NHSPS does not apply to primary care services where payment is determined by provisions of the National Health Service Act 2006. This was also the case for the National Tariff.

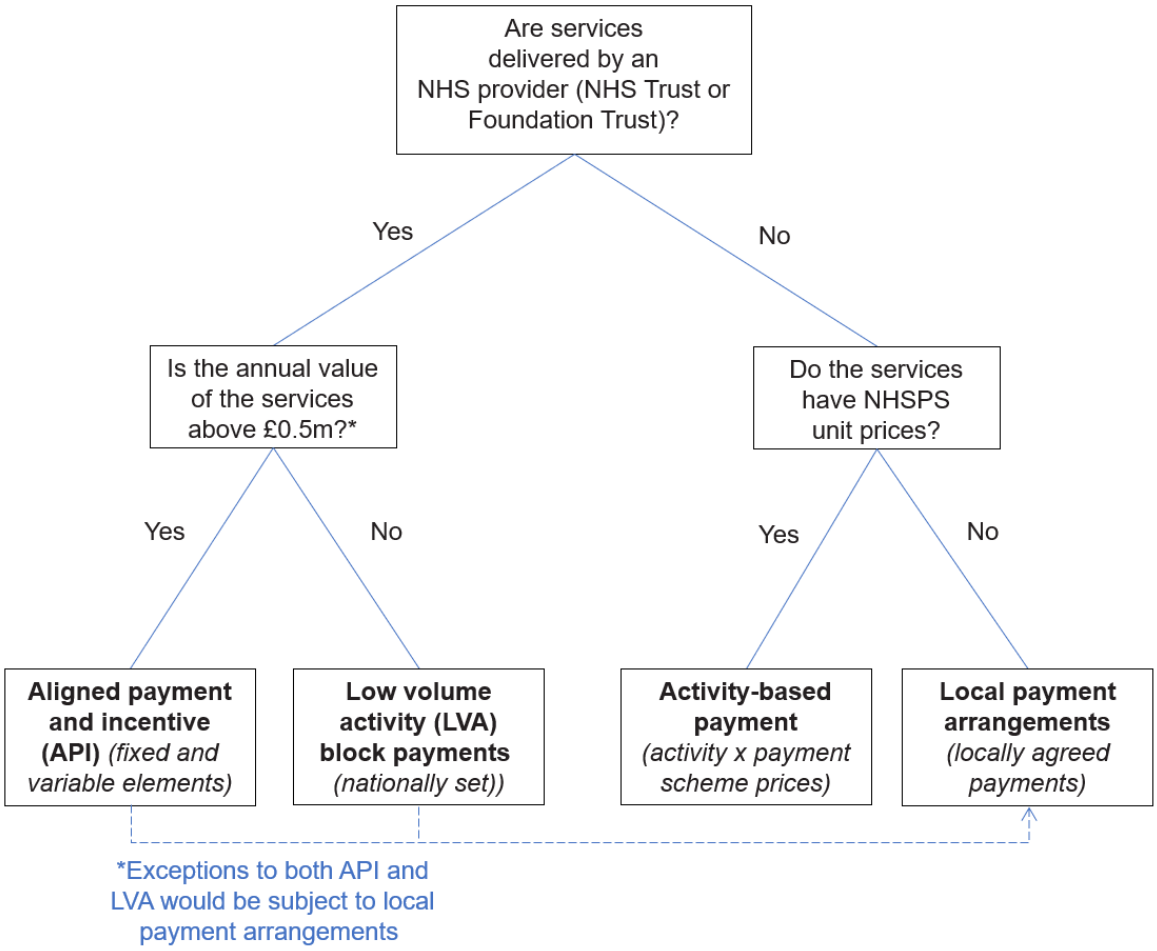
8. As such, we are proposing the NHSPS contains rules for different payment mechanisms that will apply to activity within its scope. These rules would be supported by additional information in annexes and supporting documents that would support implementation of the rules.

9. The proposed rules would, in particular, provide for four payment mechanisms:

   - Aligned payment and incentive (API) (fixed element and variable element, paying 100% of NHSPS prices for elective activity)
   - Low volume activity (LVA) block payments (nationally set values)
   - Activity-based payments (activity x unit prices)
   - Local payment arrangements (payment approach is locally determined)

2 See in particular section 77 of, and Schedule 10 to, the 2022 Act.
3 Section 114A of the 2012 Act.

10. The following diagram summarises when each payment mechanism would usually apply.



11. In Section 5, this consultation notice sets out proposals that apply, regardless of the payment mechanism. This includes the proposed two-year duration, the cost uplift and efficiency factors and the core principles that we think should apply to payment arrangements, regardless of the mechanisms used.

12. We then set out our proposals for each payment mechanism:

- Aligned payment and incentive (API): Section 6
- Low volume activity (LVA) block payments: Section 7
- Activity-based payment: Section 8
- Local payment arrangements: Section 9.

13. We are proposing to calculate and publish prices, based on 2022/23 National Tariff prices (see Section 10 and Annexes DpA and DpD).

14. The amended 2012 Act specifies that, in setting the NHSPS, NHS England must have regard to differences in the costs incurred in providing services to different people, and differences between providers and the services that they provide. This is to ensure a fair level of pay for providers of those services.[4] In this document, we explain how we have done this in developing our proposed payment mechanisms and prices. The impact assessment also sets out the expected impact of our proposals, including an equality assessment.

15. We hope that clearly focusing on the rules for the different payment mechanisms will make the NHSPS simpler and easier to understand and use in practice. We have also worked to ensure the NHSPS proposals are fully aligned with the Operational Planning Guidance and NHS Standard Contract. Please contact pricing@england.nhs.uk if you have questions about anything contained in this consultation.

[4] Section 114A(7) of the 2012 Act.

3. Responding to this consultation

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

16. The proposals for the 2023/25 NHSPS are subject to a statutory consultation process as required by the 2012 Act.[5] As well as enabling parties to provide views on the proposals, which we consider before final decisions on the NHSPS, the consultation allows ICBs and providers of NHS-funded services to object to the proposed NHSPS. The statutory consultation period is 28 days, ending on 21 January 2023. However, given the launch of the consultation in December, and the bank holidays for Christmas and New Year, we will continue to consider objections and feedback submitted until midnight at the end of **27 January 2023**.

17. For the National Tariff, we were required to consult on the Tariff proposals, but the objection process related only to the proposed method for setting national prices. Under the amended 2012 Act, both the consultation and the objection process covers all proposals for the NHSPS. We welcome comments on any of these proposals and will consider your responses before making a final decision on the content of the 2023/25 NHSPS.

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

19. Please submit your feedback through the online survey.[6] The deadline for submitting responses is midnight at the end of **27 January 2023**.

20. Please contact pricing@england.nhs.uk if you have any questions on the running of this consultation or the proposals it contains.

5 Section 114C Health and Social Care Act 2012.
6 Available from: www.engage.england.nhs.uk/pricing-and-costing/2023-25-nhsps-consultation

4. How we worked with stakeholders to develop our proposals

21. We have engaged with providers, commissioners, representative bodies, other teams and departments within NHS England and other appropriate stakeholders throughout the development of our proposals. We have engaged particularly closely with ICB and NHS provider leaders, as well as colleagues at the Department of Health and Social Care and Treasury to develop our proposals for reimbursement of elective activity.

22. Engagement included:

- regular discussions about policies in development with representative bodies and their members, such as the HFMA, royal colleges, NHS Providers, NHS Confederation and Independent Healthcare Providers Network
- taking part in external events relevant to payment policy development
- continuing co-design sessions with stakeholders from regions, ICSs, providers, commissioners and think tanks to explore developing policy proposals and longer-term payment system development
- working with clinical groups, including GIRFT clinical leads and National Casemix Office expert working groups, to consider cost data and prices
- running a series of virtual workshops and webinars, and accompanying online survey, to get feedback on initial policy proposals during July 2022.
- holding a webinar in October 2022 to provide an update on policy developments.

23. The July webinars and workshops proved popular, with more than 800 people attending the workshops and almost 300 people attending or watching the webinars. The October webinar was also very well-attended, with almost 600 people either participating in the live session or watching the recording.

24. An online engagement tool was used during the July workshops to gather views on specific questions. Attendees were asked to show their support or otherwise for a policy by giving a score between 1 (strongly oppose) and 10 (strongly support). The in-meeting ‘chat’ (via the online meeting platform used) was also very busy, with more than 1,000 substantive questions and comments from attendees who used it to give more detail of their opinions, as well as asking questions and responding to comments from others.

25. The engagement tool was also used to ask attendees to indicate the type of organisation they represent. Of those that responded to this question (809), 412 (51%) represented providers and 323 (37%) represented commissioners.

26. The online survey received 35 responses. The majority of these (21 – 60%) were from providers, with five (14%) commissioners.

27. Thank you to everyone who gave their time and participated in this engagement. Your feedback has helped shape the policies presented here.

28. We will continue to engage on our work as we develop the next NHSPS. Please contact pricing@england.nhs.uk if you have any questions about this or would like to register for updates about the payment system.

29. The rest of this document sets out our proposals for the 2023/25 NHSPS.

5. Proposals applying to all payment mechanisms

5.1 Duration

- **We propose to set the NHSPS for two years – 2023/24 and 2024/25.**

About this proposal

30. We are proposing to set the NHSPS for two years – 2023/24 and 2024/25.

31. For the second year, we are proposing a formula would be used to update the cost uplift and efficiency factors (see Section 5.5). These would be applied to payment arrangements for 2024/25 with no further amendment to the NHSPS (and no further consultation) required. We would also publish an updated set of prices to reflect the updated cost adjustment factors.

32. We may also decide that some changes to the NHSPS are needed for 2024/25. If so, there are two possibilities. If the changes are not so significant as to require publication of a new edition of the NHSPS, we can consult on the specific amendments only (eg changes to the high cost drugs and devices lists). Otherwise, we will be required to consult on a new NHSPS.[7]

Why we think this is the right thing to do

33. The National Tariff was set on a single-year basis, other than for 2017/19. However, there has been consistent support from stakeholders for setting the payment system for a longer period. We have been told that providing this certainty would help local areas plan more effectively and reduce the administrative burden.

34. Previously, the National Tariff was required to set £ values for all national prices – so, in a multi-year Tariff (as in 2017/19), all of the prices had to be set out as part of the consultation. This made it difficult to accurately predict factors such as inflation or CNST contributions. The amended 2012 Act allows the NHSPS to use formulas to set prices (eg, update for inflation at a set

[7] Section 114E Health and Social Care Act 2012

date). This would address some of the potential pitfalls of setting the payment system for a longer period, such as the estimated inflation figures proving to be incorrect.

35. In our July engagement, we asked about support for setting the NHSPS for one year, two years, or to align with the duration of the planning guidance. At the workshops, most popular option was for aligning the duration of the NHSPS with the period covered by the planning guidance (65% of responses).

36. While the Operational Planning Guidance itself is set for one year (2023/24), allocations are being set for two years. We are proposing to also set the NHSPS for two years to provide more stability and support systems to develop longer-term plans.

5.2 Payment principles

- **We propose that all payment arrangements support productivity and efficiency and follow the same core principles.**

About this proposal

37. The 2022/23 National Tariff included local pricing principles that must be applied whenever providers and commissioners agree a local payment approach. The API rules also require these principles to be considered for any agreements, and for any departure from the API arrangements.

38. We are proposing to broaden the scope of the local pricing principles so that they become payment principles that apply to all payment mechanisms in the NHSPS.

39. Compared to the Tariff's local pricing principles, we are proposing to expand the principle on transparency to highlight the importance of good data quality. We are also proposing a new principle, of considering how any payment approach will support Operational Planning Guidance priorities.

40. This would mean that providers and commissioners must use the following principles when applying any payment mechanism:

    - The payment approach must be in the best interests of patients.
    - The approach must promote transparency and good data quality to improve accountability and encourage the sharing of best practice.

- The provider and commissioner(s) must engage constructively with each other when trying to agree payment approaches.
- The provider and commissioner(s) should consider how the payment approach could contribute to reducing health inequalities.
- The provider and commissioner(s) should consider how the payment approach contributes to delivering Operational Planning Guidance objectives.

Why we think this is the right thing to do

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

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

43. We are proposing to include data quality in the principles to help ensure that the move to blended payment continues to support the submission of accurate and complete data. This data is used in national healthcare monitoring and reporting, as well as the calculation of prices, and should continue to be a high priority for all parties.

44. We are proposing to include a principle that explicitly requires providers and commissioners to consider the Operational Planning Guidance so that payment agreements are developed in the context of wider system goals, such as elective recovery.

5.3 Cost adjustment: 2023/24 cost uplift factor

- **We propose to set the NHSPS cost uplift factor for 2023/24 at 2.9%.**

About this proposal

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

describes the proposed cost uplift factor for 2023/24. Section 5.5 describes our proposal for setting the cost uplift factor for 2024/25.

46. The cost uplift factor is applied to the prices and LVA payment values published as part of the NHSPS. Providers and commissioners must also have regard to it as part of API and local payment arrangements.

47. We have calculated the proposed 2023/24 cost uplift factor based on an assessment of cost pressures. This involved gathering initial estimates across several cost categories and then reviewing them to set an appropriate figure for the NHSPS, which in some instances requires an adjustment to the initial figure. Table 2 outlines the cost categories and the source for initial estimates.

Table 2: Costs included in the 2023/24 cost uplift factor

Cost category	Description	Source for initial estimates
Pay	Assumed pay growth, pay drift and other labour costs	Internal data Department of Health and Social Care
Drugs	Expected changes in drug costs included in the NHSPS.	Internal data Office for Budgetary Responsibility
Capital	Expected changes in the revenue consequences of capital.	Office for Budgetary Responsibility
Unallocated CNST	Expected changes in CNST contributions that have not gone through the HRG level CNST uplifts.	NHS Resolution
Other	General inflation for other operating expenses.	Internal data Office for Budgetary Responsibility

48. In setting the general cost uplift factor, each cost category is assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure from published 2018/19 financial accounts. Table 3 shows the weights applied to each cost category.

49. For the cost weights, we used previous National Tariff cost uplift factors to adjust the 2018/19 consolidated accounts data to produce a projected set of 2023/24 cost weights.

Table 3: Elements of inflation in the 2023/24 cost uplift factor

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.1%	68.9%	1.5%
Drugs	1.3%	2.4%	0.0%
Capital	4.0%	7.1%	0.3%
Unallocated CNST	1.5%	2.2%	0.0%
Other	5.5%	19.3%	1.1%
Total			2.9%[8]

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

- Purchase of healthcare from other bodies, which includes a combination of costs and cannot be discretely applied to one specific category.
- Education and training, which are not included in the NHSPS and have instead been funded by Health Education England.
- High cost drugs, which are not reimbursed through NHSPS prices.

51. We propose to update the cost uplift factor for 2024/25 using a formula (see Section 5.5.

Why we think this is the right thing to do

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

53. As Table 3 shows, total indicative pay cost change is valued at 2.1% for 2023/24. This reflects the fact that allocations for 2023/24 include a nominal

[8] Note: calculations are done unrounded – only one decimal place displayed.

2% for pay at this stage. As presented here, the pay cost estimate explicitly does not pre-judge the outcome of the pay review body process, the outcome of which will not be known until 2023 and which we will then reflect. If further information is available prior to the publication of the final NHSPS, we will look to update the estimates of the cost uplift factor, where it is practical to do so.

54. The uplift assumptions for drugs, capital and other expenses are reliant on an inflation assumption. Our methodology uses the latest GDP deflator rate for 2023/24 (3.2%), which was published in November 2022.[9] Our previous forward-looking estimate of inflation was too low, so we are adding the difference to this estimate – an additional 0.8%. This makes the base 2023/24 GDP deflator assumption 4.0%.

55. Total drug uplift is estimated at 1.3% for 2023/24. This is calculated based on an assumption of unit costs for generic drugs changing by the inflation rate. The unit costs for branded medicines are assumed to be fixed, so the expected change is set at zero. These estimates are weighted based on the proportions of generic and branded medicine for Tariff-included drugs, which calculates the final estimate.

56. Total change in the revenue consequences of capital is estimated at 4.0%, using the inflation rate. This estimate of change would be assumed to apply for depreciation and private finance initiative (PFI).

57. Total change in unallocated CNST, which is included in the Tariff but cannot be allocated to HRG subchapters, is estimated at 1.5%. This is based on the change in contribution rates for unallocated CNST as a proportion of the total CNST collection from NHS providers for 2022/23.

58. Total change in other operating costs is estimated at 5.5%, using the inflation rate and an additional uplift of 1.5% to account for additional energy costs. This estimate of change is assumed to apply to a wide range of costs not covered by the above categories.

[9] The GDP deflator is a broad measure of general inflation, estimated by the Office for Budget Responsibility (OBR). Published at www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-november-2022-autumn-statement

5.4 Cost adjustment: 2023/24 efficiency factor

- **We propose to set the NHSPS efficiency factor for 2023/24 at 1.1%.**

About this proposal

59. The cost uplift factor adjusts payments and prices up, reflecting our estimate of inflation. The efficiency factor adjusts them down, reflecting our estimate of the average efficiency providers can be expected to achieve year-on-year. This section describes the proposed efficiency factor for 2023/24. Section 5.5 describes our proposal for setting the efficiency factor for 2024/25.

60. 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.

61. Our estimate of the level of efficiency that is stretching but achievable is based on evidence of the historical efficiency achieved by the sector.

62. Setting the efficiency factor inappropriately can have adverse impacts on providers, commissioners and patients because:

    - setting an efficiency factor too high may challenge the financial position and sustainability of providers. Providers may not be adequately reimbursed for the services they provide, which could affect patients' quality of care.
    - setting an efficiency factor too low may reduce the incentive for providers to achieve cost savings and reduce the volume of services that commissioners can purchase with given budgets, affecting patients' access to services.

63. We are proposing to set the efficiency factor for 2023/24 at 1.1%. This is consistent with the technical efficiency and productivity expectations set out in the NHS Long Term Plan.

64. We propose to update the efficiency factor for 2024/25 using a formula (see Section 5.5).

Why we think this is the right thing to do

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

66. We are proposing to set the 2023/24 efficiency factor at 1.1% as our judgement is that this would be challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure.

67. Our proposal is supported by analysis of the ten-year efficiency trend of NHS acute providers.[10] It is also based on a consideration of other relevant evidence, for example the financial position of the NHS provider sector and external estimates of NHS productivity.[11]

68. Prior to 2022/23, the analysis was based on an econometric model of cost variations between providers over time explained by i) the outputs they produce and ii) factors outside their control. The remaining trend over time is interpreted as trend efficiency. Residual differences between trusts are used to estimate the distribution of efficiency across the sector.[12] The model includes data from 168 acute trusts for the period between 2008/09 and 2017/18.

69. However, the model was not run for 2022/23 or 2023/24. The 2021/22 run of the model suggested that trusts have become 0.9% more efficient each year on average. Around this trend, we continue to judge that there is substantial variation in efficiency that could justify an efficiency factor greater than 0.9% – for example, if organisations with greater efficiency opportunities improved their efficiency at a greater rate.

70. The NHS's overall efficiency requirement for 2023/24 and 2024/25 will be higher than the 1.1% NHSPS efficiency factor. This will be achieved through measures outside of the NHSPS, and allocative efficiency/productivity gains.

---

10 It is still not possible to extend the economic model to other sectors, such as ambulance, community and mental health, due to the availability of data. This will continue to be reviewed in future years with further external evidence considered.

11 Such as published by York, Centre for Health Economics and Office for National Statistics. See, for example: www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity; www.york.ac.uk/che/research/health-policy/efficiency-and-productivity/

12 For a detailed description of the model, see the Deloitte report, Methodology for efficiency factor estimation.

5.5 Cost adjustments: setting factors for 2024/25

- **We propose to use a formula to update the cost uplift and efficiency factors for 2024/25, updating the data used to calculate the factors.**

About this proposal

71. Section 5.3 and 5.4 describe the process used to set the cost uplift and efficiency factors we are proposing for 2023/24. For 2024/25, we are proposing to apply the same process to set the cost adjustment factors, using more recent data.

72. This would mean the cost uplift factor is set based on:

    - The OBR GDP deflator for 2024/25.
    - Changes in CNST contributions (provided by NHS Resolution).
    - Information on the NHS pay award (provided by the Department of Health and Social Care).
    - Other relevant data.
    - Any costs arising from new requirements in the Mandate to NHS England.

73. The efficiency factor would be set based on an assessment of the evidence around catch-up potential and trends in efficiency and financial pressure. In addition, we may consider using more recent data to rerun the econometric model of cost variations between providers over time.

74. Once calculated and published, the updated cost uplift and efficiency factors would be applied to 2024/25 payments on the basis already set out in the NHSPS.

Why we think this is the right thing to do

75. The same process has been used to set the cost uplift and efficiency factors for the National Tariff for a number of years. These processes are also being proposed for the NHSPS cost adjustments for 2023/24. By continuing to use these established approaches, we can ensure consistent and robust cost adjustment factors are set.

76. We are proposing to update the factors for 2024/25 using this formula approach, rather than attempting to estimate them at the same time as the

2023/24 factors as much can change over the course of a year. Using more up to date information to set the factors for 2024/25 should mean that they more accurately reflect the cost pressures and efficiency opportunities for that year.

5.6 Excluded items

- **We propose that certain high cost drugs, devices and listed procedures, and MedTech Funding Mandate products, are excluded from core payment mechanisms. We are proposing to update the lists of these items for 2023/24.**

About this proposal

77. In the National Tariff, several high cost drugs, devices and listed procedures, and listed innovative products (containing items covered by the MedTech Funding Mandate), were excluded from price calculation and reimbursement. Instead, they were reimbursed separately, following local pricing rules set out in the Tariff.

78. For the 2023/25 NHSPS, we propose to introduce an excluded items pricing rule (closely following the local pricing rules in the Tariff) that would continue to exclude these items from core payment mechanisms. However, as was the case in 2022/23, funding for some high cost drugs would be included in the API fixed element (see Section 6.2). The high cost drugs list in Annex DpA includes a field to indicate which drugs would be included in the fixed element.

79. We have reviewed the lists of high cost drugs and devices for 2023/24. This has involved running a nominations process, where stakeholders can submit requests for additions or removals from the lists, as well as horizon scanning to identify new items that might come to market during 2023/24. Nominations can now be submitted for items to be considered for 2024/25, although any changes would require a separate ‘amendment’ consultation before being implemented. Any NICE-approved items that come to market while the 2023/25 NHSPS is in effect would be excluded.

80. There were a relatively high number of nominations submitted for 2023/24, compared with previous years. For the high cost drugs list, there were nominations for 11 items to be added and 5 items to be removed. For the high

cost devices list, there were nominations for 40 items to be added but no items were nominated for removal. There were also nominations for two device categories.

81. The nominations and findings of the horizon scanning were discussed with the NHS England High Cost Drugs Steering Group and High Cost Devices Steering Group, who provided recommendations.

82. Following these meetings, and in line with the advice of the steering groups and Specialised Commissioning, we are proposing to:

    - add 87 drugs to the high cost drugs list; 13 of these are drugs to treat Covid-19
    - add four devices to the high cost devices list.

83. We are also proposing to remove one drug (Bardoxolone Methyl) from the list of items where funding should be included in API fixed elements. It remains on the high cost drugs list but would be excluded from both prices and API fixed elements.

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

85. We are not proposing to make any changes to the innovative products exclusion list, but would change its name to the MedTech Funding Mandate products list. This would continue to comprise the eleven items covered by the MedTech Funding Mandate. With the exception of Spectra Optia, the cost of these products should be excluded from core payment arrangements, with the API fixed element including funding for implementation (see Section 6.2). As Spectra Optia is capital equipment, a separate funding mechanism is being developed via a collaborative approach between the NHS England innovation team, the national specialised commissioning team and the Academic Health Science Networks. See *NHS provider payment mechanisms* for more details of how API should support innovation. There are also resources available from the MedTech Funding Mandate FutureNHS workspace.

86. During 2022/23, there was some confusion about the appropriate reimbursement of drugs delivered via homecare. We are proposing to make the guidance clearer that funding for all drugs delivered via homecare should be included in the API fixed element (see Section 6.2).

Why we think this is the right thing to do

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

88. The nominations form is intended to allow any stakeholders to submit suggested changes to the exclusion lists, providing evidence to support their nomination. This is supplemented by the horizon-scanning work to give as full a picture as possible of items that should be considered for exclusion.

89. We are not proposing to accept all of the nominations for additions to the drugs and devices lists. This was for a range of reasons, including nominations relating to items already covered by categories on the lists (for example, chemotherapy drugs). Others were not recommended for inclusion on the list by the steering groups either because they were not felt to be sufficiently high cost, were unlikely to be approved for use within 2023/24 or would be subject to alternative payment routes.

90. We are proposing the change for Bardoxolone Methyl as NHS England Specialised Commissioning no longer fund it on a block basis, so removing it from API fixed elements would ensure a consistent approach to reimbursement.

91. For the MedTech Funding Mandate list, we worked with the NHS England innovation team to review products against the criteria for inclusion on the list. The items proposed are covered by the MedTech Funding Mandate and would not otherwise be paid for by the NHSPS. As such, we are proposing to make no changes to the list.

92. Annex DpA shows our proposed high cost drugs, devices and listed procedures, and MedTech Funding Mandate products lists for 2023/24. We will consider nominations and horizon scanning information to decide whether to update the list for 2024/25. If we decide that we do want to update the list, the changes would be subject to an amendment consultation.

5.7 Best practice tariffs

- **We propose that achievement of best practice tariff (BPT) criteria would either be reflected by making annual adjustments to API fixed elements or, for BPTs relating to elective services, using activity-based payments.**

About this proposal

93. Since they were first introduced in 2010/11, BPTs have been designed to incentivise quality and cost-effective care. This continues to be the case and in the 2022/23 National Tariff, BPTs formed part of the API variable element, with adjustments made to the fixed element depending on the level of BPT achievement actually delivered, compared to that planned for in setting the fixed element.

94. For 2023/25, we are proposing to change this design, creating two types of BPT – annual BPTs and elective activity BPTs. These categories draw a distinction between BPTs relating to elective services activity and those that apply to other services, with funding agreed as part of the API fixed element. The intention is that BPTs form part of the overall payment approach for the relevant services. This would mean that they are either part of the API fixed element (see Section 6.2) or, for elective activity BPTs, the API variable element (see Section 6.3) or activity-based payment (see Section 187). BPTs would not apply to LVA arrangements.

95. Table 4 summarises the proposed category for each BPT. This is reflected in Annex DpC, which sets out BPT guidance.

Table 4: BPT categories

Best practice tariff name	Annual BPT	Elective activity BPT
Acute stoke care	Y	
Adult renal dialysis	Y	
Adult asthma – aged 19 and over	Y	
Chronic obstructive pulmonary disease	Y	
Diabetic ketoacidosis or hypoglycaemia	Y	
Early inflammatory arthritis	Y	
Emergency laparotomy	Y	
Endoscopy procedures		Y
Fragility hip and femur fracture	Y	
Heart failure	Y	
Major trauma	Y	
Non-ST segment elevation myocardial infarction	Y	
Paediatric diabetes	Y	
Paediatric epilepsy	Y	
Parkinson's disease	Y	
Pleural effusion		Y
Primary hip and knee replacement outcomes		Y
Rapid colorectal diagnostic pathway		Y
Referral of appropriate post-myocardial infarction (STEMI) patients to cardiac rehabilitation	Y	
Spinal surgery*	Y	Y
Transient ischaemic attack	Propose to retire	

**The spinal surgery BPT would operate as an annual BPT for non-elective activity*

96. For annual BPTs, providers and commissioners must consider the provider's share of the agreed system activity plan. Any additional funding for agreeing improved BPT performance must be agreed up front, at the start of the year, and paid as part of the fixed element (see Section 6.2). There would be no in-year adjustments for BPT performance. Providers and commissioners should use prior year performance, as well as any agreed improvement or investment plans, to inform appropriate levels of BPT funding.

97. Elective activity BPTs would be paid using NHSPS unit prices for the relevant BPT where the criteria are achieved.

98. We have also engaged with clinical teams on all existing BPTs to ensure that they remain relevant and clinically appropriate. Following this, we are proposing to make minor changes to the criteria for:

    - Emergency laparotomy – updated with a combined metric that includes risk assessments and increased peri-operative team input to manage an increased number of older people.
    - Paediatric diabetes – minor changes to criteria including requiring quarterly rather than annual audit data submission, removing requirement for local patient experience surveys, adding a criteria around self management technology and adding flexibility to change payments for areas with high deprivation.
    - Rapid colorectal diagnostic pathway – minor changes to the pathway to include a fecal immunochemical test (FIT) and remove the reference to complying with the 18-week wait timescales.

99. We are also proposing to retire the transient ischaemic attack BPT.

100. If implemented, we intend to evaluate the impact of the changes to BPTs to inform future payment and incentive scheme developments.

101. We are also proposing to bring together provider performance against all the metrics in the retained BPT areas (mainly clinical audit data) and publish this. This would add transparency to how providers are performing and be used to help discussions in agreeing fixed payments.

Why we think that this is the right thing to do

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

103. We have received a great deal of feedback that the administrative burden of the variable element design in the 2022/23 National Tariff was disproportionate. This was the most common reason given for requests to vary away from the API design.

104. The proposed BPT design continues to highlight these areas of best practice and provides detailed guidance to support them (see Annex DpC). However, by removing in-year adjustments for annual BPTs, introducing an annual adjustment process as part of planning, the administrative burden should be significantly reduced.

105. In the July engagement workshops, there was support for moving BPTs to an annual process (mean score 6.6/10; median 7/10).

106. We have also undertaken a detailed review of each BPT to ensure it is still relevant. We asked NHS England policy teams to review the 2022/23 criteria for each BPT. Where appropriate, we also discussed the BPTs with national medical directors and other clinical teams. We are proposing to follow the advice received, making changes to the clinical criteria, eliminating some local data requirements where there was deemed to be excessive burden and updating some references and guidance to more up-to-date published positions. The updated guidance is set out in Annex DpC.

107. We are proposing to retire the transient ischaemic attack BPT as the clinical and policy leads advised that it is no longer necessary.

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

6.1 Scope

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

About this proposal

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

109. The 2022/23 National Tariff includes a £30 million API threshold for providers and commissioners in different ICSs. Relationships with an annual value below this threshold were not subject to API. We are proposing to remove this threshold for the 2023/25 NHSPS.

110. This would mean the only NHS provider activity excluded would be:

- where there is an LVA arrangement in place (see Section 7.1)
- the service is a single specialised service individually procured from an NHS provider.

111. Activity outside the scope of API would be subject to either LVA or local payment arrangements (see Section 9.1).

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

Why we think this is the right thing to do

113. We are proposing that almost all secondary healthcare delivered by NHS providers is covered by API arrangements. We believe that using the same payment approach for almost all services and sectors will encourage collaboration and support providers and commissioners to deliver appropriate services for their populations.

114. We propose that API would apply to NHS providers as it would avoid fragmentation of payment approaches and would support system working. Fixed payments are already widely used by NHS providers, for example the block payments used as part of the NHS response to Covid-19. It would be more difficult to use these arrangements for non-NHS providers where open book accounting may not be possible and there may be less variation in casemix.

115. We are proposing to remove the £30 million threshold (below which API does not apply for providers and commissioners in different ICSs) so that NHS providers have a common payment approach.

116. During the July engagement workshops, attendees had mixed views on removing the £30m threshold. The mean feedback score for all attendees was 6.0/10 and the median score was 7. Attendees who identified themselves as commissioners were slightly less supportive (mean 5.8; median 6) than those identified as providers (mean 6.0; median 7).

117. The online survey asked about the preferred approach to the contract value threshold below which API wouldn't apply. 49% of respondents preferred to retain the £30 million threshold, with only 11% of respondents preferring to remove it.

118. There were a number of concerns, in both the workshops and the survey responses, about the potential administrative burden of an increased number of API contracts – particularly for relatively small amounts of money. However, as there are a smaller number of ICBs than CCGs, and the LVA arrangements cover lower value contracts, we do not think that the number would be unreasonable. In addition, the great majority, by value, of contracts would be covered by a relatively small number of API agreements. In addition, CQUIN variable payments would not apply to API arrangements with a value below

£10m (see Section 6.4) and we are also proposing to simplify the arrangements for BPTs (see Section 5.7).

119. There was also a lot of discussion about the proposed £0.5m LVA threshold, and the extent to which the delegation of Specialised Commissioning services to ICBs would increase the number of relationships coming into scope of API. The LVA proposals would mean that the value of delegated services are not included in the calculation of the LVA payment values for core ICB commissioned services and threshold. For more details about proposals for the LVA arrangements, see Section 7.

6.2 Design: fixed element

- **We propose that the API fixed element should be set to fund an agreed level of activity, excluding elective activity.**

About this proposal

120. We propose that providers and commissioners locally agree their API fixed element, which should fund an agreed level of activity. It should be set at a level that is stretching but achievable and aligns with the system plan.

121. The fixed element would be expected to cover funding for:

- an agreed level of acute activity outside the scope of the elective activity variable element discussed in Section 6.3
- maternity, mental health, community and ambulance services
- expected BPT and CQUIN achievement
- chargeable overseas visitors
- CNST contributions
- services and drugs delivered via homecare
- implementation costs of MedTech Funding Mandate products and models of care.

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

123. The supporting document, *NHS provider payment mechanisms*, gives more details of the proposed fixed element. We are also planning to produce worked examples that would be published on our FutureNHS workspace: Payment system and costing support.

124. We are also developing tools to support areas to set their fixed element. These will be available on FutureNHS and include:

- ICB benchmarking dashboard, which allows users to consider cost data at an ICB level, benchmarked with peers
- Costed pathways, which provide a method for costing patient pathway, highlighting variation from clinical best practice guidelines in activity and cost.

125. These tools should be used constructively, supporting systems to identify opportunities for efficiency. Any changes to funding as a result should be linked to identified opportunities and changes to how care is being delivered. Please contact pricing@england.nhs.uk if you have any questions about the tools, or have difficulties in accessing the FutureNHS workspace.

Why we think this is the right thing to do

126. The fixed element would cover the majority of funding under API arrangements for most providers. The fixed element would be set to deliver a level of activity agreed between the provider and commissioner. This would include some services which support elective recovery (such as outpatient follow ups, where the transformation of services and shifts in activities to more appropriate settings may be financially disincentivised under a payment by activity reimbursement system). However, most elective activity would be outside the scope of the fixed payment and be included in the elective variable element (see Section 6.3).

127. We are proposing a fixed element because it should help provide financial stability, helping support longer-term planning and transformation. It should also help systems achieve financial balance.

128. The fixed element is also consistent with the goals for payment system reform set out in the NHS Long Term Plan.

129. We have been developing tools to provide information that might be helpful to calculate fixed elements, in addition to NHSPS prices. We are not mandating the use of these tools, but encourage providers and commissioners to use them to work together to identify opportunities for efficiency and related changes in care delivery.

6.3 Design: variable element – elective activity

- **We propose that providers are paid 100% of NHSPS prices for elective activity.**

About this proposal

130. The large backlog in elective care is a significant issue for the NHS and the patients who rely on it. We want the NHSPS to include an elective funding mechanism which means that providers are paid based on the level of activity they deliver. Additional funding has been made available to commissioners, via the elective recovery fund (ERF) to help tackle the elective backlog. 6.2

131. We propose that providers are paid 100% of NHSPS unit prices for elective activity delivered. This would mean the following:

- Where a provider delivers more than the elective activity target set in their contract, they will continue to receive 100% of NHSPS unit prices for all such activity.
- Where a provider delivers less than the activity target set in their contract, they will only receive 100% of NHSPS unit prices for the activity they have delivered.

132. ‘Elective activity’ would cover:

- elective ordinary and day case
- outpatient procedures with an NHSPS unit price
- outpatient first attendances
- diagnostic imaging and nuclear medicine
- Chemotherapy delivery.

133. ERF funding will also be used to fund outpatient follow-ups, radiotherapy, critical care related to elective procedures and other wider elective pathway

costs, such as pathology. However, the elective variable element would not apply to these services.

134. Where services meet the criteria for an elective activity BPT (see Section 5.7), the BPT unit price should be paid.

135. Non-NHS providers would be paid using the activity-based payment mechanism (see Section 8).

Why we think that this is the right thing to do

136. For 2023/25, we want NHSPS rules for elective activity to ensure that payment arrangements support providers to deliver as much activity as is affordable within the NHS settlement, meeting or going beyond activity targets where appropriate.

137. We considered various options for how best to do this, ranging from an exclusively activity-based payment approach to one with a far larger fixed element linked to 2022/23 levels of activity, with variable funding earned above this level.

138. We have engaged extensively with colleagues from ICBs, providers and government on this proposal, and have heard a range of views. Many ICB representatives were concerned that a fully variable element would make it harder for them to plan, as well as raising concerns about potential affordability. Some providers were also concerned that it might make it more difficult to change delivery models. There were also questions about the impact on elective capacity of factors outside of their control (such as non-elective pressures).

139. However, the approach we are proposing gives providers maximum financial incentive to deliver the elective activity targets they are being set. This was strongly supported by some stakeholders, who felt that it would be one of the most effective levers to drive increased levels of activity. The proposed approach would also ensure that NHS and non-NHS providers are paid at the same rate for the same activity.

140. We are proposing that the variable rate is 100% of NHSPS unit prices to ensure providers have the resources they need to deliver the extra activity. There was considerable feedback from 2022/23 that the 75% variable rate,

covering only variable costs, was not sufficient, as well as some concern that the rate was different for NHS and non-NHS providers.

141. In the July engagement sessions, there was a mixed level of support for changing the variable rate to 100%, with a mean score of 5.9/10. It was slightly more popular among providers (6.0/10) than commissioners (5.6/10). Responses to the online survey were equally split between those who supported or strongly supported a 100% rate and those who opposed or strongly opposed it.

142. During 2022/23, both during our July engagement and at other events, we have heard a large amount of feedback raising concerns about the interaction of the National Tariff's API rules and the ERF. Our proposed approach to elective activity for 2023/25 should ensure that elective recovery funding is more straightforward to operate in-year.

6.4 Design: variable element – CQUIN

- **We propose that, for provider-commissioner relationships with an annual value of £10m or more, the variable element should reduce payments where CQUIN criteria have not been fully achieved.**

About this proposal

143. In setting the API fixed element, providers and commissioners should assume full achievement of CQUIN criteria. We propose that the variable element should then be used to adjust payments if this is not delivered.

144. We are proposing to introduce a £10m threshold, below which there would be no payment adjustments to reflect levels of CQUIN achievement. However, reporting would still be required for all in-scope indicators.

145. The details of the proposed CQUIN indicators for 2023/24 are available from our website. The list of indicators has been revised, with ICB- and NHS England-commissioned services combined into a single list. The combined list contains a smaller number of indicators than previous years. All indicators included on the list are intended to align with the broader objectives being set for the NHS:

- Improving access (in primary and secondary care, including non-acute)

- Achieving Long Term Plan commitments on clinical quality, particularly in areas such as cancer, cardiovascular disease and mental health.
- Ensuring patient safety and improving patient experience.
- Reducing health inequalities.

146. In deciding on the list of indicators, we have tried to make sure the burden is appropriate when balanced against the benefits of the indicator.

Why we think that this is the right thing to do

147. As with BPTs (Section 5.7), the CQUIN variable element is intended to flow money to and from providers where actual performance is different from plan, reinforcing the financial incentive to maintain or improve quality in these priority areas.

148. We have received a great deal of feedback on CQUIN, both during the July engagement workshops and from other events. We have frequently heard concerns about the administrative burden being disproportionate to the benefits of the scheme.

149. Our proposals for 2023/25 aim to address these concerns by having a smaller number of indicators overall. In addition, setting the threshold at £10m greatly reduces the number of contracts eligible for CQUIN while ensuring that the scheme applies to 97% of contract value.

6.5 Design: specialised services

- **We propose that the API rules set specific payment approaches for reimbursement of certain specialised services, departing from the default API model where appropriate.**

About this proposal

150. All activity delivered by NHS providers is in scope of API. This includes specialised services commissioned by NHS England Specialised Commissioning.

151. For many of these services, commissioning is expected to be delegated to ICBs from 2024/25 onwards (although there may be some small piloting

arrangements in 2023/24). While the commissioner may change, the payment rules would continue to apply for 2024/25.

152. Given the specialised nature of these services, it is hard to apply a standard payment approach that provides appropriate incentives and supports optimum ways of working. We are therefore proposing to set API rules specifying different payment approaches for the following services:

- **Radiotherapy** – reimbursement via fixed element only, with variable element not applied.
- **Chemotherapy** – reimbursement on activity basis, using locally agreed prices for activity without a pulsihed NHSPS price
- **Renal transplants, haematopoietic stem cell transplantation (HSCT), Cardiothoracic Transplantation Services, Cardiothoracic Transplantation Services and treatment costs relating to NICE decisions (such as CAR-T)** – locally agreed payment arrangements that have regard to NHS England Specialised Commissioning guidance and detail set out in Annex DpB.
- **Genomic testing** – reimbursement on activity basis, using locally agreed prices.

153. We also propose that funding previously received by providers through specialist top-ups, paid in addition to Tariff prices for specific activities, would be paid to providers as part of their fixed payments, rather than on a variable basis. Unit prices would continue to be slightly reduced (top-sliced) to reflect the amount allocated to specialist top-ups – see Section 10.2.

154. We will also be working on the payment approach for non-elective specialised surgery (such as spinal surgery) where the activity requires broadly similar resources whether elective or non-elective. We will look at how to align reimbursement for these services with the payment approach for elective services.

155. The NHS England Specialised Commissioning team will be producing additional guidance for some specific specialised services which are within the API fixed element. This relates to the management and co-ordination for services which are best managed at a whole provider level, or network of providers, and then risk shared across commissioners accessing the service.

This will predominately relate to services with significant cross-boundary flows where activity is not reported through SUS, for example the specialised prosthetic service. The guidance will also include a co-ordinated approach to critical care services, aligning the commissioning footprint with the Operating Delivery Networks (ODN) footprints and relevant GIRFT recommendations.

Why we think this is the right thing to do

156. By their nature, specialised services are uncommon – and often high cost. It is therefore appropriate that different payment arrangements are applied to these services to make sure that they can operate as effectively as possible. Payment signals also need to be correct to support the ongoing delegation of commissioning these services to ICBs.

157. We are proposing the payment arrangements set out above for the following reasons:

- **Radiotherapy** – the way that radiotherapy is delivered is changing, with patients receiving fewer but longer treatments in a shorter space of time (hypofractionation). Currencies are still based on the old model of care, with prices for a session below the cost of a new session. Therefore we are proposing that radiotherapy funding is included in the fixed element with no variable element.
- **Chemotherapy** – it is desirable for chemotherapy to be part of the elective variable element. However, the current delivery HRGs relate to the chemotherapy regimen used and the regimen list has not been updated for some time, meaning more activity is defaulting to SB17Z (Deliver Chemotherapy for Regimens not on the National List), which does not have a published price. We therefore propose allowing Specialised Commissioning to locally agree the prices to use for the variable element for SB17Z which takes account of the casemix in this HRG.
- **Renal transplants, haematopoietic stem cell transplantation (HSCT), Cardiothoracic Transplantation Services, Cardiothoracic Transplantation Services and treatment costs relating to NICE decisions (such as CAR-T)** – where not highly specialised, these services are only delivered at a small number of centres. Activity is expected to increase significantly. Our proposal is intended to enable the

right incentives to build capacity, support mutual aid and patient choice (as funding will follow the patient) and ensure providers are fully funded for additional activity which will provide long-term system savings (eg from a reduction in renal dialysis).

- **Genomic testing** – In line with the NHS genomics strategy, there is a need to support the continued expansion and development of Genomic Testing Services. Commissioners and providers will need to work in partnership to transition to a funding model which facilitates long-term financial and service planning. The proposed activity-based payment approach should allow this. As this is such a rapidly evolving service, there are no current unit prices to use for a variable payment. An ongoing exercise with Genomic Laboratory Hubs will help to determine indicative prices for use in 2023/24. More information will be sent to participating providers in due course.

158. These changes to the default API payment model should support appropriate reimbursement of specialised services.

6.6 Variations from API design

- **We propose that any variations to the API design set out in the NHSPS would need to be approved by NHS England.**

About this proposal

159. Subject to approval from NHS England, providers and commissioners may vary the payment arrangement on condition that:

- the arrangement is consistent with the payment principles (see Section 36)
- the mechanism allows a provider to earn additional funding for doing more elective activity than planned
- the provider is set a target level of activity that aligns with the overall commissioner target
- both provider and commissioner agree to the variation.

160. Providers may agree differential elective activity targets (above and below the commissioner target) where this supports the agreed system plan, but the overall commissioner target must be maintained.

161. Any proposals to vary the API design would need to be approved by NHS England.

Why we think this is the right thing to do

162. We want to ensure a consistent payment approach is used for all provider/ commissioner relationships. This would be the best way to ensure that payment is consistent with agreed targets and delivers the payment system goals of making the most efficient use of available funding.

163. Where providers and commissioners want to move away from the default API approach, this proposal would ensure that this is done in a way that is consistent with system goals.

7. Payment mechanism: block payment (low volume activity)

7.1 Scope

- **We propose that low volume activity (LVA) arrangements apply for almost all NHS provider/commissioner relationships with an annual value of less than £0.5m.**

About this proposal

164. We propose that almost all NHS provider/commissioner relationships with an annual value below £0.5m will be subject to low volume activity (LVA) block payment arrangements.

165. The only exceptions to this would be:

- services provided by ambulance trusts, including patient transport services
- non-emergency inpatient out-of-area placements into mental health services where these are directly arranged by commissioners
- elective care commissioned by an ICB where there is no contractual relationship to enable the transfer of existing patients under patient choice arrangements.

166. Only NHS providers would be covered by LVA arrangements – we propose that non-NHS providers are out of scope. Where there are small volumes of patient activity being delivered by a non-NHS provider which is geographically distant from the commissioner, the parties may choose to operate under existing Non-Contract Activity (NCA) arrangements, as set out in the NHS Standard Contract Technical Guidance. NCA arrangements may also apply to NHS provider services outside of the scope of LVA (as described in paragraph 165).

167. Where ICBs are taking on delegated NHS England services, the expected value of these service would be added to the initial LVA payment value, covering the services already commissioned by an ICB. However, the LVA threshold would be applied based on the initial LVA payment value only. This could mean that the final LVA value for some provider/commissioner relationships is above the £0.5m threshold (ie LVA for non-specialised services + value of delegated services = >£0.5m).

Why we think this is the right thing to do

168. The purpose of the LVA approach is to reduce the number of transactions for relatively small amounts of money. This has been shown to reduce the administrative burden of processing these transactions.

169. We are proposing that LVA arrangements apply only to NHS providers as non-NHS providers would require a billing relationship with the commissioner. As such, the LVA approach would not be suitable.

170. We are proposing to set the LVA threshold at £0.5m as we feel this strikes an appropriate balance between capturing a large number of transactions and retaining appropriate levels of control.

171. Analysis shows that setting the threshold at £0.5m would mean that around 7,600 relationships would be subject to LVA, with an overall value of £430m (less than 1% of total contract values). Increasing the threshold to £1m makes relatively little change – increasing the number of relationships to around 7,800 and the total value to £590m.

172. During the July engagement workshops, the median score for retaining the LVA threshold at £0.5m was 5 out of 10. Attendees who identified themselves as representing providers were slightly more supportive (median score of 6 out of 10), but commissioners' median score was also 5. However, responses to the online survey were more supportive, with 48% saying that the £0.5m threshold was 'about right', compared with 20% saying it was too low and 6% saying it was too high. The NHS Standard Contract team also received feedback supportive of the £0.5m threshold during their summer engagement.

173. There was some concern – often from representatives of larger acute trusts – that keeping the threshold at £0.5m would lead to a significant increase in

burden if they would then need to negotiate a large number of new API arrangements. This was a particular concern in light of planned delegation of specialised services.

174. To help address this, we are proposing that the value of delegated services do not contribute to the LVA threshold calculation.

7.2 Design

- **We propose that ICBs pay providers nationally set LVA values, calculated based on three-year rolling average data.**

About this proposal

175. We propose that, where the LVA arrangements apply (as described in Section 7.1), ICBs must pay each trust identified on the 2023/24 LVA payments schedule the calculated amount. The LVA payments schedule is published in Annex DpA and identifies those NHS provider/commissioner relationships where, on the basis of historical activity, the value of activity is expected to be below the £0.5m threshold for 2023/24.

176. The proposed 2023/24 LVA payments schedule values have been calculated as follows:

- **Acute services** – three-year average based on SUS activity from 2018/19, 2019/20 and 2021/22, priced using 2022/23 prices with 2023/24 cost adjustments applied. Activity data from 2020/21 has not been used due to the impact of the Covid-19 pandemic on this data.
- **Mental health and community services** – as these services are not included fully within SUS, three-year average finance payment data (from 2017/18, 2018/19 and 2019/20) has been used and increased in line with core ICB allocation growth.

177. ICBs should pay the amount included on the LVA payments schedule to each Trust in quarter one 2023/24.

178. Where LVA applies, no further payments or amounts should be transacted during 2023/24 (note the exceptions in paragraph 165). However, providers and commissioners could choose to agree a contract for the services that could be used in place of the LVA arrangements.

179. For 2024/25, LVA payment schedule values would be updated to reflect the revised cost uplift and efficiency factors (see Section 5.5).

Why we think this is the right thing to do

180. The proposed design for the LVA continues the approach used during 2022/23, with commissioners paying providers a set amount. The LVA approach has been very strongly supported since its introduction, with stakeholders reporting that it has led to a significant reduction in the administrative burden. During the July engagement, the proposal to continue with LVA as part of the NHSPS was strongly supported (mean score 6.8/10, median 8/10).

181. We have calculated these amounts using three years' data to ensure any anomalies do not have a disproportionate effect. However, we have decided not to include 2020/21 in the calculation for acute services, given the significant impact of Covid-19 on the data. For mental health and community services, the data from 2017/18 – 2019/20 is the best available.

182. During engagement, we heard a number of stakeholders raising concerns that not all cost items were captured in SUS, which might lead to inaccuracy in the LVA payments. We will do some further work to investigate how to capture non-SUS information, but feel that SUS data is the best available estimates for 2023/24.

183. The aim of the LVA arrangements is to reduce the transaction burden for relatively small values of activity. The nationally set LVA payment values are part of this. While they will not always be entirely accurate in any given year, as they are set using a three-year average, any discrepancies would be evened out over time. As such, we would not allow variations to the nationally set LVA values as that would risk causing issues for future years' payments. Providers and commissioners can choose to enter into a contract in place of LVA arrangements, but this would be at their own risk.

8. Payment mechanism: activity-based payment

8.1 Scope

- **We propose that activity-based payment is used for all services delivered by non-NHS providers where there is an NHSPS unit price for the activity.**

About this proposal

184. We propose that activity-based payment applies to all services with NHSPS unit prices, when delivered by non-NHS providers.

Why we think this is the right thing to do

185. This proposal would mean that non-NHS providers are paid in a different way to NHS providers (although the API elective variable rate would also pay NHS providers 100% of unit prices – see Section 6.3). Paying non-NHS providers on an activity basis, for services with unit prices, is appropriate as this reflects the contractual arrangements generally used for this activity. It also provides clarity on the prices to be paid nationwide, reducing variation and the need for negotiation. Paying on the basis of unit prices also matches the variable rate which is payable to NHS providers under API agreements, which should help facilitate patient choice, with funding following the patient.

186. We recognise that the cost base and casemix of NHS and non-NHS providers can vary, while NHSPS prices are calculated based on NHS cost and activity data alone (see Section 10.2). However, non-NHS provider primarily deliver elective services so using the same prices as the API elective variable element (described in Section 6.3) is the best approach to aid elective recovery.

187. In addition, non-NHS providers do not have to submit cost data so only NHS provider cost and activity data can be used to set prices. The lack of available cost data would also make it difficult for commissioners to agree fixed elements if non-NHS provider activity were in scope of API.

8.2 Design

- **We propose that unit prices are paid for activity, with market forces factor and best practice tariffs applied.**

About this proposal

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

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

190. Providers would also be paid best practice tariff (BPT) prices for services that meet the criteria for elective activity BPTS, as set out in Annex DpC.

191. Providers and commissioners would be able to agree to vary away from published prices where appropriate. They would need to submit details of the variation to NHS England. Provider and commissioner would be required to consider the NHSPS payment principles when agreeing any variation to the published prices (see Section 36).

Why we think this is the right thing to do

192. The activity-based payment rules would be intended to replicate the payment approach used in the National Tariff Payment System and, before that, Payment by Results. The payment approach is well understood and has been widely used.

193. We propose that MFF values continues to apply whenever NHSPS prices are used. The MFF is a measure of unavoidable cost differences between healthcare providers, and a means of offsetting the financial implications of these cost differences (see Section 10.4).

194. We propose that the NHSPS continues to include BPTs. We are proposing that relevant BPTs form part of the overall payment approach for the relevant services. As such, for activity-based payments, the elective activity BPTs would be paid on an episodic basis, so that they can appropriately incentivise and reward providers for meeting BPT criteria.

9. Payment mechanism: local payment arrangements

9.1 Scope

- **We propose that local payment arrangements are used for any activity not covered by one of the other three payment mechanisms.**

About this proposal

195. Local payment rules would be applied for services delivered by non-NHS providers where a unit price is not published in the NHSPS, and for services delivered by NHS providers that are excluded from API or LVA. Where a guide price is published, this could be used to support local payment arrangements, but there is no requirement to use these prices. Local payment arrangements can be used by any commissioner – both ICBs and NHS England.

Why we think this is the right thing to do

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

197. The rules for API, LVA and activity-based payment would cover almost all activity in scope of the NHSPS. The rules for local payment support providers and commissioners to agree appropriate payment methods.

9.2 Design

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

About this proposal

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

- Providers and commissioners may agree the payment approach but, when doing so, they must:
  - apply the NHSPS payment principles (see Section 36)
  - have regard to the cost uplift and efficiency factors specified in the NHSPS (see Sections 5.3 and 5.4)

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

Why we think this is the right thing to do

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

201. Where providers and commissioners find it hard to agree on a payment approach, asking NHS England regional team to help resolve the issue should ensure that payment is aligned with other financial flows.

202. In the National Tariff, the general local pricing rules stated that activity-based payment (using national or unit prices), should be used if providers and commissioners are not able to agree a payment approach. However, in the NHSPS rules, activity with unit prices would not be subject to local payment arrangements and so this cannot be used as a default. In addition, ICBs and ICS partners should be working collaboratively, so this feels like the appropriate place for an agreement to be made.

10. Prices: role, calculation and related adjustments

10.1 The role of prices

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

About this proposal

203. An important part of the National Tariff Payment System was national prices – these were mandated to be used for payment, unless a local variation or local modification was applied.

204. The National Tariff also included some non-mandatory guide or benchmark prices. These were developed to support local payment arrangements, as a starting point for local price setting. They would be set where appropriate information to set national prices was not available, but we had been told prices would be helpful for local discussions.

205. For 2023/25, prices continue to have an important role in the NHSPS. Under the 2012 Act the NHSPS rules can specify prices. We are proposing to publish two categories of specified price:

    - Unit prices – to be used for API elective variable element and activity-based payment. They can also be used as benchmark information to support API fixed element setting. BPT prices are a type of unit price.
    - Guide prices – to be used as benchmark information and to support local payment arrangements.

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

207. Non-elective prices are classified as guide prices as all non-elective activity would be expected to be covered by API fixed elements. In addition, the change in reporting of same day emergency care that is due to come into

effect from 1 April 2023 may change the casemix of activity that is used to calculate the non-elective prices. As such, the prices may not reflect the costs of care and so are being set as guide, rather than unit prices.

Why we think this is the right thing to do

208. The proposals for the 2023/25 NHSPS would require prices playing a different role in different payment mechanisms. Clearly differentiating between unit prices, which must be used in certain circumstances, and guide prices, which are never mandatory, should help avoid confusion about the status of the prices.

209. The rationale for how the prices would be used as part of the payment mechanisms themselves is discussed in each payment mechanism section.

10.2 Calculating 2023/24 prices

- **We propose that 2023/24 prices are calculated by updating 2022/23 National Tariff prices for inflation and efficiency.**

About this proposal

210. We propose to calculate NHSPS unit prices for 2023/24 by updating 2022/23 National Tariff prices, making adjustments for inflation and efficiency (the cost uplift and efficiency factors).

211. This would mean that the prices continue to be based on 2018/19 cost and activity data. It would also mean that the following aspects of the 2022/23 National Tariff price calculation are rolled over:

- currency specification (see Annex DpB for guidance on certain currencies)
- manual adjustments used for 2022/23 prices
- top-slice for specialist top-ups (see Section 6.5 for details of how the specialist top-ups would be applied)
- adjustments for 2022/23 high cost drugs and devices.

212. We propose to set the prices cost base in the same way as was used for National Tariff prices. The cost base is the level of cost that the NHSPS would allow providers to recover (were prices used), before adjustments are made

for cost uplifts and the efficiency factor is applied. We are proposing to set the prices cost base by equalising it to that which was set in the previous year, adjusted for activity and scope changes (see Annex DpD for details).

213. The 2022/23 National Tariff prices were initially calculated with a 2.8% cost uplift factor and 1.1% efficiency factor. However, during 2022/23, there were a number of changes to the cost uplift factor to reflect:

- Inflation (May 2022 – cost uplift factor, 3.5%; efficiency factor, 1.1%)
- Pay award (September 2022 – cost uplift factor, 5.2%; efficiency factor 1.1%)
- Reduction in national insurance contributions (November 2022 – cost uplift factor, 4.7%; efficiency factor 1.1%)

214. A revised set of prices was published to reflect each of these cost uplift factor. The proposed prices for 2023/24 are based on updating the November 2022 prices.

215. The proposed 2023/24 prices would be calculated using largely the same method as previous National Tariff prices. This is described in detail in Annex DpD. In summary, this would involve the following steps:

- Setting draft price relativities – for 2023/24, this would be the 2022/23 National Tariff prices published in November 2022.
- Making manual adjustments to the price relativities – we are proposing manual adjustments for cataract surgery and termination of pregnancy prices and to adjust for some high cost drugs and devices (see Section 10.3)
- Scaling prices to the cost base
- Adjusting prices for inflation and efficiency (see Sections 5.3 and 5.4).

216. Prices for 2024/25 would be set using the updated cost uplift and efficiency factors, calculated by applying the formula set out in Section 5.5.

Why we think this is the right thing to do

217. The prices published for the 2022/23 National Tariff were calculated using 2018/19 cost and activity data – patient-level costs (PLICS) and hospital episode statistics (HES).

218. During the July engagement, there was generally strong support for setting prices by rolling over 2022/23 price relativities. Some stakeholders raised concerns that the source data (2018/19) may not reflect current clinical practice. There were also concerns about the accuracy of the PLICS data, as 2018/19 was the first mandated PLICS collection.

219. We considered trying to use more recent data to calculate a new set of prices. However, both the 2019/20 and 2020/21 data has been affected by Covid-19. This has meant that the unit cost data is atypical as counts of activity are low but many of the costs of delivering activity have still been incurred, meaning unit costs are very high. If prices were set on this basis, it is likely they would not reflect the costs of delivering services in 2023/24.

220. Rolling over the 2022/23 price relativities requires the rolling over of the currency design used for the prices. It also means that manual adjustments and other price changes, such as the top-slice of prices for specialist top-ups, continue to be applied.

10.3 Changes to price relativities

- **We propose to make manual adjustments to price relativities in the following areas: cataract surgery, termination of pregnancy services, adjustments for high cost drugs and devices.**

About this proposal

221. As set out in Section 10.2, the proposed prices for 2023/24 would be calculated using 2022/23 prices as initial price relativities. However, we are proposing to make changes to the following price relativities for 2023/24:

- BZ34* (cataract surgery prices) – We propose equalising the price of BZ34A and BZ34B and creating a £150 differential between these and BZ34C. In 2022/23 prices, we moved additional money into the BZ34* prices (following clinical advice). For 2023/24, we are proposing to remove this additional money, adding it back to the rest of the BZ chapter prices.
- MA5* (termination of pregnancy prices) – We propose splitting the daycase/elective/outpatient procedure prices and those for non-elective activity.

- DZ66Z (Respiratory system) – We propose adjusting the day case and elective price to remove the endobronchial valve from the scope of the HRG. This reflects the move of the device onto the high cost devices list. This will cover the cost of the procedure plus MDT within the scope of DZ66Z elective and day case patient. There is no adjustment for non-elective activity.
- Somatropin was removed from the high cost drugs list in 2022/23, with £300,000 put back into prices as a result. However, the vast majority of spend on somatropin is as a drug delivered via homecare, which was not reflected in this figure. Funding for all drugs delivered via homecare should be included within API fixed elements (see Section 6.2). As such, rather than increase the amount put into prices, we propose to remove the £300,000, very slightly reducing all prices.

222. Changing the price relativities would not affect the overall amount of money allocated to each HRG chapter. Making the changes described above would mean other prices in the chapter would slightly change to compensate.

223. Annex DpA shows the proposed prices. Annex DpD gives more detail of the proposed calculation method and the cash in/cash out approach used to make the adjustments described here. During this consultation we will be undertaking further clinical engagement on the proposed changes to price relativities and will consider any feedback received along with consultation responses.

Why we think this is the right thing to do

224. We are proposing to make these manual adjustments to address specific issues that have been identified.

225. We are proposing to change the cataract surgery prices following analysis which suggests that a much larger proportion of cataract activity is grouping to the BZ34A HRG than can be readily explained by changes in patient complexity. Equalising the price of BZ34B and BZ34A should ensure there is fair and affordable reimbursement of this activity.

226. We are proposing to change the termination of pregnancy prices following feedback that the prices do not accurately reflect costs, meaning that the majority of providers and commissioners are choosing to vary away from

them. Splitting the prices so there are separate daycase/elective and non-elective prices should allow providers and commissioners to use prices that more closely match the costs of the activity delivered. In Annex DpB, we have included more information on termination of pregnancy, including how prices could be used and related reporting for these services.

227. We are proposing the changes for DZ66Z and somatropin to address errors identified in the 2022/23 prices following changes to the high cost drugs and devices lists. We are also proposing to strengthen the guidance to make clear that the API fixed element should include funding for drugs delivered via homecare that are excluded from the high cost drugs list in Annex DpA.

10.4 Market forces factor

- **We propose that the market forces factor (MFF) continues to be applied to prices. We propose to update the data used to set MFF values.**

About this proposal

228. The market forces factor (MFF) is a measure of unavoidable cost differences between healthcare providers, and a means of offsetting the financial implications of these cost differences. Each NHS provider is assigned an individual MFF value. This is used to adjust commissioner allocations and was a national variation within the National Tariff – this meant that the MFF was applied wherever prices were used (so the total amount paid was price x MFF value).

229. We are proposing that the MFF continues to be used as part of the NHSPS – this means that the NHSPS rules would provide that wherever prices are used (whether API variable element or activity-based payment) they should be varied by the MFF value applicable to the provider in question. Providers and commissioners should also consider changes in MFF values when agreeing the API fixed elements as any cost information used may reflect out-of-date MFF figures.

230. The MFF was comprehensively reviewed and updated in 2019/20. This led to significant changes to MFF values, which were proposed to be phased in using a five-step glidepath to ensure that the impact on revenue and

allocations did not cause unacceptable volatility. The 2022/23 National Tariff moved to the fourth step of this glidepath.

231. For 2023/24, rather than moving to the fifth step of the glidepath, we are proposing to update the data used to calculate MFF values. The 2019/20 MFF update was based on data from 2014-17. Our proposed update would instead use data from 2017-20.

232. The same MFF values would be used for 2024/25, unless we consulted on revised values.

233. This update would mean all NHS providers received new MFF values. The proposed values are published in Annex DpA. For more information, see *A guide to the market forces factor*.

Why we think this is the right thing to do

234. The scale of the changes following the 2019/20 MFF update required the introduction of the five-step glidepath. Following the update, we undertook to review the MFF more frequently to ensure that such a significant change was not needed in the future. As such, for each year since 2019/20, we have analysed the potential impact of moving to the next step of the glidepath to ensure it would be reflective of the unavoidable costs faced by providers. For 2023/24, this analysis suggested that the projected values for the fifth step of the glidepath would not be reflective of these costs.

235. We considered whether it would be appropriate to respond to this by either not making any changes to MFF values (keeping them on the fourth step of the glidepath, as in 2022/23) or updating the data used to calculate them.

236. The main reason that the 2019/20 MFF update caused such a significant change in values was that the source data was around 10 years' old. By 2023/24, the underlying data for the current MFF values would be an average of eight years' old. The cumulative effect of not updating the data may mean larger revisions are necessary in the future, similar to the 2019/20 MFF update.

237. During the July engagement workshops, we asked for views on whether it would be preferable to update the data or to make no changes to MFF values. There was very strong support for updating the data – with 71% of those who

responded preferring this option and only 26% preferring to leave the values unchanged.

238. We are proposing to leave the MFF values unchanged for 2024/25 as more recent data will be affected by Covid-19 and may not be appropriate to use to update MFF. However, during 2023/24, we will consider if updating MFF values would be the right thing to do and could use an amendment consultation to propose changes if necessary.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of alternative formats on request.