2021/22 National Tariff Payment System

Guidance on the aligned payment and incentive approach

September 2021

Contents

1. Introduction

1. The 2021/22 aligned payment and incentive approach is designed to achieve a stable transition from the 2020/21 emergency payment arrangements and set the foundation for the development of the payment system for 2022/23 and beyond.[1] The design of the aligned payment and incentive model for 2021/22 is therefore not a 'final' design; however, it supports a number of key objectives linked to the NHS Long Term Plan.

2. The aligned payment and incentive approach is based on the blended payment model introduced in the 2019/20 tariff. In line with the commitments in the NHS Long Term Plan, a blended payment approach remains the direction of travel for the NHS payment system.

3. Aligned payment and incentive agreements comprise two components:

   - **A fixed element** based on funding an agreed level of activity (see Section 3).
   - **A variable element** to increase or reduce payment based on the actual volume and quality of activity undertaken (see Section 4).

4. As part of the NHS Standard Contract, all members of an ICS/STP are also required to agree a System Collaboration and Financial Management Agreement (SCFMA). This supports local arrangements to identify risk placement across systems and to specify risk mitigation and sharing of any gains or losses (see Section 5).

5. The aligned payment and incentive approach aims to support the delivery of ICS/STP system plans and encourage collaboration to agree the best way to use the resources available to systems. It provides a consistent approach to paying for both acute and non-acute secondary healthcare services, helping to address issues associated with a fragmented payment system. For more details on the reasons why the payment system needs reform, please see the supporting document *Payment and the NHS Long Term Plan*.

[1] For details of the proposals for the 2021/22 National Tariff Payment System, see the consultation notice, available from: www.england.nhs.uk/publication/2021-22-tariff-consultation/

6. The aligned payment and incentive approach also supports the continued collection of high quality costing, counting and coding information in a number of ways, including the following:

   - It provides a consistent approach across all of secondary care – acute, ambulance, community and mental health. It places greater focus on the whole system, seeking to achieve parity of data quality across all sectors.
   - Over time, the fixed element would be based on the latest available data and information. It also encourages local flexibility to forecast future requirements. High quality data will be vital to evidence this.
   - Clinicians should have an enhanced role in determining the level of fixed elements and how funding is disbursed within a provider or system in an efficient and innovative manner. Again, high quality data and information will be needed to support proposals, and to evaluate them.
   - Providers can build up the cost and activity profile in a number of ways, including making use of existing currencies (such as healthcare resource groups (HRGs) and those described in Annex B) as well as currencies that are being developed, such as the non-mandatory community currencies described in the supporting document *Community services currency guidance: frailty and last year of life*.
   - The approach should also refocus the effort going in to counting and coding by both commissioners and providers. The focus should move away from managing disputes and the technical nuances of a payment system and towards collaborating to develop a joint understanding of the true cost of service provision.

7. We are conscious of the rights of patients enshrined in the NHS Constitution and of our respective responsibilities and duties as set out in the NHS Constitution and other related legislation. No aligned payment and incentive agreement, or the manner in which participating parties conduct themselves, should infringe or compromise those rights, responsibilities and duties. All parties should ensure that this does not happen.

8. In addition, when constructing aligned payment and incentive agreements, providers and commissioners should abide by the National Tariff Payment System (NTPS) principles for local price setting:

   - The approach must be in the best interests of patients.

- The approach should promote accountability and encourage system working.
- Providers and commissioners must engage constructively with each other.

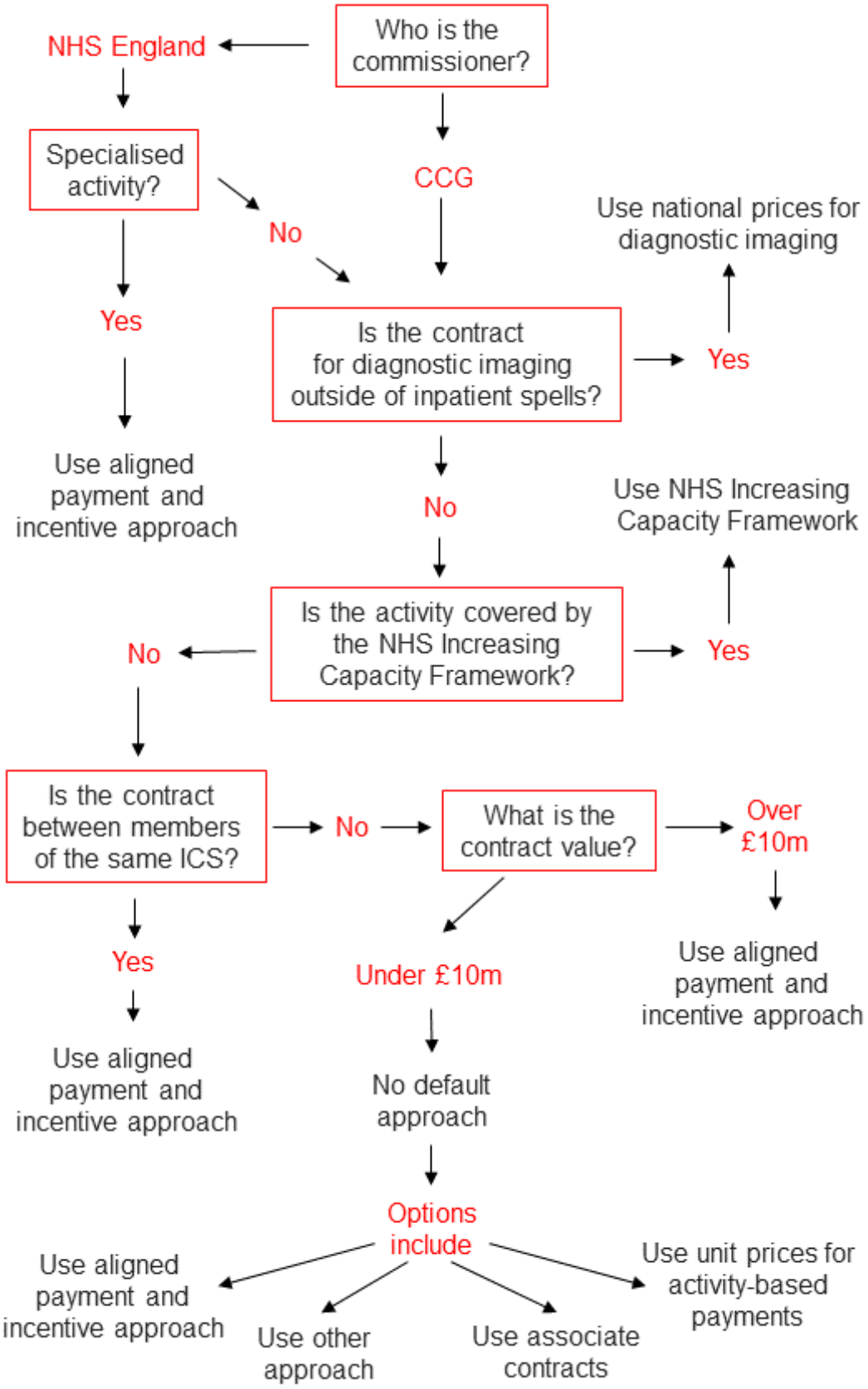
9. Section 3 of the 2021/22 NTPS sets out the aligned payment and incentive rules. Appendix 1 of this document illustrates how the approach could apply for maternity services.

2. Scope of aligned payment and incentive agreements

10. The aligned payment and incentive approach is applicable to almost all services within the scope of the NTPS – that is, all NHS-funded secondary care services (including acute, maternity, community, mental health and ambulance services), subject to the thresholds set out in Section 3.1. Unbundled diagnostic imaging services continue to have national prices, although providers and commissioners can agree a local variation to include these services within aligned payment and incentive agreements.

11. Contracts between providers and commissioners who are members of the same ICS should use the aligned payment and incentive approach, regardless of value. For contracts between commissioners and providers that are members of different ICSs, different arrangements may apply depending on contract value and whether the contract is subject to the NHS Increasing Capacity Framework. Figure 1 summarises the arrangements.

Figure 1: Application of the aligned payment and incentive approach



2.1 Contract threshold

12. The aligned payment and incentive approach applies to all contracts between commissioners and providers who are members of the same ICS, unless the contract is awarded under the NHS Increasing Capacity Framework.

13. For other commissioner and provider relationships, aligned payment and incentive agreements are required for contractual relationships (between an individual commissioner and a provider) with an expected annual **value of £10 million or more** (again, unless the contract is awarded under the NHS Increasing Capacity Framework). This expected annual value should be calculated by reference to the estimated value of the contract for that year if unit prices were applied, or the contract outturn value for the financial year 2019/20

14. For contractual relationships (between an individual commissioner and a provider not in the same ICS) with an expected annual value of **below £10 million,** but not under the Framework, contract partners are free to pursue other approaches, such as block payments or the use of unit prices published in the NTPS, to construct their own arrangements. It may be desirable, for example, for a single specialty provider with many CCG contracts below £10 million to transact on a payment by activity basis rather than enter into different discussions across many different systems. Equally, an acute provider who has experienced relatively stable contract outturn values with a CCG in a different system over recent years, may decide that a block or fixed payment approach would be more desirable. However, if the commissioner and provider cannot agree a pricing approach, the unit and BPT prices set out in the tariff must be applied.

2.2 NHS England commissioned services

15. All NHS England Specialised Commissioning contracts will use the aligned payment and incentive approach, irrespective of value.

16. All other NHS England commissioned services contracts, such as health and justice, are subject to the thresholds set out in Section 2.1.

2.3 NHS Increasing Capacity Framework

17. Activity contracted under the NHS Increasing Capacity Framework is not covered by the aligned payment and incentive approach – instead the rules require the use of the unit and BPT prices published in the tariff, subject to any payment rules under the Framework. Where the NHS Increasing Capacity Framework isn't used, this guidance and the associated rules for aligned payment and incentive agreements apply, subject to the £10 million threshold described in Section 2.1. It is worth noting that the Framework doesn't automatically apply uniformly to specific activity – the same activity may be covered by the Framework in one area but not in another.

2.4 High cost exclusions

18. The costs associated with a range of high cost drugs, devices and listed innovative products have historically been removed from national prices, with exclusion lists published in the tariff workbook (Annex A, tabs 14a, 14b and 14c). Providers received the funds for these on a 'pass through' or 'cost and volume' basis. The rationale for this was that usage was not necessarily uniform across patients and providers (and so incorporating these costs into prices would likely either under-reimburse or over-reimburse a provider) and that the cost of the excluded item was high compared to the HRG price. This meant funding could be volatile with changes in activity.

19. As the aligned payment and incentive fixed element provides a greater level of funding certainty, some of this risk is reduced.

20. As such, where usage is relatively stable and predictable (albeit still high cost relative to the individual unit price of the associated activity), costs should be included in the fixed element, accompanied by associated funding. This would include all drugs and devices commissioned by CCGs.

21. Some drugs and devices commissioned by NHS England will continue to be excluded from the tariff and paid for, according to the local pricing rules, on a cost and volume basis. Annex A indicates which drugs and devices should have funding included in the fixed element for NHS England Specialised Commissioning contracts. Specialised Commissioning and providers may agree to fund other drugs outside of the aligned payment and incentive fixed

element. This would be a local departure, using the provisions in aligned payment and incentive rule 6.

22. For high cost devices, all 26 NHS England commissioned device categories will be excluded from the aligned payment and incentive fixed element. The reimbursement process, via the high cost tariff-excluded devices (HCTED) programme, is published under separate guidance. Funding for CCG-commissioned high cost devices should be included in the fixed element. Annex A contains the list of high cost devices, and whether they should be included in the fixed element.

23. All items on the innovative products list (Annex A, tab 14c) are excluded from the tariff and funding should not be included in the fixed element.

2.5 Evidence-based interventions

24. The aims of the Evidence-Based Interventions (EBI) programme are to prevent avoidable harm to patients, to avoid unnecessary patient activity, and to free up clinical time by only offering interventions funded by the NHS that are evidence-based and appropriate.

25. In the 2019/20 NTPS a national variation was introduced such that certain procedures, identified by the EBI programme, would not attract reimbursement unless an individual funding request (IFR) is made and approved.

26. For 2021/22, providers and commissioners will agree a fixed element to deliver an expected level of activity. This should reflect non-payment of EBI category 1 interventions (as specified by the EBI programme). For all elective activity within the scope of the variable element (see Section 4), the conditions around EBI activity remain. This means a provider can only claim reimbursement at the agreed variable rate (50% by default) for EBI activity if an IFR has been approved.

3. The fixed element

27. The aligned payment and incentive approach involves the majority of funding being agreed through a fixed element. While there is local freedom to choose how to derive the expected value of the services captured by the fixed payment – drawing on clinical expertise, new models of care and up-to-date information – the supporting guidance provided here should help providers and commissioners arrive at an agreed fixed payment.

28. The following steps provide a high-level guide for constructing a fixed payment. These steps can then be interpreted and modified locally as needed. The steps calculate a value for a full year. If an agreement is for provision of services for a period less than 12 months, providers and commissioners should make pro-rata adjustments, including to the £10 million threshold and agreed activity levels, to reflect the shorter period.

29. Alongside the principles set out at paragraph 8, the fixed element should be:

    - reflective of efficient, expected provider costs – maximising the utility of every NHS pound
    - used for delivering high-quality services agreed between commissioners and providers – patients receive the best possible care and experience
    - adjusted to reflect system planning assumptions – the health of populations is considered and improved.

30. The fixed element should be based, as far as possible, on the efficient cost to the provider of delivering an agreed level of activity. In this document we have set out three options for calculating the fixed element that could be considered (see Section 3.2).

3.1 Identifying the services in scope

31. Section 2 describes what should be included within the scope of aligned payment and incentive agreements and what is to be determined locally.

32. Providers and commissioners must first identify and agree the exact services that the fixed element will cover. This is likely to capture ‘business as usual’

services the provider will carry forward from the previous year, along with any anticipated changes to services based on agreed service transformation plans or in response to COVD-19.

33. Activity explicitly out of scope is unbundled diagnostic imaging services, which retains national prices. However, providers and commissioners can agree a local variation to include these services within the fixed element.

34. Other activities out of scope include research grants, private patients, car parking and other activities not covered by the scope of the NTPS (see Section 2 of the 2021/22 NTPS).

35. Some services included in the fixed element may also attract additional reimbursement through the variable element (see Section 4).

3.2 Calculating the baseline fixed element

36. This section describes possible approaches to calculating the fixed element. The aligned payment and incentive rules state that for any agreement, providers and commissioners should apply the principles for local pricing in Section 4.1 of the 2021/22 NTPS, and have regard to cost adjustments (see Section 3.3 of this document).

37. Here we describe the following potential approaches to setting the fixed element:

    - Basing it on 2019/20 provider outturn contract values.
    - Using the latest available or historic provider-reported cost information (eg, 2019/20 reference costs or PLICS).
    - Using forward-looking planned or predicted costs.

38. These high-level approaches are not prescriptive and would not capture the many different local circumstances and contextual factors local areas face. We expect that they will lead to a figure which acts as a pragmatic starting point for providers and commissioners and will then need to be adjusted further to reflect 2021/22 plans (see below). Moreover, any agreed fixed element must be affordable and reflect the efficient cost of care delivery as far as possible.

Provider 2019/20 outturn contract values

39. This approach uses provider 2019/20 outturn contract spend as the starting point. The fixed payment would then be calculated via the following steps:

    - Start with the 2019/20 contract outturn value, less the value of unbundled diagnostic imaging as calculated using the 2019/20 NTPS rules.
    - Make adjustments for:
      - inflation and efficiency for 2020/21 and 2021/22, as set out in Section 3.3
      - changes in market forces factor (MFF) values for 2020/21 and 2021/22
      - the service specification and contract requirements, reflecting changes to the service scope.
    - Add amounts for the following:
      - the expected value for the provision of high cost drugs, devices and listed procedures specified in Annex A, tab 14a and 14b
      - any funding as agreed by the ICS in addition to the amounts above.

Advantages	
Uses previously agreed values	Most provider plans should be relatively stable year-on-year (COVID-19 will have had a big impact for 2020/21, but these costs are being funded outside the tariff). As such, this approach can save time and resource compared with an approach which builds costs up from scratch.
Based on recent costs	Data and information relating to 2019/20 finances should be readily available.
Quick and straightforward	It can get providers and commissioners to quickly arrive at an initial value and therefore get to further discussions around possible adjustments.

Disadvantages	
Can bake in inefficiencies/older service design funding	The rollover of previous financial figures may not challenge providers to perform in a more efficient way or to create more value for the system.
Not transparent	During the process, commissioners could forgo visibility on the provider cost elements.
Variation in costs	2021/22 costs may vary significantly from previous revenues particularly in light of COVID-19 - increasing cost risk within the system.

Provider-reported cost information

40. This method derives an initial value for the fixed element based on a provider's reported costs. This should use the most up-to-date costing information (ie, 2019/20), but costs from previous years should also be considered, particularly where there are concerns around data due to the impact of COVID-19 in Q4 2019/20.

41. Using 2019/20 costs as a baseline, the provider's direct cost of services is identified (for example, through departmental profit and loss accounts), then aggregated together to get the total direct cost of services. To account for overhead costs, the provider and commissioner could agree to jointly calculate and apply a contribution factor on top of the total direct costs of services to get a total estimated cost. Alternatively, the provider could add overhead costs to the total direct costs of services, using 2019/20 as a baseline to get the total provider costs.

Advantages	
Stronger foundation	Using historic provider costs may provide a more realistic provider cost base compared with 2019/20 outturn contract values.
Places more process around payment setting	This could lead to payments being more reflective to the costs of delivery, and the ICS allocation apportioned in a way that adds more value to the system.

Disadvantages	
Costs inconsistent	Costing information could be inconsistent across service areas leading to a fixed payment that is too high or too low
Variation in costs	2021/22 costs may vary significantly from previous costs, particularly in light of COVID-19.

Provider-forecasted cost information

42. Using this approach, providers project their internal costs for the year ahead and apportion these costs back across services to build a forward-looking, cost reflective fixed element.

43. This method uses the provider departmental profit and loss accounts, categorising them into direct or overhead departments. Direct cost departments would use the system plan and anticipated patient casemix information to build up a cost profile of what their departments need for the forthcoming year. Overhead departmental costs are budgeted and apportioned back across direct departments using local agreed methodology to get a total cost per department. These departmental costs are then either used to build a service cost profile or can be further broken down by activity, using more granular apportioning methodology.

44. As noted above, not all services will fall within the scope of the fixed element. There should be a further adjustment to reflect, as far as possible, the costs covered by the fixed element. This can be done by removing the average cost of the activity not covered, using the unit prices published in the tariff or provider average costs (direct and indirect) where possible.

Advantages	
Future-focused costing	Compared to using historic information, costs are built from planned costs and so more reflective of the expected costs of delivery.
Greater granularity	Allows for greater detail and context, which is useful for more effective planning discussions.

Disadvantages	
Process can be both time consuming and complex	The process of building these costs can be quite time consuming. Getting to an agreed methodology may be difficult as determining what factors drives overhead costs across departments can be complex.
Not all areas may have a degree of openness required	It's also implicitly assumed that there is openness and transparency between the commissioner and provider during this process.
Forecasting during COVID-19	Any type of forecasting must recognise the inherent risks, none more so with the uncertainty of COVID-19. Risk sharing is one way to mitigate against this, but forecasting risk remains.

3.3 Further adjustments to the baseline fixed element

45. Whatever approach to agreeing a baseline fixed element is used, the initial figure will need to be further adjusted to reflect factors such as cost uplifts, efficiency, growth and service changes.

46. As a first step, inflation, CNST and efficiency adjustments may need to be made to bridge the gap between the contract outturn values/ historic costs and the current year. Recent tariff cost adjustments are:

	2020/21 NTPS	2021/22 NTPS
Cost uplift factor (inflation and CNST)	2.5%	3.1%
Efficiency factor	1.1%	1.1%

47. Any changes in MFF values also need to be applied to the fixed element value. Other price adjustments such as specialist top-ups should already be captured within the source data used in the first step (eg contract outturn values) and so no further amendment should be needed.

48. Next, there needs to be a consideration of any changes to the delivery of services or new models of care and any anticipated variations in demand since the reference period. This should include both national changes (such as changes in funding requirement for services between CCGs and Specialised Commissioning, eg genomics, complex knee revisions) as well as local and system-level plans.

49. Consideration should also be given to any adjustments that may be required to reflect NHS England's determination of the required level of activity or appropriate level of funding for specialised services to be delivered.

50. Finally, the value of the fixed element will need to give regard to how any additional funding, such as protected funding for mental health services, passes from CCGs or NHS England to providers. This funding is distributed outside of the tariff and so should not form part of aligned payment and incentive agreements. However, it should be considered as part of the fixed element discussions and when agreeing funding levels which align with system envelopes and affordability.

51. For 2021/22, CQUIN funding has been transferred to the national tariff. To reflect this, the initially agreed fixed element should be uplifted by 1.25% (unless the fixed element is based on 2021/22 NTPS unit prices, which have already been uplifted by 1.25%). This assumes that providers will fully attain CQUIN metrics. If attainment is less than this, payments should be deducted from the provider as part of the variable element.

4. The variable element

52. The variable element will work in conjunction with the fixed element to help deliver specific aims. Fundamentally, it is a process which targets specific activities, paying more for activity above an agreed baseline (whether volume, quality or outcomes) and recouping funds if that baseline is not reached.

53. While the fixed element of the aligned payment and incentive approach is intended to fund an agreed level of activity, the variable element redistributes funding for additional elective activity or maintaining and improving quality of care.

54. In agreeing the variable element, local areas should consider how best to incentivise high priority activity, particularly those which address health inequalities.

55. In 2021/22, the variable element will apply to elective activity and best practice tariff (BPT) and CQUIN attainment. An expected level of elective activity and BPT attainment should be agreed as part of the fixed element.

56. For elective care, any additional activity undertaken above this planned baseline level attracts 50% of the unit price published in Annex A of the 2021/22 NTPS, with relevant national variations applied (eg MFF and specialist top-ups). If actual activity is lower than the baseline, funds are recouped at 50% of the unit price (adjusted for national variations). This includes all elective ordinary, day cases and outpatient procedures with a published unit price.

57. For BPTs, if the achievement of BPT criteria is different to what was expected in agreeing the fixed element, the difference between the actual and planned BPT values should be used to adjust the fixed element.

58. For CQUIN, if the attainment of CQUIN metrics is less than 100%, payment should be deducted from providers in accordance with guidance issued by NHS England.

59. The details set out above give the default design of the variable element. Providers and commissioners may decide to use alternative designs where

appropriate by local agreement. However, areas that want to apply adjustments other than 50% for actual activity, or that seek to remove adjustments for BPT and CQUIN achievement, would need to apply to NHS England and NHS Improvement for approval.

60. The variable element is a tool which can be applied to help tackle other aims. Providers and commissioners are encouraged to consider the use of a variable element where appropriate. When doing so, they will need to take into account of: the activity it will be applied to; how that activity is classified and the data available to support this; how this activity is covered by the fixed element or another payment model; agreeing baselines; and, the amount paid/recouped above/below baselines.

5. Risk sharing

61. Well-designed risk sharing agreements encourage partners to work collaboratively across organisational boundaries and to collectively manage risk across their system.

62. An agreed risk sharing mechanism can help to achieve a more desirable outcome by supporting and complementing aligned payment and incentive agreements. All payment approaches share the risk of activity and/or financial deviations between partners in some way. While the blend of fixed and variable elements seeks to minimise the issue, a predominantly fixed arrangement does allocate risk in a particular way. However, a broader approach may be needed, particularly if there is uncertainty around what is an appropriate level of fixed payment.

63. Given that the allocation and ownership of risk should be determined locally, a nationally prescribed risk sharing mechanism is not appropriate as it wouldn't be responsive to all circumstances. However, the NHS Standard Contract requires all organisations within an ICS/STP to agree a System Collaboration and Financial Management Agreement (SCFMA) as a means for recording locally agreed risk sharing arrangements. The SCMFA is intended to capture details of the organisations involved and the scope of the risk share; the aims and the agreed governance; and, the sharing of gains and losses and any break clauses.

64. More information on the SCFMA is available at: www.england.nhs.uk/nhs-standard-contract/21-22/

Appendix 1: Using the aligned payments and incentive approach for maternity services

Maternity payment in 2021/22

Under the 2021/22 national tariff, almost all secondary care activity, including maternity services, are covered by aligned payment and incentive rules. This appendix gives details of how the approach could be applied to maternity services.

In some circumstances providers and commissioners may agree to use alternative payment approaches, including activity-based prices. We recommend that any activity-based payments for maternity services are based on HRG-level prices, rather than the maternity payment pathway (MPP) prices. This would:

- reduce the chances of double payment
- reduce the current provider-to-provider transactional burden for maternity services
- ensure activity across maternity services is appropriately resourced.

Both HRG and MPP prices for maternity services are published in Annex A (tab 7a), while details of the pathway are available in Annex B.

Fixed and variable elements for maternity services

The 2021/22 aligned payment and incentive approach comprises fixed and variable elements. These are intended to achieve various objectives, some examples of which are set out in the Table 1.

Table 1. Core components of payment for 2021/22 and possible applications

Fixed element	Fixed elements can be used to provide certainty, and support planning and forecasting. For maternity services, fixed elements should be aligned to Local Maternity System (LMS) plans. It is therefore strongly recommended that there is LMS representation in setting fixed elements. The fixed element should support delivery of system objectives, including the training of staff to meet these needs.
Variable element	For 2021/22 the variable element will be used for elective services as a means to address the waiting list backlog. It will also serve to incentivise high quality care through BPTs and CQUIN.

Ensuring the fixed element reflects the resource requirements of maternity services

As set out in Section 3.2, there are a number of options for calculating the fixed element. Local LMS representation when agreeing fixed elements is strongly recommended in order to ensure system plans, and associated payments, are supportive of system-wide maternity service objectives.

If basing the fixed payment on historic data, any changes to service models for maternity services between the source data and 2021/22 should also be reflected in adjustments. This could be changes in the expected level of births, or changes to the configuration of service delivery between providers across a system.

It is recommended that the fixed element should also include consideration for Maternal Medicine Network funding, as set out later in this guidance.

Where there is expected to be material provider-to-provider flow of activity, such as between providers within the same ICS, the fixed element should be adjusted for anticipated provider-to-provider charging. This would reduce the need for invoicing for maternity services in-year which has previously occurred under the MPP arrangements.

To determine a fixed element that considers provider-to-provider payments, historic activity (HRG) and cost information (PLICS) should be used, rather than historic

payment information. This is because under the MPP only the lead provider receipted resources directly from the commissioner for each pathway.

Where there is uncertainty, or a risk that there will be material deviation from planned activity, risk share agreements can be agreed in advance, provided the agreements are compliant with the SCFMA.

Maternal Medicine Networks

The fixed element should be agreed based delivering an agreed level of activity, including new approaches to delivering services. An example of this is funding of Maternal Medicine Networks.

The NHS Long Term Plan commits to formally establishing Maternal Medicine Networks to support regional maternal medicine referrals for care and opinion, ensuring women with acute and chronic medical problems have timely access to specialised advice and care at all stages of pregnancy. This would be hosted from existing maternity service providers, with each network spanning across multiple system footprints. There are expected to be 18 networks nationally. The specialist activity has historically been undertaken in a range of organisations, with resources flowing through burdensome provider to provider arrangements.

In order to improve the payment process, it is proposed that the Maternal Medicine Centres, the host organisations, receive the required capacity funding from their lead commissioner, with adjustments made to other commissioner allocations to balance this. The intended result is a consistent standard of service provided in appropriately funded centres, with minimal transactional burden to all organisations.

This would be transacted through adjustments to fixed elements. Fair share contributions would be agreed locally, for example by proportion of births by commissioner. These contributions would then be allocated to the Maternal Medicine Centre's lead commissioner and built into their fixed payment. Each commissioner would then adjust the fixed elements paid to their constituent providers to reflect this.

Note that this is not a new service, but rather a proposal to improve the current resource flow arrangements. However, establishment of Maternal Medicine Networks nationally is a key enabler to reducing the triennial rate of maternal deaths.

Maternal Medicine Networks are central to NHS England and NHS Improvement's strategy to reducing mortality for all women. They are also set out as an essential action for managing complex pregnancies in the Ockenden Report,[2] an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. This is set out in a letter to NHS Trust and Foundation Trust Chief Executives, at Immediate Action 4b.[3]

[2] www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf
[3] www.england.nhs.uk/wp-content/uploads/2020/12/Ockenden-Letter-CEO-Chairs-final-14.12.20-1.pdf

Contact us:

NHS England and NHS Improvement

Wellington House
133-155 Waterloo Road
London SE1 8UG

improvement.nhs.uk
pricing@improvement.nhs.uk

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

Publishing Approval Reference: PAR743