2023 finance and payment – engagement

July 2022

Please access www.menti.com and use code: **1844 1193**

About this workshop

- The session involves a series of short presentations and questions.
- The content of the workshop focuses on policies being considered for 2023/24 – and potentially 2024/25. (We refer to the 2023/25 payment scheme, but the duration will be subject to consultation – and something we welcome your views on!)
- We will not be focusing on the financial arrangements for the rest of 2022/23. If you have any questions about these, please contact pricing@england.nhs.uk.

Please note: This workshop is sharing policies in development. They are not final and will be subject to change as we continue to receive feedback, both internally and externally, and undertake further work.

Giving feedback

- The purpose of these events is to help you understand what we are currently planning for 2023 – and to get your views on the policies while they are being developed.
- To give your feedback **during the event**:

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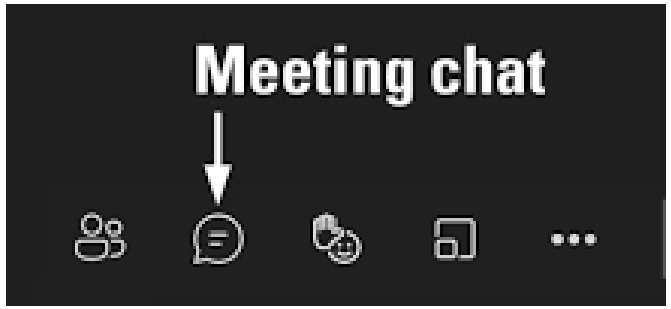


- **After the event**, please share your thoughts via our **online survey**, which closes on 27 July 2022. The online survey has questions on more topics than are covered in Menti.
- You can also email any thoughts, comments or questions to: pricing@england.nhs.uk.

Draft development timeline

NHS payment scheme
Engagement and gathering feedback on potential policies **July 2022**
↓
Further engagement on specific policies and future payment system development **September 2022**
↓
Consultation on proposed NHS payment scheme (potentially alongside planning guidance) **October/November 2022**
↓
Publication of final 2023/25 NHS payment scheme (subject to consultation) **February 2023**
↓
2023/25 NHS payment scheme takes effect **1 April 2023**

Introduction and context for proposals

2022 Health and Care Act

- The **Health and Care Act has received Royal Assent**, which means, as of 1 July 2022:
    - 106 Clinical Commissioning Groups (CCGs), Monitor and the NHS Trust Development Authority have been abolished
    - 42 Integrated Care Boards (ICBs) have been established, creating 42 Integrated Care Partnerships (ICPs) with local authorities
    - Duties and powers of all NHS organisations will be established or removed as part of a new legal framework.

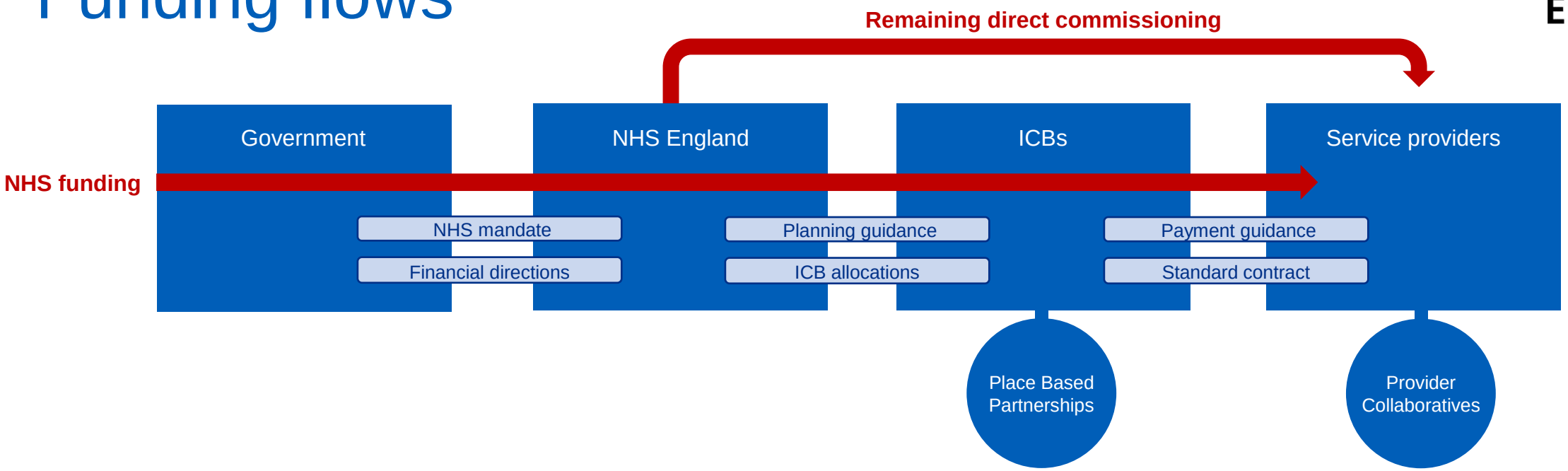
Health and Care Bill granted Royal Assent in milestone for healthcare recovery and reform

The Health and Care Bill has today received Royal Assent by Her Majesty The Queen, enacting the most significant health legislation in a decade into law.

From: Department of Health and Social Care and The Rt Hon Sajid Javid MP
Published 28 April 2022

Schedule 10 of the Act sets out the new requirements for the payment system for secondary healthcare – replacing the National Tariff Payment System with the **NHS payment scheme**.

Funding flows



The government continues to set out its **objectives for the NHS in a mandate** (no longer needing to be annual) and confirms overall budgets each year.

Funding **flows from NHS England to a local commissioning body** through an allocation based on population need, while not destabilising local economies.

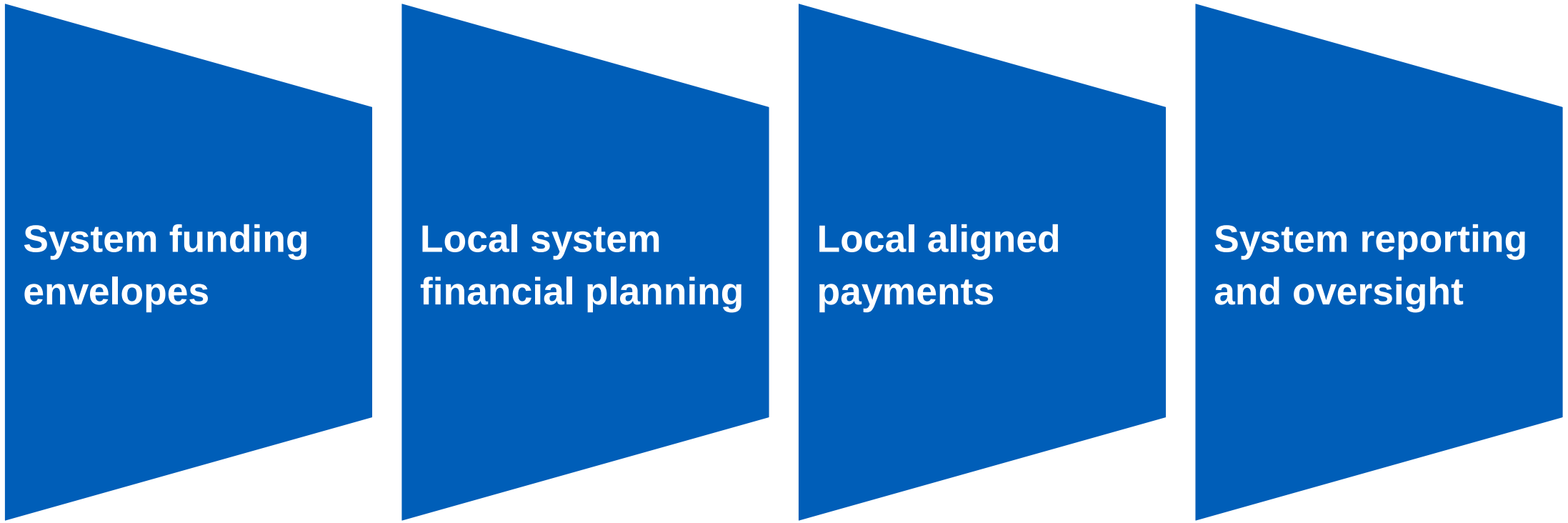
ICBs **agree contracts with and make payments to NHS trusts and Foundation Trusts**, in line with national payment and contracting guidance.

ICBs will **take on many of the commissioning functions currently held nationally**. Some ICBs will be delegated these functions upon establishment, while others will be delegated over time. NHS England will retain responsibility for some highly specialised services.

Financial framework - principles

The focus of the NHS financial framework is on enabling systems to collaborate on delivering shared local objectives.

Recent financial frameworks – system-level enablers



System allocations and baseline reset

The key steps to setting ICB allocations will be:

1. Determine **target** allocations based on relative need and relative unavoidable costs for each ICB's population;
2. Establish **baselines** (the previous year's allocations plus any adjustments);
3. Apply **base growth** – uplift baseline and target allocations for cost inflation, general efficiency, demographic growth and non-demographic service investment;
4. Calculate how far the baseline allocation is away from the target ('**distances from target**');
5. Apply **convergence** (or '**pace of change**') policy – how quickly ICBs move towards their target allocation each year. This policy balances stability of funding with moving ICBs furthest from target closer to it over a deliverable period of time, ensuring resource is allocated fairly.

ICB allocations baselines for 2023/24 will have adjustments for:

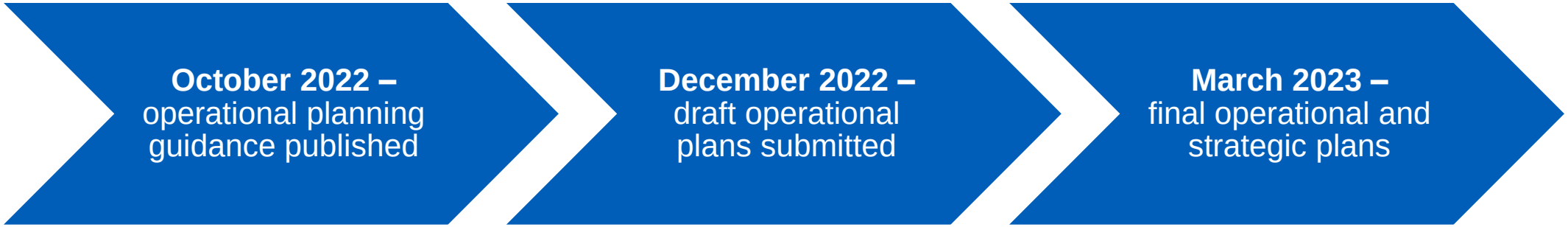
1. Baseline re-set exercise
2. New delegations of services.

The baseline reset exercise started in June 2022. It is intended to adjust for the £5bn issued to systems in 2020/21, based on provider footprint rather than population.

National guidance about the baseline reset, and supporting materials, have been issued via NHSE regional teams.

Multi-year planning

- Under the Health and Care Act, systems (ICBs and partner trusts / foundation trusts) will need to develop **five-year strategic plans**.
- We are currently considering the feasibility of asking systems to develop **operational plans for the first two years (2023/24 and 2024/25)**. This could use the following timeline:



- The Standard Contract would continue to apply for 12 months, although longer-term contracts can be agreed.

Multi-year planning should support service transformation and help systems avoid cliff-edges when shifting activity between settings. The payment system proposals are intended to support this.

Costing

National cost data for all services will be essential for national and local decision making. It will also support systems to understand efficiency opportunities across services, pathways and populations.	Patient-level costs are now mandated for all sectors (acute, ambulance, mental health and community). Reference costs will no longer be collected.	We are expecting that all acute services not yet at patient level will be included in the National Cost Collection next year (summer 2023).
We are reviewing the currencies used for cost collections for acute, mental health and community services.	We are exploring ways to categorise costs as fixed, semi-fixed and variable, and the breakdown of overhead costs.	We are looking at the feasibility and potential benefits of more frequent cost collections, as well as aligning national and local cost collections more closely.

From national tariff to NHS payment scheme

From national tariff to NHS payment scheme

What is not changing

- The payment scheme governs transactions between providers and commissioners.
- The payment scheme rules establish the amount that should be paid.
- NHS England will calculate and publish prices.
- Consultation is required before any new payment scheme is implemented.
- Majority of activity in scope will be subject to blended payment.

What is different

- Collaboration not competition is the main driver for improvement.
- The amount payable can be set in different ways, drawing on information other than prices.
- Payment rules can be set by reference to factors including status of provider.
- Additional flexibility to support longer-term payment rules, eg setting prices using formulas.
- Consultation is on proposals for the scheme, not just on national prices.

Blended payment – overview

A **fixed element**, set based on forward-looking forecasts of activity and costs.

At least one of…

variable element

risk-sharing element

quality- or outcomes-based element

Blended payment – aligned payment and incentive

A **fixed element**, set based on forward-looking forecasts of activity and costs.

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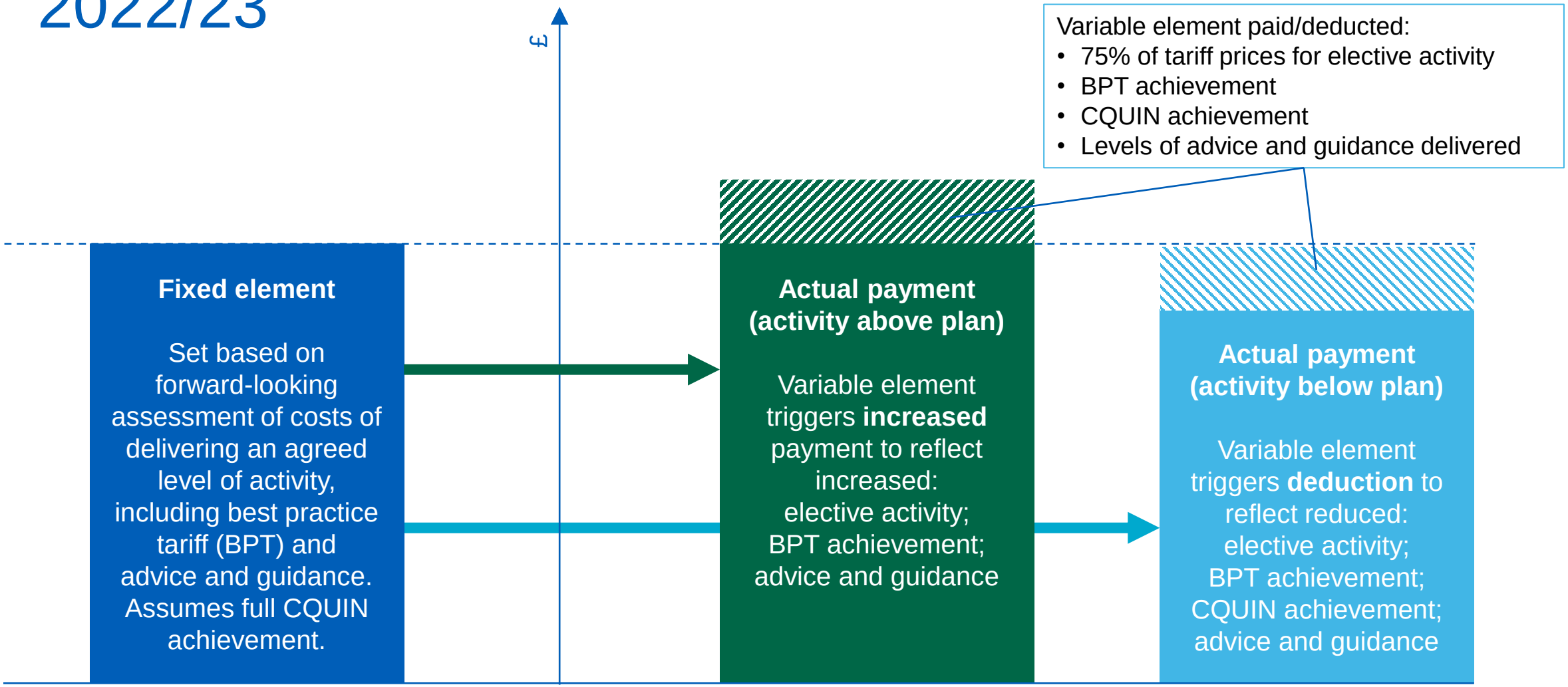
At least one of…

- **variable element**
- **risk-sharing element**
- **quality- or outcomes-based element**

Aligned payment and incentive (API) – 2022/23



Evaluation of API

- In order to **continuously improve our payment policy**, we have been carrying out a **mixed methods evaluation of the API payment model.** We are also undertaking examining the role of **place and provider collaboratives.** Please contact apievaluation@england.nhs.uk
- Initial insights include:

Need for simplicity moving out of Covid and emergency payment

There are cultural challenges in moving to collaboration

Financial quality incentives need to be consistent with collaborative working

Provider collaboratives have a key role ensuring best use of resources

Positive shift in focus toward cost and shared vision around ICB allocations

Can be difficulty getting appropriate data for the fixed element

Payment system 2023/25 – overarching policies

NHS payment scheme – structure

- To simplify its presentation, the payment scheme would focus on its payment mechanisms:

Payment mechanism		Expected to apply to
1	Aligned payment and incentive (API)	Almost all NHS provider/commissioner relationships
2	Block contract	NHS provider/commissioner relationships with an annual contract value below £0.5m (low volume activity – LVA)
3	Unit prices	Independent sector services (covered by published prices); activity not covered by API
4	Local agreement	Activity not otherwise covered

- We want to understand where areas want to depart from the payment mechanisms set out in the NHS payment scheme. There will be a variations process, and any locally agreed payment approach would need to consider the local payment principles:

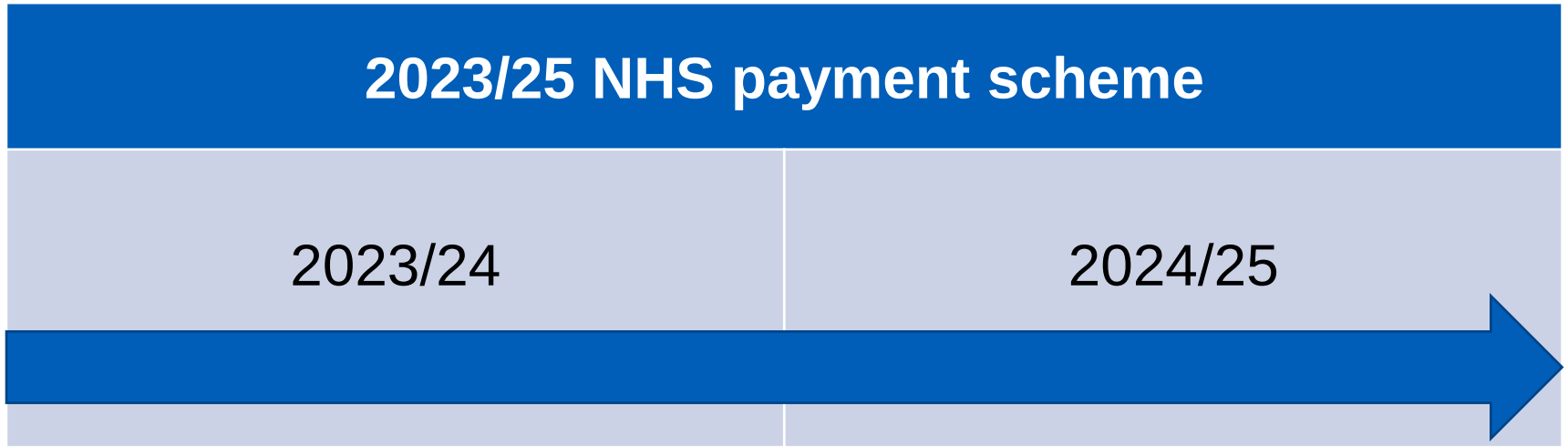
Be in the best interest of patients

Promote transparency

Be the result of constructive engagement

Consider health inequalities

Duration



- The payment scheme rules are set for two years. Inflation, efficiency and prices for 2024/25 would be set based on a formula. This would mean no separate consultation for 2024/25.
- Were the outcome of applying the formula very different to that intended, a different approach could be used. However, there would need to be a consultation before any other approach were implemented.

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Elective recovery fund (ERF)

- The Elective Recovery Fund is a key plank in supporting and enabling elective recovery.
- For 2022/23, ERF operates as follows:

Systems allocated extra £2.3bn to fund 104% of 2019/20 activity	Goal is to deliver 110% of 2019/20 completed pathways	ERF funding should be included within API fixed elements	API variable element adjusts funding (75% of tariff price) to reflect actual activity, compared to 104% of 2019/20

- We expect there to be continued support for elective recovery during 2023/24. However, this may not use the same design as 2022/23.
- We welcome feedback on the ERF, and suggestions for improvements – please use the chat and the online survey.

High cost drugs and devices

- Funding for high cost drugs and devices should ensure they can be accessed where required without risking destabilising standard payment arrangements (ie API, prices, etc) by representing an unpredictable or disproportionate pressure.
- For devices, all listed high cost devices should be excluded from standard payment arrangements.
- For drugs, the following table summarises the situation:

	Drugs which are very expensive and/or unpredictable in their use, including newly introduced drugs (Currently 376 drugs)	Drugs which are still relatively expensive but been in use for a longer period and are more predictable in their use (Currently 55 drugs)	Drugs which are more stable in their costs and use, or are off patent, and are likely to have been in use for a number of years
API fixed element	Excluded	Included	Included
Unit prices	Excluded	Excluded	Included

- Where items are excluded, they should be paid for by the relevant commissioner on a cost and volume basis.
- **We are not proposing to change the way the funding for high cost drugs and devices operate for 2022/23.**
- We are reviewing the list of items excluded from both prices and API, working with specialist steering groups.

Payment and health inequalities

Feedback to 2021/22 tariff policy proposals				
Uncertainty to what impact API could have on health inequalities	Published information did not specifically address health inequalities	View policies would not directly impact health inequalities but implementation might	Concerns payment could increase health inequalities, eg local discretion for specialised treatment	Disparity between API and Low Value Contracts.

Under the 2022/23 National Tariff:

- API rules and guidance state that reducing health inequalities should be considered when establishing the contract, underpinned by analysis of suitably disaggregated data. Providers and commissioners are also asked to consider using the Core20Plus5 approach to achieve better and more sustainable outcomes.
- Local payment principles updated to include consideration of how payment approach could reduce health inequalities

For 2023…

- There is much more to do to support improvements in health outcomes, reducing health inequalities.
- We are currently exploring areas where the payment system may support improvements in health inequalities. These include:
    - A PLICS Index Model which could help ICBs prioritise resources in certain areas by protected characteristics and geography
    - adjustments to the allocations formula to enable a fairer approach
    - a review of the CORE20PLUS5 clinical areas; maternity, hypertension, respiratory, cancer and mental health, supported by the development of guidance and implementation tools

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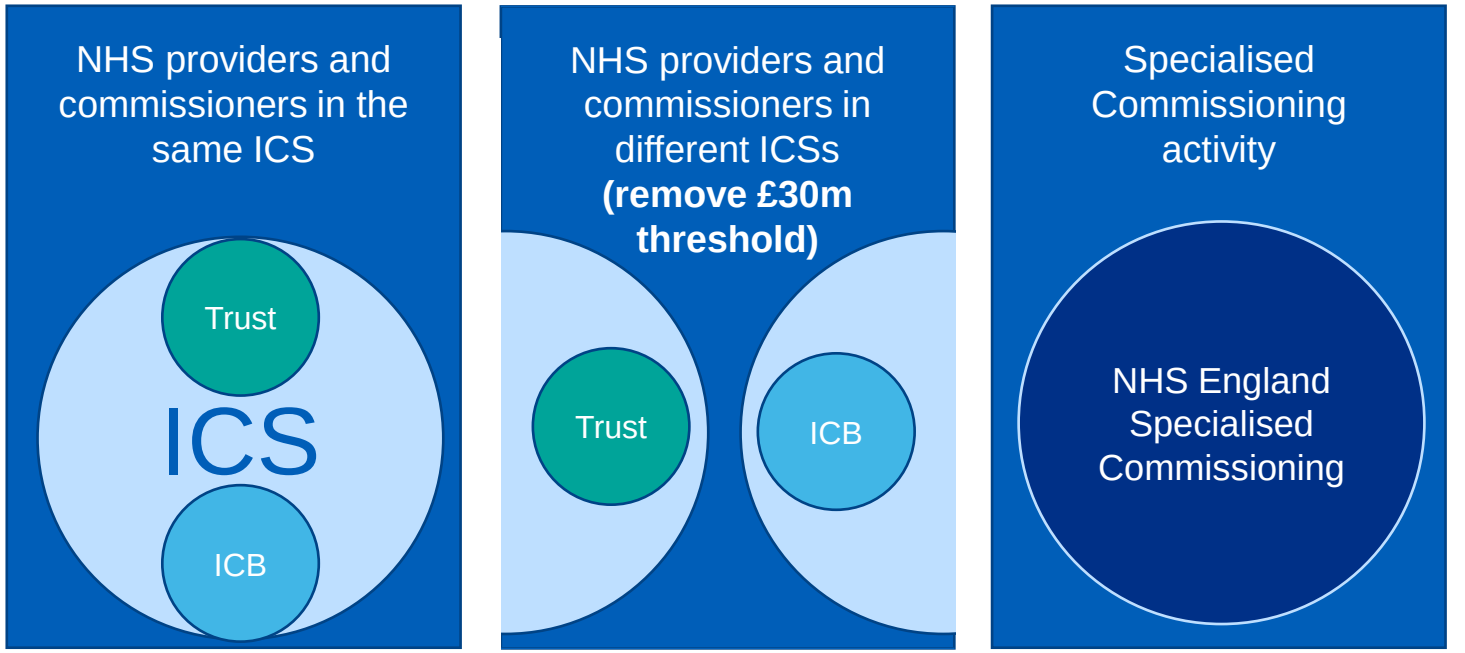
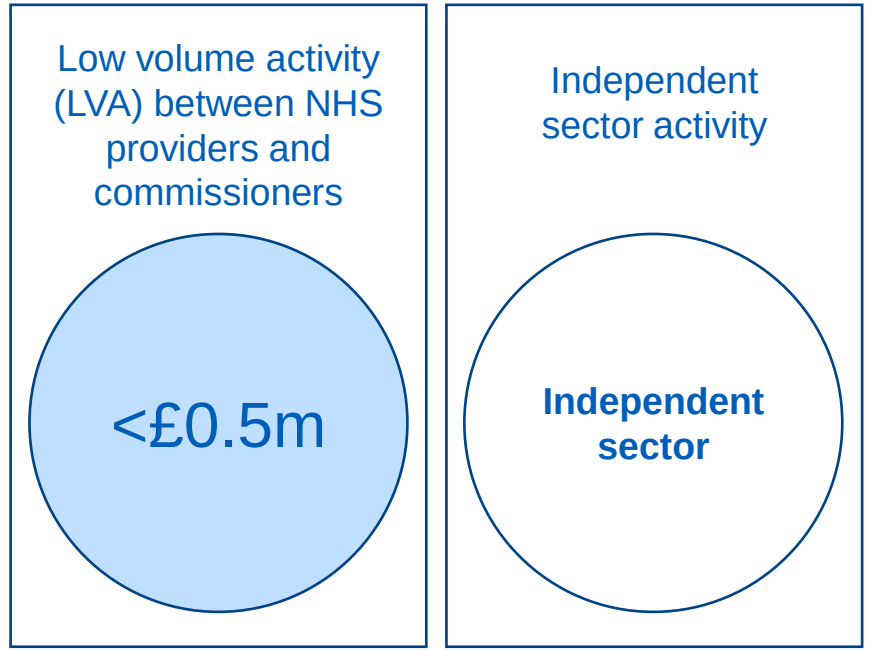
Payment mechanisms 1 and 2:
Aligned payment and incentive and block contracts

Scope

Covered by API arrangements

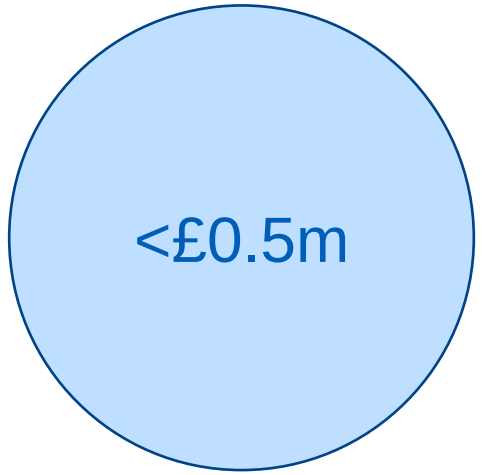


Not covered by API arrangements



Low volume activity

- For NHS providers (other than ambulance trusts), we have established a new system to fund small flows of activity from commissioners (at ICB footprint), where there was no contractual arrangement, formerly non-contracted activity (NCA)..
- In 2022/23, where the expected annual value of a funding flow was below £500,000, a single fixed value was paid, once, by the ICB to the provider.
- The fixed value is set by NHS England using a three-year rolling average of SUS activity (for acute providers) and finance payments data (for non-acute).
- Implementation of LVA led to a significant reduction in administering these small flows of activity, removing circa 0.5m transactions from the system.



- For 2023/25, we expect LVA arrangements to be mandated through a rule in the NHS payment scheme.
- We are reviewing the arrangements, in particular:
  - whether the threshold is set at the correct level
  - updating the 3 year average LVA values as appropriate.
- The NHS Standard Contract team will also be seeking feedback on the LVA arrangements.

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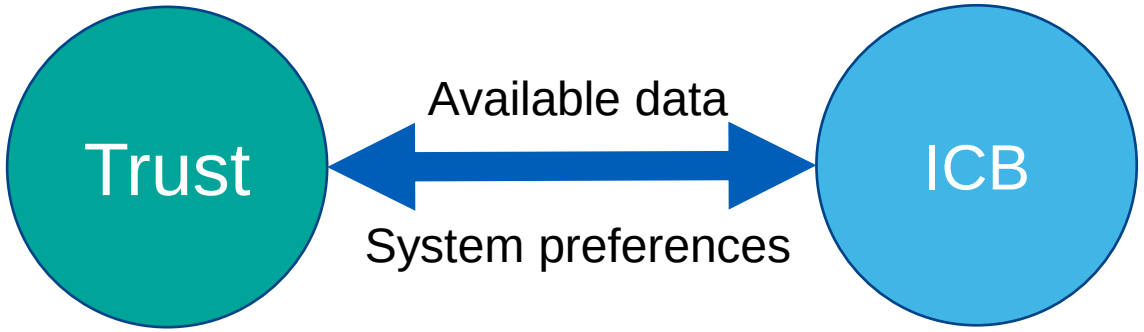
Fixed element – overview

- The fixed element should be based on a **forward-looking assessment** of the suitable level **of payment required** to deliver the activity identified in the **system plan**.
- Payment scheme rules would **not specify** how the fixed payment should be calculated.
- It will need to be agreed between the provider and commissioner and will depend on available data and local system preference. This should include consideration of previous years' income and adjustments for service transformation, inflation, efficiency, etc.



- A whole system planning approach is expected to be used when setting the fixed element.

Information to support fixed payments

- While there would not be a nationally prescribed approach to setting the fixed element, we expect to produce some national data that should be considered when agreeing these payment levels.
- These data would be shared through various tools, which are currently being developed (and available on FutureNHS for feedback). These include:

PLICS analysis – gives an ICS view of published PLICS information, identifying potential efficiencies through peer benchmarking

Analysis of best practice – pathway transformation, within a whole system, using national best practice information

- We want systems to use the information in the tools to consider the areas where they have greatest variations from their peers, and where there may be opportunities for efficiencies.

We will be running a deep dive session on 20 July where we will go in to more detail of the products

PLICS analysis – illustrative example 1/2

1. The PLICS output for a **hypothetical** ICB shows that the ICB's providers are delivering services, on average, 4.5% more costly than the national average. Drilling down to HRG subchapter level shows some services around 10% more costly.

HRG Subchapter Description	Total Costs for ICB (£m)	Total ICB Costs per 1,000 weighted population	National Average costs per 1,000 population	Difference from Average
Ear, Nose, Mouth, Throat and Neck Disorders	£5.0	£3,347	£3,013	11.1%
Orthopaedic Non-Trauma Procedures	£64.5	£43,013	£39,044	10.2%
Ear, Nose, Mouth, Throat and Neck Procedures	£16.7	£11,163	£10,170	9.8%
Obstetric Medicine	£55.2	£36,776	£33,547	9.6%
Non-admitted Consultations	£135.6	£90,390	£82,464	9.6%
.....				

2. Services are then broken down into activity and unit costs. For the 9.6% higher cost of non-admitted consultations, this breaks down into 16.5% more consultations per head of population than the national average. These are being undertaken 5.9% more cheaply than average.

			Activity per 1,000 population			Unit Cost		
HRG Subchapter Description	Total Costs for ICB (£m)	Difference from Average	ICB	National	Difference	ICB	National	Difference
Ear, Nose, Mouth, Throat and Neck Disorders	£5.0	11.1%	157	168	*-6.5%*	1,140	960	*18.8%*
Orthopaedic Non-Trauma Procedures	£64.5	10.2%	618	612	*-8.1%*	2,139	1,960	*20.3%*
Ear, Nose, Mouth, Throat and Neck Procedures	£16.7	9.8%	1,553	1,603	*4.4%*	412	364	*5.8%*
Obstetric Medicine	£55.2	9.6%	1,581	1,542	*-2.1%*	1,139	1,066	*12.7%*
Non-admitted Consultations	£135.6	9.6%	200	172	*16.5%*	185	196	*-5.9%*

PLICS analysis – illustrative example 2/2

3. A further drill down to HRG/TFC level would then allow further detail underlying the variation. In our example, the higher than average non-admitted consultations is being driven by consultant-led ophthalmology follow-up attendances being 50% higher than expected.

Treatment function description	Consultant led 1st	Consultant-led follow up	Other consultation
General Surgery Service	5%	2%	4%
Urology Service	-6%	-1%	0%
Ophthalmology Service	0%	50%	10%
Pain Management Service	10%	3%	3%
Diabetes Service	5%	5%	-10%

4. The drill down would also look at provider level data, so that if an ICB-wide average cost was higher than expected, they could look to see which services/HRGs were causing this and at which providers:

Unit costs	Provider A	Provider B	Out of System Providers
Orthopaedic Non-Trauma Procedures	£2,240	£1,800	£3,000

In our (hypothetical) example: ophthalmology services are identified as having higher than average costs due to higher than expected follow-up appointments, while orthopaedic non-trauma procedures are identified as having high unit costs due to out-of-system providers.

These services should therefore be looked at in setting future fixed payments.

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Variable element – elective activity

- The variable element is primarily designed to help deliver goals which we don't feel are wholly supported by the fixed element.
- For elective recovery, where actual activity is different to plan, funding is increased or decreased by 75% of the unit price. This helps to support plan, but recognises that actual delivery across the system may differ.
- We are considering whether to continue with these arrangements or if there would be merit in:

Simplifying out of system arrangements (where possible)

Moving to 100% variable rate

- We don't believe a variable payment linked to any acute non-elective activity would be appropriate, given the aims to reduce this demand where possible. We are exploring how a variable payment for mental health or community services could support this aim.
- Linked to the variable element is risk sharing. We are not proposing any specific risk sharing arrangements, but we continue to support their use at a local level.

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Variable element – quality of care

- We want to retain a care quality aspect to API. This currently takes the form of the existing quality-related payment schemes: CQUIN and best practice tariffs (BPTs).
- It is important to recognise that this variable element should be seen as one part of a broader set of levers for improving quality such as CQC, QOF, Investment and impact fund (IIF), etc
- For 2022/23, the majority of systems have applied to NHS England to disapply some or all of the CQUIN and BPT schemes. This continues the trend pre-pandemic of providers not transacting BPTs and CQUIN in their aligned incentive contracts.
- Possible options for 2023/24:

Repurpose BPTs so that they support systems in setting fixed payments – essentially move the BPTs to an annual process to align with planning.

Refocus CQUIN so that it is clearly aligned with fewer, high priority national objectives (eg those set out in the NHS Long Term Plan refresh). Reconsider its scope and value

Collate, nationally, CQUIN and BPT metrics on a quarterly basis so that there is transparency around provider performance.

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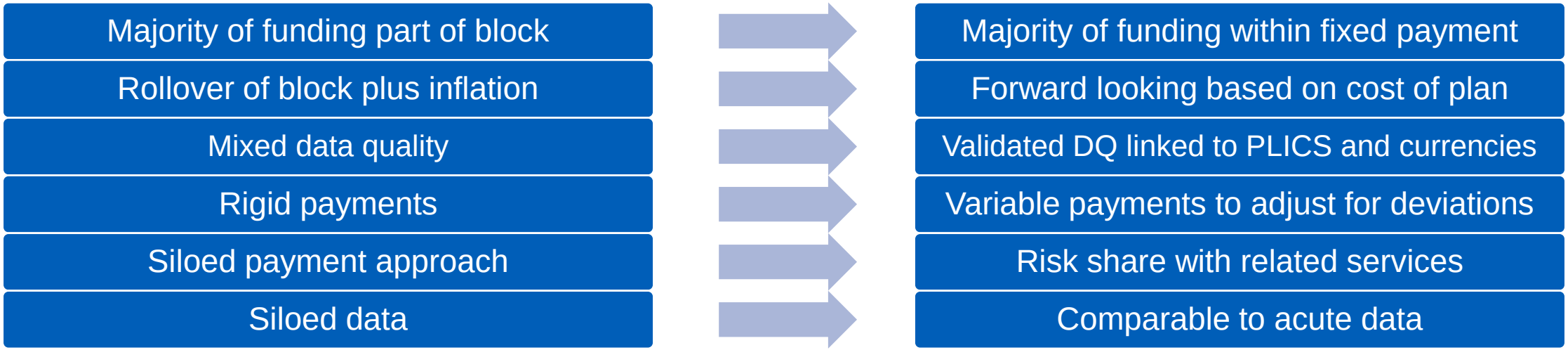
API for non-acute services

Strategic objectives

- Fully implemented currency models for all community and mental health areas
- Community and mental health currencies integrated to PLICS and CSDS/MHSDS
- Rich data source to inform design of a fixed payment which is reflective of costs of delivering forward looking system plan
- Pre-agreed variable payment and risk share to mitigate risks around possible unexpected deviations from plan
- Alignment to wider system payment models (acute, ambulance etc)



API for non-acute services: example

Illustrative example of implementing API for community dialysis services

Current arrangements	Potential future arrangements
Block funding arrangement based on previous years, adjusted for inflation and efficiency	Majority of payment included in the fixed element, covering the expected level of funding to deliver the annual planned dialysis activity, including any additional equipment and training requirements
Data quality poor and difficult to benchmark	Data quality consistent, with linked currency and PLICS information. Data can also be compared between clinics, community teams and emergency services to support identification of efficient care models and best practice
Payments not adjustable if actual dialysis activity varies from plan (under or over)	Variable payment is agreed (eg at marginal cost), which stipulates how payment envelope should be adjusted for activity level above or below plan. Could include flex where variable payment not needed or “break glass” in case of extreme variation
The payment arrangements for dialysis are separate to related services	There are aligned incentives with related services, such as primary care referral services, MDT teams and transplant services to support joint working and better patient outcomes

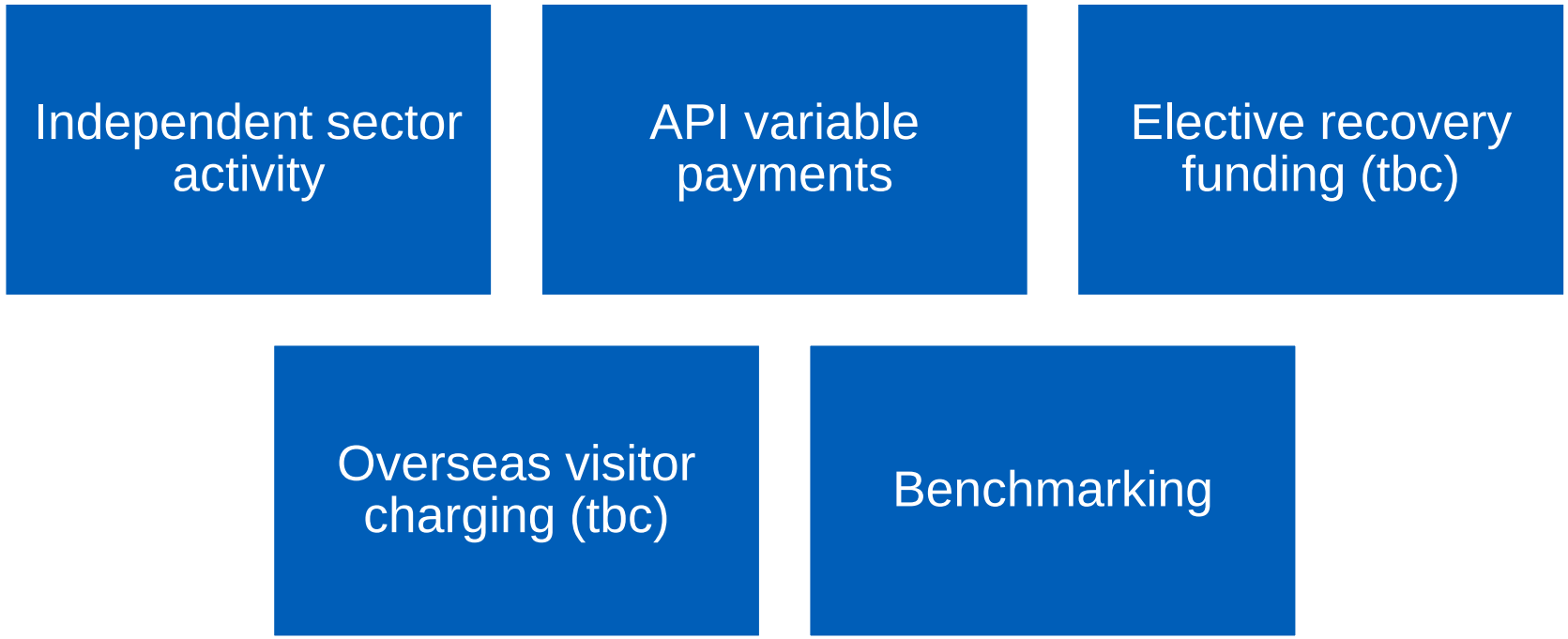
Variations to API

- The vast majority of funding in an API agreement should captured by the fixed element, which is wholly locally determined.
- We want to retain a degree of this flexibility around the variable element. Providers and commissioners – with support of their system(s) – can adopt a different approach if it can demonstrate that it will deliver the goals of the variable element.
- **There will be a continued requirement for NHS England to approve these.** This is to ensure that both payment system and wider NHS goals are being delivered.
- We have been fairly strict this year; a function of API being newly introduced and the strong need to recover from Covid as quickly as possible. We are still developing the approach for next year – please share your views using the online survey.

Payment mechanism 3:
Unit prices

Role of prices

- The proposed NHS payment scheme would specify that prices should be used for:



- We would not expect prices to be mandated in setting API fixed element but can be use as part of the national standardised benchmark.

Setting prices

- Prices will continue to be calculated and published for all services previously covered, and available for use where appropriate.
- Prices for 2023/24 to be set as rollover of 2022/23 tariff prices (and currency specification). They would be updated for inflation (pay, CNST, etc) and efficiency.
- Prices would continue to include adjustments including specialist top-ups, high cost drugs and devices, outpatient frontloading.
- Previous national variations, such as market forces factor (MFF), would be applied where prices are used.

Updating prices using formulas

- Under the 2022 Health and Care Act, in addition to specified prices, prices can be set as formulas, rather than £ values.
- Prices in consultation may need to be updated before final payment scheme, to reflect final inflation/efficiency figures, CNST, etc.
- Prices for 2024/25 may be set as formula (such as % increase based on GDP deflator) of 23/24 – or reissued using payment scheme amendment process (for example, if the outcome of the formula would be very different to that expected).
- In the consultation, we would include best available estimates of potential inflation figures.

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Pricing analysis

- The process of setting prices involves analysis of a huge range of data. We are working on a number of projects to use this analysis to help identify key issues. This includes:

Impact of COVID-19: We are doing analysis on the effect of COVID on the average cost (and calculated price) of some services, identifying areas where clinical practice may have changed, leading to a sustained cost change.

Data quality monitoring: We are actively monitoring data quality through trend analysis and quality metrics. We are working with stakeholders to develop the metrics as well as take action on improving data quality. We are considering whether to produce a data quality benchmarking tool, either as part of an existing product (such as the Model Health System) or standalone.

These projects will be covered in more detail in a September 2022 webinar.

Other policy areas

Market forces factor

- The market forces factor (MFF) calculation method and data was extensively updated for the 2019/20 National Tariff. A five-year ‘glidepath’ was introduced to transition the changes, through to 2023/24. MFF values for 2022/23 represent stage 4 of this glidepath.
- While the MFF may have less direct impact on payments under API, it remains applicable to prices (whenever they are used) and is also used in calculating commissioner allocations.
- The current MFF values are based on data from 2014 – 2017. There is, therefore, a risk that the values will no longer be reflective of unavoidable costs, given changes over time.
- Analysis suggests that continuing to the fifth step of the 2019/20 glidepath may move MFF values in a direction inconsistent with more recent data. As such, for 2023/25 we are considering two options:

Keeping MFF values at stage 4 of the 2019/20 glidepath (ie no change from 2022/23)

Updating the underlying data and publishing a new set of MFF values

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Innovation

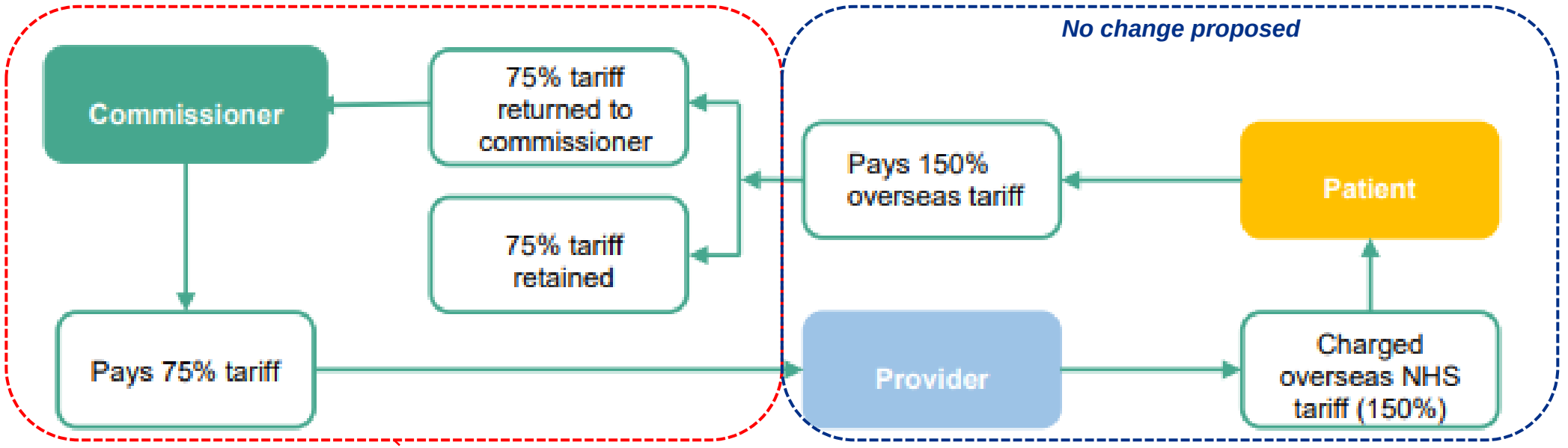
- The 2022/23 tariff set out the payment approach for products covered by the MedTech Funding Mandate. This was part of a larger project, working with the NHS England innovation team, to ensure payment policy removed barrier and created positive enablers for innovative technologies.
- For 2023, we are moving into phase two of this project, which will focus on developing appropriate payment approaches for digital technology, new models of care and ways of working. We are intending to develop payment policy proposals to support generic innovations and specific support for six innovations reviewed
- These are likely to include:

Virtual consultations	Anticipatory care	Integrated diabetes model of care
Virtual wards	Hypertension case finding	UEC system optimisation/reducing ambulance handover delays

- We will also evaluate the 2022/23 policy on MedTech and update the list of items covered by MedTech mandate

To find out more about the development of innovation payment policy, please join our deep dive webinar on 21 July

Overseas visitor charging – risk share options



Option 1	Option 2
Reinstate nationally mandated provider/commissioner risk-share arrangement at 75%	End episodic risk-share. Instead, local arrangements should be agreed as part of setting the API fixed element.

Option 2 would involve:

- Understanding current levels of chargeable overseas visitor (COV) activity and how much income is recovered
- Agreeing plans for improving COV recovery
- Building risk-share income for the accepted unrecovered element explicitly into the upfront agreement of API terms
- This could be reviewed and re-set on a periodic (e.g. annual depending on the contract term) basis to reflect latest information

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Longer-term developments

Currency development

- To function effectively, systems need standardised data for benchmarking, planning and commissioning services.
- Currencies offer a consistent formula for understanding populations and care provided, supporting an enhanced understanding of patient complexity across a system footprint.
- This will be integral to collaborative working, supporting a common language across providers, irrespective of size or organisation type.
- Currency information should be used for payment. However, currencies are based on clinical information and should therefore also be useful for service planning and understanding the needs of a population.
- Currencies allow stratification of populations based on need and complexity, supporting population health approaches.

Systems will:

- Collectively ensure processes are in place to facilitate the collection of quality data which will be used to derive currencies.
- Use currency information to support the building of effective blended payments, embedding currencies and related data into decision making processes.

We will:

- Use currencies to inform payment rules and guidance.
- Support the development of meaningful currencies, ensuring that currencies cover all services provided.
- Continue to develop non-acute currency models based on population need. Prioritising these currencies to ensure equity across services.
- Review existing models to ensure they support system intelligence.

Further payment development projects

Long Term Plan refresh

- Ensure payment system supports delivery of objectives and commitments set out in the NHS Long Term Plan refresh.
  This could include commitments on net zero, health inequalities and specific services.

Health inequalities

- Support Core 20 Plus 5. Align payment development with health inequalities. Support implementation of changes to allocations related to cost differentials for different population group ratios.

Currency development

- Community: testing and demonstrating CDS data and PLICS through the currency.
  Mental health: Develop the currency model and communicate it with users. Start testing how data flows through currencies.

Whole system approach

- Consider how payment policy can be better aligned across the whole system and how funding can most effectively flow across the whole patient and population pathway.

Tools, products and other information

- Improve current products and make sure access and use aligns with sector and NHS England objectives.
  Develop criteria for prioritising future product development.

Co-production webinar for future payment development planned for September 2022

Next steps

We are running the following webinars to go into more detail in some areas:

2023 finance and payment – Q+A; 18 July, 1-2pm

Information products to support fixed payments; 20 July, 12-1.30pm

Innovation and payment in the NHS; 21 July, 12-1pm

We will contact you soon about further engagement planned for September 2022.

You can also find out more about our work on our **FutureNHS workspace**