Introduction to the NHS Payment scheme

A briefing for finance staff not directly involved in contracting and commissioning services, or who have recently moved into the field. It may also be of interest to non-finance staff.

14 February 2024

Purpose of this briefing

The NHS in England is primarily funded by public monies via allocations from the government to the Department of Health and Social Care (DHSC) based on the outcomes of the three yearly parliamentary spending review. Funding is allocated to NHS England, most of which is passed to integrated care boards (ICBs) which commission services from NHS and non-NHS providers of healthcare for their populations. In addition, some services are directly commissioned by NHS England. This briefing focuses on the commissioning of secondary and tertiary healthcare from NHS providers by ICBs and NHS England, which is currently governed by the terms set out in the NHS England payment scheme[1] and the NHS standard contract [2].
While outside of scope for this briefing it should be noted that non-NHS providers of healthcare are also governed by the NHSPS and standard contract, but with a degree of flexibility depending on the services being provided and the overall contract value.
The briefing is aimed at finance staff in all sectors who may not be directly involved in the contracting and commissioning of services, or who have recently moved into roles in this field. It may also be of interest to non-finance staff supporting the strategic design of services and pathways in their organisations and wider integrated care systems (ICSs).
We have included a section towards the end of the document highlighting other sources of information that are available on this topic, including further details of the overall process of allocating funds through the layers of the public sector structure.

A brief history

The split between organisations purchasing and providing healthcare was first introduced in the NHS in the early 1990s as part of the National Health Service and Community Care Act 1990[3]. The act formally introduced an internal market in the NHS, coinciding with the introduction of NHS trusts and GP fundholding. Since that time there have been multiple versions of the purchaser/provider split and corresponding methods of allocating funds to pay for healthcare services.

Payment by results

The most well-known and well-established of these was the activity-based payment model called Payment by Results (PbR) which was first introduced in 2003/04 and applied to secondary healthcare, predominantly for acute services. Between 2003 and 2020 this was the system for reimbursing healthcare providers in England for the costs of providing treatment, based on the use of a national tariff payment system that linked a preset price to a defined measure of output or activity. PbR was designed to give greater accuracy in the recovery of cost; to enable incentives for capacity to be more achievable as payment followed the activity; to reduce waiting lists; and to facilitate patient choice. The PbR model was enacted via a set of prices and rules set out in annual national tariff payment system documentation[4].

Blended payment

The NHS long term plan[5], launched in January 2019, signified a commitment to transform the way that services are delivered as medicine advances, health needs change and society develops. The plan recognised the need to focus on population health management and reducing health inequalities for long term sustainability, and that this would require increased collaboration and cross system working. It was also acknowledged that organisational structures and funding regimes would need to evolve to meet these changing ways of working.

The first steps towards this were taken in 2019/20 with the introduction of blended payment arrangements for acute emergency care and adult mental health services. In essence, these allowed commissioners and providers flexibility to agree the fixed and variable element of contracts, with the variable element being agreed based on outcomes, risk share and/or activity levels as appropriate to local circumstances. The aim was to develop payment arrangements that were sufficiently flexible to address system wide population health aims.

By 2020, with the agreement of NHS England, some commissioners and providers were also planning to introduce blended arrangements in other services, deviating further from the PbR approach.

Aligned payment and incentive

Following a suspension of normal contracting arrangements in 2020/21 and 2021/22 (see box), the 2022/23 national tariff payment system formally introduced the aligned payment and incentive approach (a form of blended payment).

Response to the Covid-19 pandemic

In March 2020, NHS England suspended normal contracting arrangements, putting in place a temporary financial regime which immediately moved all providers to payments based on block contracts and funding of actual expenditure incurred. This reduced administrative burden and enabled focus on core clinical activities. Special finance and contracting arrangements remained in force throughout 2020/21 and 2021/22. Further details of Covid-19 arrangements can be found on the NHS England website (see March 2020 Covid-19 finance guidance and Guidance on finance and contracting arrangements for H1 2021/22 for example)

From April 2023 the national tariff payment system was replaced by the NHSPS which builds on the evolution described above and will continue to evolve to meet the changing demands on services, to support ongoing financial sustainability across the NHS and to retain alignment with greater collaboration and system working.

The remaining sections of this briefing provide an overview of the principles of the NHSPS and sets out some of the current core conditions.

Overview of the NHS payment scheme

As with the previous payment systems outlined above, under NHSPS arrangements a contract for a specified range of healthcare services is agreed between each provider and commissioning organisation. This includes contract values, service specifications, performance measures and activity levels. The contract is expected to be based on the NHS standard contract with contract values set in accordance with the NHSPS rules where they are in scope.
There may be local variations to the contract structure or the payment model, but these must be agreed with NHS England on a case-by-case basis.

Scope

The NHSPS applies mainly to secondary and tertiary service provision, which is the care provided in or directly related to hospital services, including community services, and relates to both physical and mental health. Tertiary services refer to provision of highly specialised treatment that is usually only available in a limited number of healthcare settings.
Most service provision is commissioned locally by ICBs. This includes general medical and surgical services, maternity, emergency care, intensive care, mental health care and community services. ICBs will also commission some specialist services from their local provider organisations, including children's general medical care, children's community and outpatient mental health, and adult cancer services. ICB commissioning covers most of the care in the NHS. A limited number of services are nationally commissioned by NHS England[6], including services deemed to be specialised or highly specialised.
Not all commissioning of services is within the scope of the NHSPS, for example primary care. Separate payment rules apply to the areas outside the scope of the NHSPS. A full list of services not in scope is outlined in section 2 of the NHSPS guidance and summarised in Appendix A.

Contract values

Before the start of each financial year, providers and commissioners will agree an expected contract value. There will be one contract value agreed for each provider/commissioner relationship. Providers will have agreements with multiple commissioners and conversely commissioners will contract with many providers.
The activity values will be the relevant currencies for the services provided[7], and these will determine the prices to be used for financial value calculations. For example, the acute contract uses healthcare resource groups (HRG) as currencies of the planned and actual activity levels; mental health uses attendances and inpatient bed days, and ambulance services use incidents and patient journeys.

Coding activity to healthcare resource groups (HRG)
In acute services, following most patient episodes, trained clinical coders review the clinical notes and apply unique and precise codes to the aspects of patient care. World Health Organisation International Classification of Disease version 10 (ICD10) codes are used to classify diseases and other health conditions, with NHS England defined The Office of Population Censuses and Surveys - Classification of Surgical Operations and Procedures (OPCS) codes to classify interventions and procedures. An algorithm takes the clinical coded information and assigns the patient episode to an HRG. HRGs are designed to group patient diagnosis and procedures where they are deemed to be similar in resource consumption.

Payment mechanisms

To take into account the different provider/commissioner relationships, based on service provision and expected levels of activity, the NHSPS contains four different payment mechanisms which can be used depending on circumstances.
The most common mechanism is aligned payment and incentives (API) but there are also mechanisms to allow for low volume activity (LVA) block contracts, activity-based payments or local agreement. Payment mechanisms are described in more detail later in the next section.

Use of national and local pricing

Regardless of the payment mechanism used, expected contract values need to be agreed at the start of a contracting period, usually the start of the financial year. Recalculation of the actual value will be required throughout the year where applicable, for example, for the variable element of API, for any activity-based payments and potentially for some local agreements.
NHS England's technical documents[8] provide the steps to calculate contract values, enabling consistency and equity between contracts. In calculating and agreeing the fixed and variable elements of the contract, providers need to be mindful of meeting the conditions of service set out in their contracts.
National unit (mandatory) and guide (non-mandatory) prices are supplied for use in financial calculations for the contract, although some flexibility is allowed where local factors provide more appropriate values. Unit and guide prices are based on historic national average costs adjusted for many factors, including inflation and efficiency. The contract may also have local incentives for quality improvement or capacity changes.

Contract cycles

Most provider/commissioner contracts are annually agreed, but there may be longer time periods built into the contract for planning purposes.

The NHSPS is currently published on a two-year cycle, with only minor updates in the second year of the cycle. The current mandate NHSPS covers the two-year cycle for 2023/24 and 2024/25.

For each change to the NHSPS, NHS England holds a statutory engagement process, followed by a formal consultation with stakeholders. For example, in mid-cycle 2023/25, NHS England worked with stakeholders at engagement sessions (July 2023) and held a consultation (December 2023 to January 2024) about the changes proposed for the 2024/25 financial year.

Payment mechanisms and rules

Aligned payment and incentives (API)

API is the payment mechanism applicable to most NHS contracts for patient care. It is a blended payment, made up of variable and fixed elements.

- The variable element funds elective (planned) care, outpatient procedures, outpatient first attendances, chemotherapy, and some diagnostic imaging. There will be expected levels of activity set to aid planning, but the contract is activity-based. The provider receives funding for the actual level of activity delivered[9] Prices are mandated, called unit prices.
- The fixed element is a stable, pre-agreed value for the expected annual level of activity in all services outside of the scope of the variable element. This includes emergency care (non-elective inpatients and emergency departments) to ensure the payment mechanism does not deter the consistency of service provision. Prices can be the national guide price or a local price.

Other payment mechanisms

- If the relationship between commissioner and provider has an expected contract value below £0.5m there is an option to contract using a low volume activity payment mechanism. This allows contracts to be agreed in block form even if some activity falls into the variable criteria for API. The aim is to avoid excessive contract monitoring bureaucracy.
- Activity-based payments are predominantly used for contracts between commissioners and non-NHS providers but can also be used where services are subcontracted by one NHS provider to a separate NHS provider.
- Finally, contract values for activity not covered by any of the other payment mechanisms are determined by local agreement. For example, services outside acute hospitals may use block contracts, especially if electronic information is not available to fulfil the API variable pricing criteria. This is the case of community services where there is not a full electronic patient record and limited currencies, so it is not possible to easily calculate the impact of variation in activity levels.

Other payment scheme considerations

The NHSPS has many separate elements to reflect the complexity of healthcare service provision. This complexity is covered in the documentation and technical guidance, including the annexes and other supporting files. For example, the following areas have separate payment rules.

- Quality incentives can be built into contracts, generating higher payments for achievement of targets. One of these is Commissioning for Quality and Innovation (CQUIN), which is built into the fixed element of an API contract, assuming full achievement. This is under review. Local quality incentives may be within contracts as part of either fixed or variable elements.
- Best practice tariffs cover 18 HRGs or sub-HRGs, incentivising achievement of national quality standards. In these areas, the best practice tariff is paid where specific criteria is met and is set at a level to include the additional cost associated with achieving that criteria. To incentivise providers to meet these criteria, the standard national tariff is set lower than the cost of the treatment. An example of a best practice tariff is one that incentivises the recording of outcome measures in primary hip replacement surgery.
- Advice and guidance services are where a provider's consultant gives information to other clinicians without any direct clinical intervention. For example, hospital pharmacy advice and guidance may provide specialist medication reviews for GP surgeries. The contract value is fixed for a planned level of activity, although this can be adjusted if the use of the service is higher or lower than expected.
- Market Forces Factor (MFF) is applied to national prices to uplift them for the cost of living in the provider's local area. The MFF is a multiplier adjustment to national guide or unit prices for the local cost of living, ensuring local reimbursement is appropriate for the local costs. For example, London has a much higher cost of living than Cornwall and the MFF reflects this. The MFF is not applied to local prices if they are built from local cost, as this already includes the local cost of living.
- Specified high cost drugs, devices, innovation products and innovative procedures have special reimbursement rules, these are often based on actual cost and referred to as pass through costs.

Other factors related to the NHSPS

Commissioning for specialised services

Specialised services[10] are those that support people with a range of rare and complex conditions. This often involves treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions, often involving treatments that are cutting-edge and innovative. Specialised services are not available in all areas so patients may need to travel to a tertiary care centre.

The prescribed specialised services (PSS) tools[11] sets out the list of services that are classified as specialised or highly specialised by NHS England. The list is updated

annually.
Whether a particular patient event falls within these definitions will be based on the clinical coding of the patient's health condition(s) and the care provided, using the PSS identification rules tool.
At time of writing all PSS activity is commissioned nationally by NHS England using national prices. The commissioning is within the scope of the NHSPS. The centralised commissioning is designed:

- to establish service specifications, policies and reimbursement schemes based on clinical best practice
- to ensure that complex decisions about new treatments are supported by evidence of safety and effectiveness
- to enable clinicians to be included in discussions of clinical priorities, likely relative clinical benefit and relative cost funding whilst still facilitating innovation
- to enable consistency of access to these services across the country.

The commissioning of some specialised services will be delegated to ICBs over the next few years to support the move to system collaboration and enable local pathway decision making. For example, adult cardiac services, cancer services, and many children's services which were previously commissioned by NHS England will move to ICB commissioning. The roadmap for transfer of commissioning responsibility gives a plan for several years starting in April 2023, ensuring that knowledge is built into the local commissioners. However, these services will still be regarded as specialist and will be subject to national reporting and service monitoring.
Some services will remain commissioned by the NHS England specialised commissioning team including burns care, transplantation services and veterans' complex mental health services.

Elective recovery fund (ERF)

During the Covid-19 pandemic, a considerable amount of elective activity was cancelled to facilitate the emergency care needed. Progress to restore pre-pandemic activity levels has been slow, and the ERF was established with the aim of redressing the balance between emergency and planned care and supporting improved waiting list times for patients. The ERF is not part of the NHSPS but is a temporary incentive payment to enable providers to return to higher levels of activity. The use of the ERF has slowed the adoption of the full API model. However, it has proved integral to overcoming the operational challenges in some organisations.
While the ERF is in place target levels of activity are set as part of the fixed element in the API contract, using national prices. Targets are set by NHS England individually for each provider based on their variance from pre-pandemic levels of activity.
The calculation of the ERF value has proven complex, as has the ability of providers to achieve the required levels of activity, but the fund and associated targets are expected to continue at least for 2024/25.

Payment scheduling

Providers need stability of funds to pay for the cost of delivering their services, for example, salaries. So the annual expected contract value is divided into 12 monthly payments and cash is transferred monthly to them. This mechanism is straightforward for any block-based agreements, including the fixed element of API contracts, as the agreed value is the final value.

For any variable contract elements, the funds transferred at the end of the month usually represent the planned value. There will then be an adjustment payment made a month later when the clinical coding[12] information is finalised. There is a national timetable of freeze dates after which no further adjustments can be made. Activity that is not coded, or is incorrectly coded at a freeze date, risks not being included in payment calculations.

For example, based on a provider delivering acute hospital care under an API based contract, payment related to January service provision is likely to be as follows:

- an initial payment based on one twelfth of the contract value, paid at the start of January for cash flow purposes
- there may then be an adjustment payment made at the start of February, based on initial clinical coding information
- when the clinical coding is finalised during February, and at the freeze date early in March, the activity recorded will be used to make any adjustments for January's final data.

Other sources of information

This briefing is a short overview of payment systems for secondary and tertiary care for NHS commissioners and providers. Listed below are additional resource providing more detail, and information about other types of payment systems for UK healthcare.

HFMA:

- *Introductory guide to NHS finance chapter 19 – How providers of NHS services are paid updated* November 2023.
- *HFMA introductory guide to NHS finance*, updated July 2023

NHS England Pricing Team:

- *2023/25 National payment scheme*, March 2023
- *2022/23 National tariff payment system*, March 2022
- *2023/25 NHS Payment Scheme - A guide to the market forces factor*, March 2021
- *Elective recovery fund technical guidance*, January 2023
- FutureNHS workspace *Payment system support*

One NHS Finance

- *NHS Payment Systems and Contracts*, 2021
- Finance Innovation Forum, *Innovation 12 - Service Level Agreement Monitoring efficiency*, April 2022.

NHS England other:

- One NHS Finance, *NHS-funding 101 – a bird's eye view of how the NHS spends money* March 2023
- NHS England Standard Contract team, *NHS standard contract*, March 2023
- FutureNHS workspace, *NHS Standard Contract*
- NHS England and NHS Arden & GEM CSU, *increasing capacity framework*, November 2023
- NHS England Accelerated Access Collaborative, *MedTech Funding Mandate and MedTech Support,* August 2023
- FutureNHS workspace, *The MedTech Funding Mandate*
- NHS England Specialised Services, *National Programmes of Care and Clinical Reference Groups*, November 2023
- NHS England Specialised Services, *NHS England commissioning functions for delegation to Integrated Care Systems*, June 2022
- FutureNHS workspaces – search *Specialised Services* or *Specialised Commissioning* from the Future NHS home page.

Appendix A: Items outside the scope of NHSPS

Item	Example
Public health	Facts, resources and information on major public health issues
Primary care	GP surgeries
Personal health budgets	Allocations of NHS resources that individuals can use to meet their health and wellbeing goals in ways that do not rely on commissioned agreements.
Integrated health and social care providers	Mental health and social care services that were joint funded prior to the Health and Social Care Act 2022. Sometimes called pooled budgets.
Contractual incentives and sanctions	Local incentive payments
Providers within the UK devolved administrations	Welsh local health boards
Overseas patients	Patients not permanently resident in the UK, self-funding their care, or where funding is from their home country's government in a reciprocal agreement.
Private patients	Patients self-funding their treatment outside of NHS commissioned services, or where their funding is from private healthcare insurance.

Footnotes

1 NHS England, NHS payment scheme

2 NHS England, NHS standard contract

3 K Government, National Health Service and Community Care Act, June 1990

4 NHS England, National tariff payment system

5 NHS England, NHS long term plan, January 2019

6 NHS England, Specialised services

7 NHS England, NHSPS Annex B Guidance on currencies 2023/25

8 NHS England, 2023-25 NHS Payment Scheme

9 Note that at the time of writing there are special arrangements are in place to associated with elective recovery fund arrangements which are designed to address the Covid-19 elective activity backlog.

10 NHS England, Specialised services

11 NHS Digital, Prescribed specialised services tools

12 Not all care is clinically coded. Acute outpatient services are not mandated to be clinically coded and community and mental health services have different methods of recording the care given.

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance.

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