Response ID ANON-BM6B-HCQM-G

Submitted to 2026/27 NHS Payment Scheme consultation
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Introduction

What is your name?

Name:
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What is your email address?

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Are you responding as an individual or on behalf of your organisation?

Organisation

If responding on behalf of your organisation, please tick here if you are the authorised responder:
Yes

About your organisation

Organisation name:
FODO - The Association for Eye Care Providers and NCHA - The Association for Primary Care Audiology Providers

Organisation type:
Representative body

Responding on behalf of multiple organisations

Yes

If yes, how many organisations are you responding for?:
2

If yes, please list the organisations (and codes if known), separated by commas:

FODO - The Association for Eye Care Providers, NCHA - The Association for Primary Care Audiology Providers

Accepting or rejecting the proposed NHS Payment Scheme

Do you accept or reject the proposed 2026/27 NHS Payment Scheme?

Reject

Please explain the reasons for your answer, particularly if you have chosen to reject the proposals:

While we are not an NHS Trust/ICB (authorised responder), we would reject the 2026/27 NHSPS because, in our view, some proposals are inconsistent with NHSPS payment principles (please see our response to specific consultation questions).

If they were implemented, what impact do you feel the policies outlined are likely to have on equality and addressing health inequalities?

Negative impact

Do you have concerns that there are distinct groups with protected characteristics that our policies may impact negatively?:
Yes, older people and people with disabilities.

Please explain the reasons for your answers:

We are concerned that NHSPS proposals risk further distorting pricing signals and that this will have an adverse impact on resource allocation and those in greatest need of healthcare. In addition, because of the ongoing NHSPS bias towards hospital models of care, we are concerned that people with long-term conditions are more likely to be negatively impacted by the delay in tackling block contracts and shifting care out of hospital. Therefore, it is highly probable that older people and people with disabilities will be negatively impacted by current proposals.

Proposals applying to all payment mechanisms

To what extent do you support the proposed one-year NHSPS?

Tend to support

Please explain the reasons for your answer:

Logical, given plans to recalculate prices and review the NHSPS so that it is better able to deliver goals in the 10 Year Health Plan (paragraph 22 Part A, policy proposals).

To what extent do you support the proposed payment principles?

Strongly support

Please explain the reasons for your answer:

We support these longstanding payment principles. It is less clear how certain proposals in this consultation meet these principles given the bias towards the hospital model of care and other workarounds - e.g. the 2026/27 NHSPS fails to promote transparency and good data quality to improve accountability, risks worsening health inequalities and will slow down delivering on the NHS planning framework.

To what extent do you support the proposed 2026/27 cost uplift factor?

Tend to oppose

Please explain the reasons for your answer:

It is difficult, if not impossible, to justify on any economic basis how healthcare inflation lags all official measures of inflation. This indicates that CUF has simply become an arbitrary figure, adjusted to control total costs on paper. This is not a harmless act as it distorts pricing signals and will ultimately result in suboptimal resource allocation.

While CUF underestimates healthcare inflation, other proposals in this consultation mean
- many NHS hospitals are on APIs/effective block contracts and will see total income increase independently of activity delivered
- non-hospital providers will only be paid for activity and suffer real terms cuts to funding while also having IAPs imposed because NHS funding is exhausted by inefficient resource allocation into the hospital models of care.
These workarounds are unlikely to meet NHSPS payment principles. More importantly, the hospital bias is so ingrained in the NHSPS that it will make it increasingly difficult for the government to deliver the 10 Year Health Plan and medium-term planning framework goals.

That is why we welcome confirmation that NHSPS will be reviewed to help deliver the 10 Year Health Plan. We would ask that the NHS pricing team actively engages with non-acute hospitals so genuine innovation that is evidenced to save money – e.g. payments for pathways of accountable care for long-term conditions – can be implemented nationally. We would be pleased to support such work and provide evidence on savings and set out how this aligns with goals in the 10 Year Health Plan.

To what extent do you support the proposed 2026/27 efficiency factor?

Tend to oppose

Please explain the reasons for your answer:

We acknowledge that the efficiency factor is based on the Spending Review 2025 (SR25) settlement and therefore we do not dispute the need for the NHS to find a 2% efficiency saving.

We however oppose setting the efficiency factor globally as this could cause avoidable harm – e.g. imposing a 2% efficiency saving on an underfunded service could cause direct harm to patients through comprised quality of care, whereas only imposing a 2% efficiency saving on an overfunded service could cause indirect harm through inefficient resource allocation.

The SR25, in our view, was meant to incentivise the NHS to ensure it rolled out best practice, not to implement top-down policies that could harm best practice. For example,
- the NHS's own evidence shows that it costs 20-25% less to deliver adult hearing care out of hospital, and in doing so the NHS can improve choice, transparency and accountability; and see more patients with the same spend
- yet many commissioners have failed to take advantage of this, instead choosing to constrain out of hospital hearing care services through real terms cuts to funding per patient, while continuing to pay hospitals more to meet the same need with less transparent/accountable pathways
- ideally, the SR25 settlement would instead have seen NHS England push through national reforms of the adult hearing service to release £100ms per cohort treated by shifting care from hospital to community.
The approach in the NHSPS therefore risks further distorting resource allocation, and in doing so it is more likely that older people and those with a hearing disability will end up disadvantaged. We would be happy to share more information with the NHSPS team if this would be helpful.

To what extent do you support the proposed approach to excluded items?

Neither support or oppose

Please explain the reasons for your answer:

NA

To what extent do you support the proposed approach to best practice tariffs (BPTs)?

Tend to support

Please explain the reasons for your answer:

We would welcome a discussion with the NHS pricing team on the potential for new BPTs for pathways of care for long-term conditions that will help deliver the 10 Year Health Plan – e.g. for conditions such as adult hearing loss and glaucoma which impact millions of adults in England and could see millions of visits per year shift from hospital to the community.

To what extent do you support the proposal to introduce payments for patient-not-present activity that results in a referral-to-treatment (RTT) clock stop?

Tend to oppose

Please explain the reasons for your answer:

We welcome the goal of avoiding double-payment (paragraph 104) but have selected 'tend to oppose' because of the lack of detail provided in the consultation document.

It would be helpful to clarify the underlying planning assumptions e.g.
- while this activity does not currently have a distinct price, it might already be costed and funded indirectly
- historically cost data should have captured department costs/overheads, and the cost of this sort of activity would be allocated to a HRG code and therefore paid indirectly via tariffs derived from average reference costs
- while NHS Trusts have shifted to APIs/blocks, this activity might still be funded via cost allocation methods that make up the fixed/variable elements with the API mechanism.
While £33 per episode might be trivial in a hospital setting, it is funding that could otherwise be spent in the community as part of delivering the 10 Year Health Plan. We are therefore keen to avoid a situation in which yet more activity and NHS budget is locked into hospital models of care, especially if there is a risk of double counting costs.

It would be helpful to therefore better understand if such payment reform can be delayed until after hospitals submit updated reference costs ahead of 2027/28 prices. This will allow them to explicitly allocate costs to this new activity code and ensure they remove any of the same costs they had previously allocated to other HRG codes.

To what extent do you support the proposed approach to abortion services?

Don't know

Please explain the reasons for your answer:

NA

Do you have any other comments on the proposals that apply to all payment mechanisms?

Do you have any other comments on the proposals that apply to all payment mechanisms?:

NA

Payment mechanism: Aligned payment and incentive (API)

To what extent do you support the proposed scope of the API payment mechanism?

Tend to oppose

Please explain the reasons for your answer:

The API payment mechanism is best suited to large providers – where the complex fixed and variable elements would work – and therefore it is logical that only NHS providers are within scope.

However, by including all services provided by these providers within the API, it becomes difficult to shift suitable services out of hospital – e.g. eye care and audiology services are locked into hospital budgets and despite long waiting lists and evidence that hospitals do not have the capacity to meet needs safely the system remains biased towards the hospital model of care. That is why there is a need to rethink the API model and release funding to help invest in out of hospital care where it is clinically safe and economically optimal to do so. This will also help deliver the government's 10 Year Health Plan.

To what extent do you support the proposed API fixed element?

Strongly oppose

Please explain the reasons for your answer:

While we recognise the importance of ICBs ensuring they minimise unintended consequences, we think the warning not to change the API fixed element if it risks destabilising services (paragraph 131) is unhelpful. This is because this is too often used as an excuse to block shifting care out of hospital and into the community. Meanwhile due to inefficient overspending on hospital activity, ICBs enforce cuts and destabilise community-based services. So, while we agree that the focus should be funding efficient cost (paragraph 134), it is important that any analysis of efficient costs includes comparing the cost of providing care in hospital to providing the same care out of hospital, and thereby ensuring the most efficient model is supported.

On balance, the current API approach remains a hospital biased system and will continue to risk distorting resource allocation, making it more difficult to deliver government goals set out in the 10 Year Health Plan. We would welcome a meeting with the pricing team so we can share the potential benefits of creating new BPT for long-term conditions with multiyear packages of care that will help reduce NHS cost per patient while delivering 10 Year Health Plan goals.

Strongly support

Please explain the reasons for your answer:

We support the need for providers and commissioners to review the fixed payments and identify funding for individual services (section 6.2). However, including outpatient follow-ups in the fixed element (paragraph 126) risks delaying the shift of activity from hospital to the community for long-term conditions like glaucoma in ophthalmology and adult hearing loss.

We strongly support the need for commissioners to 'deconstruct' fixed payments (blocks) (paragraph 127) but with services like adult hearing service the advice must go further.

For example, block payments for adult hearing services in hospital settings are not likely to vary significantly between hospitals and efficiency needs to be better defined by comparing hospitals (API) to non-hospital settings (non-API payments) – e.g. while one hospital might be more/less efficient than the other the degree of variation (after controlling for MFF) is not significant, yet NHS evidence shows the same adult hearing services can be delivered out of hospital for 20-25% less per pathway. Therefore 'deconstructing' fixed payments should focus on helping money follow the patient and ICBs should be commissioning the best value care to achieve the maximum health gain for any given NHS budget.

To what extent to you support the proposed API variable element?

Tend to oppose

Please explain the reasons for your answer:

We think the current variable element can work well when patients need to be seen in a hospital setting. However, the entire API model is strongly biased towards an NHS hospital model of care, making it difficult to shift suitable services out of hospital (see our response to other questions about API design).

To what extent do you support the proposed blended payment for urgent and emergency care?

Tend to support

Please explain the reasons for your answer:

We agree with paragraph 158 about the need to deliver the 10 Year Health Plan by shifting this and other care out of hospital and closer to home. We also agree with paragraph 159 that the current hospital funding model weakens ICB incentives to shift care out of hospitals. This is a problem with the API model in general, in that it has locked in a bias towards the hospital model of care which is now difficult to untangle (see our response to the fixed API element above).

Neither support or oppose

Please explain the reasons for your answer:

NA

To what extent do you support the proposed blended payment for radiotherapy?

Don't know

Please explain the reasons for your answer:

NA

To what extent do you support the proposed blended payment for genomic testing services?

Don't know

Please explain the reasons for your answer:

NA

To what extent do you support the proposed approach to specialised services?

Don’t know

Please explain the reasons for your answer:

To what extent do you support the proposed approach to variations from the default API design?

Neither support or oppose

Please explain the reasons for your answer:

Tinkering with API design will not help address the structural problems the model has created – e.g. locking services into hospitals because of the fixed fee element, reducing patient choice and other incentives to drive efficiencies.

Do you have any other comments about the proposed API payment mechanism?

API comments:

We welcome confirmation that NHSPS will be reviewed to ensure the pricing system is more likely to help deliver the 10 Year Health Plan. As part of this, we feel it would be in the best interests of patients and taxpayers to consult on services that are currently delivered in hospitals which could be shifted into the community. This will enable the NHS to better design API payment mechanism – e.g. excluding/extracting services that can be delivered out of hospital, so they are not hidden in API payment systems and enabling, as per the Darzi recommendations, funds to be shifted out of hospital.

Payment mechanism: Low volume activity (LVA) block payments

To what extent do you support the proposed scope of the LVA arrangements?

Strongly oppose

Please explain the reasons for your answer:

We fully appreciate the need to minimise transaction costs and therefore support the policy goals in paragraph 202. We also understand the logic of setting an annual value.

The challenge is that while £1.5m per year is a small sum for a NHS trust, it is a significant sum for out of hospital services and therefore we are not sure this should be the only criteria. For example, hospitals could agree LVA arrangements for the very type of services that should be delivered in the community for lower costs.

We therefore think it would be beneficial, as part of forthcoming work to align the NHSPS with the 10 Year Health Plan goals, to consult on which services currently delivered in hospital are well suited to being delivered in the community, and then to exclude these services from fixed API blocks and LVA arrangements.

This will allow NHS funds to follow the patient and help deliver on Darzi recommendations to shift investment from the hospital to the community in a strategic rewiring of NHS financial infrastructure.

This process would help ensure services like adult hearing care are added to paragraph 201 because NHS evidence shows it costs less to deliver this out of hospital, and therefore there is no economic case for this activity to be paid at a higher marginal price within an opaque block LVA arrangement.

To what extent do you support the proposed design of the LVA arrangements?

Strongly oppose

Please explain the reasons for your answer:

For the reasons set out above, we think LVA assumptions would benefit from a review to ensure NHSPS delivers the 10 Year Health Plan. In context we have significant concerns about the blanket 8.5% uplift (paragraph 208), as this again risks locking in the bias towards the hospital model of care at a time when community-based care is being put at risk because of overspending on hospital services.

Do you have any suggestions for a consistent way to understand activity flows between ICBs and distant mental health and community providers?:

Do you have any other comments about the proposed LVA payment mechanism?

LVA comments:

Please see answers above, about the benefit of reviewing which services should be excluded from LVA arrangements.

Payment mechanism: Activity-based payments

To what extent do you support the proposed scope of the activity-based payment mechanism?

Tend to support

Please explain the reasons for your answer:

NA

To what extent do you support the proposed design of the activity-based payment mechanism?

Tend to support

Please explain the reasons for your answer:

NA

Do you have any other comments on the proposed activity-based payment mechanism?

ABP comments:

Given the economic evidence on DRG based pricing systems and hospital activity – in terms of transparency and efficiency – we would hope that NHS trusts are eventually transitioned back to the same model. This will help enable patient choice and tackle existing market distortion caused by the multiple pricing/funding models that are being imposed based on provider type without due regard to patient rights as set out in the NHS Constitution.

Payment mechanism: Local payment arrangements

To what extent do you support the proposed scope of the local payment arrangements?

Tend to support

Please explain the reasons for your answer:

While we support the scope, we do think there are benefits in reviewing this as part of the review of NHSPS to ensure it helps deliver the 10 Year Health Plan.

To what extent do you support the proposed design of the local payment arrangements?

Strongly support

Please explain the reasons for your answer:

We support the instructions about what an ICB "must" do (paragraph 228). Unfortunately, and a major design flaw with local payment arrangements, is that there is no real accountability when ICBs ignore payment principles and refuse to apply CUF. In our experience, ICBs continue to prioritise hospital funding and enforce unrealistic and unsustainable cuts on out-of-hospital services. This needs to change if the NHS is to deliver on the 10 Year Health Plan and meet the efficiency savings agreed in the SR25 settlement.

To what extent do you support the proposed guide prices for ADHD and autism?

Don't know

Please explain the reasons for your answer:

NA

Do you have any other comments on the proposed local payment arrangements?

Local comments:

Yes, it remains a theoretical mechanism which is not used correctly by many ICBs. As it is the de facto mechanism for setting prices for out-of-hospital care, this again highlights the NHSPS bias towards hospitals – e.g. NHSPS provides safeguards for hospital care and limited safeguards for non-hospital providers. There is an urgent need for more guidance, support and governance to ensure the NHS starts to rebalance investment from hospital to the community, as recommended by the Darzi review.

Prices: role, calculation and related adjustments

To what extent do you support the proposed role of prices in the NHS Payment Scheme?

Neither support or oppose

Please explain the reasons for your answer:

NA

To what extent do you support the proposed approach to calculating 2026/27 NHSPS prices?

Neither support or oppose

Please explain the reasons for your answer:

NA

To what extent do you support the proposed adjustments for 2026/27 NHSPS prices?

price adjustments - High cost drugs:
Neither support or oppose

price adjustments - Ophthalmology services:
Strongly oppose

price adjustments - Stroke and pneumonia:
Neither support or oppose

Please explain the reasons for your answer:

While we do not represent ophthalmology providers, we are involved in primary eye care and monitor the potential impacts of policy decisions on patient access to care. We have significant concerns about the proposed workarounds to ophthalmology tariffs.

While it is clear that NHS England intends to proceed with the proposal, independently of consultation feedback, we wish to share our concerns about the proposed approach which we feel is inconsistent with NHSPS payment principles – e.g.

- the purpose of the proposed price cuts is to reduce independent sector ophthalmology cataract surgery activity
- the proposed cataract prices are therefore not based on any economic computation of cost but a workaround to drive down supply from a specific provider type
- the proposal would however result in NHS trusts knowingly being paid less than their cost for cataract surgery, putting quality and services at risk
- to address this, the proposal is to implement another workaround and pay way above reported hospital cost for other 'complex' ophthalmology activity
- again it is not clear how this can be consistent with NHS payment principles.

In paragraphs 286-289, NHS England expands on its reasoning, including that cataract surgery has increased significantly and inferring this is inefficient and/or other ophthalmology activity is more valuable/important. There are some challenges with these value judgements, e.g.

- NICE guidance shows cataract surgery is very cost effective and explicitly does not set vision thresholds for surgery because it recognised the risk of falls, loss of independence and other factors. If NHS England is of the view that cataract surgery is less valuable or the evidence should be reviewed, it should refer this to DHSC who can ask NICE to relook at the evidence. This would be preferable to distorting the pricing mechanism in the way that is proposed
- If NHS England believes cataract surgery has been performed on patients that did not require cataract surgery, it should investigate this separately rather than distort pricing and impact patient choice for all
- The fact is that before the growth in ISP cataract surgery, people were suffering sight loss due to delays in hospital for glaucoma care and this is still happening. Clearly the cause and effect of cataract surgery on other ophthalmology care is not as clear as the consultation presents
- It remains unclear why NHS England would on balance use alternative policy levers rather than distort pricing and in effect overpay for some hospital services to fill the gap from underpaying the same hospitals for cataract surgery, especially when many of the providers in question have had longstanding productivity/capacity issues that pre-date the growth in ISP cataract surgery

In summary, while we understand the goal of this workaround is to try and avoid breaching the NHS Constitution and Provider Selection Regime with respect to patient choice, it is unclear that distorting the pricing system is the optimal way to reduce ISP cataract provision. The proposals will also have unintended consequences, including reducing incentives to shift non-cataract care out of hospital into primary eye care settings. This will mean NHS resources continue to be used inefficiently and the NHS will fail to deliver key 10 Year Health Plan goals. We would therefore hope NHS England/DHSC will explore alternative and more evidence-based approaches to the issue they are trying to address.

To what extent do you support the proposal to update the data used to calculate market forces factor (MFF) values?

Neither support or oppose

Please explain the reasons for your answer:

Given the significant issues with how the original DRG pricing mechanism, and its benefits, have been somewhat broken over time, it is unclear that MFF modelling assumptions will overcome the issues created by API/block arrangements etc.

Do you have any other comments on prices and related adjustments?

Do you have any other comments on prices and related adjustments?:

No

Mental health and community services currency development

Mental Health and Neurodevelopmental Resource Groups (MHNRGs)

currencies - Expanding granularity of care setting and teams:
Don’t know

currencies - Expansion of additional complexity factors:
Don’t know

currencies - Inclusion of population group for Mental Health Support Teams:
Don’t know

Please explain the reasons for your answers:

NA

If 'Other', please give details:

What would you like to be covered in future engagement/webinars:

Community currencies

community - Expansion of the population groups to include other community based services such as equipment, intermediate beds and public health:
Don’t know

community - Expansion of the grouping methodology to use service lines to automate the currency development process and reduce burden wherever possible:
Don’t know

If 'Other', please give details:

What would you like to be covered in future engagement/webinars:

We want to develop mental health currency models over time. Please rank these additional dimensions in the order you feel they should be prioritised.

currencies - More granular measurement of needs within existing models (low/medium/high):

currencies - Cross-cutting need and complexity factors (may not result in specific units):

currencies - More granular units for settings (eg, secure vs. non-secure, stratifying community treatment):

currencies - Other:

If 'Other', please give details:

We want to develop the community currency models over time. Please rank these additional dimensions in the order you feel they should be prioritised.

currencies - Consider how currency model will support future payment and movement of services into community settings:

currencies - Build on tools/guidance to support collaboration and build an evidence basis for benchmarking, and service design:

currencies - Consider how currencies and payment can support reduction in waiting lists:

currencies - Other:

If 'Other', please give details:

Attention-Deficit/Hyperactivity Disorder (ADHD) and Autism

adhd - Guide prices:
Don’t know

adhd - Initial currency models:
Don’t know

Please explain the reasons for your answer:

What would you like to be covered in future engagement/webinars:
NA

Do you have any other comments on mental health and community currency development?

Comments on future payment:

NA

Any other comments

Do you have any other comments on our proposals for the 2026/27 NHS Payment Scheme?

Any other comments:

NA

Do you have any comments or suggestions on how we could improve how we engage with you on our proposals?

Engagement:

While we appreciate that hospitals will continue to dominate the share of NHS total spend that is within NHSPS scope, there are major opportunities to working directly with non-hospital providers to better understand how the NHS can reduce costs and shift significant volumes of patient activity from hospital to the community. We would welcome being part of such an engagement exercise and to provide evidence on the economic savings and clinical/system benefits our sectors can deliver as part of the 10 Year Health Plan.

How could we improve the information you are given as part of the statutory consultation and its impact assessment?:

NA