How your service is paid

A quick guide for clinicians in England to the NHS Payment Scheme for 2026/27: which payment rule covers your work, what happens when activity changes, and what to check before you assume more activity brings more money.

The main payment rules

Rule	What it covers	What happens if activity changes
API: fixed	**Most NHS trust and foundation trust care with their main ICBs**	An agreed sum for the year. Doing more or less does not change it directly.
API: variable	**Planned (elective) activity inside the same agreement**	Paid at 100% of the unit price for each case above or below plan. Your ICB will still expect activity to match the agreed plan.
UEC blend	**Urgent and emergency care**	A fixed sum, adjusted by 20% of the price for activity above or below plan. Extra emergency work earns only a fifth of its price.
Low-volume (LVA)	**Relationships worth up to £1.5m a year, around 90% of all of them**	A fixed payment set nationally. Activity changes do not change income that year.

Radiotherapy has its own variable rate (50%). Many high-cost drugs and devices are paid separately from the price. Councils, independent providers and primary care follow other contracts. Wales, Scotland and Northern Ireland fund health boards by allocation and do not use this scheme.

Same extra work, different income

20 extra planned cases × **£6,000** price × **100%** variable rate = **£120k** income

Then subtract what the extra lists, staff and consumables cost.

Illustrative prices, not real 2026/27 prices.

500 extra emergency attendances × **£300** price × **20%** UEC rate = **£30k** income

The work is real, but most of its cost is not met by extra income.

From the record to the price

Notes what you document → **Codes** diagnoses, procedures → **HRG** a payment group → **Price** if paid per case

Better documentation and coding change income directly only where activity is paid per case. Under fixed payments it still matters for planning, costing and benchmarking.

Three things that catch people out

The national price is not your cost. A procedure priced above your cost does not mean a profit; check marginal and step costs.

More activity is not more surplus. Extra lists, staff and premium pay can cost more than the income earned.

Old rules linger. PbR and the national tariff are history, and CQUIN has been paused since 2024/25. Check assumptions against the current scheme.

Before you build a case on income

1. Which commissioner pays for this work, and under which rule?
2. Is the activity in the agreed plan, or above it?
3. What does each extra case cost to deliver, including staff and theatre time?
4. If the money will not follow the activity, what is the case on patient benefit, capacity or avoided cost?

Who to ask

Finance business partner: which rule applies and what the contract assumes.

Contracting or income team: activity plans and how variances are paid.

Clinical coding team: how your activity is recorded and grouped.

Costing team (PLICS): what your service actually costs per patient.

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Five short lessons on payment systems and contracts, with worked examples.