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Who Pays for a NICE-Approved Diabetes Technology?

NHS management and funding — a working map for a National Market Access Key Account Manager

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A diabetes technology can be recommended by NICE, wanted by every clinician who has seen it work, and still reach almost nobody for two years. The gap between recommendation and use is rarely a clinical problem. It is a question of which pound pays, under which clause, approved by whom — and diabetes has an unusually large number of answers to that question, because the device is bought by a hospital through a national framework, the sensors are prescribed by a GP against an ICB budget, the money may arrive as a national top-up that is conditional on an audit return, and the clinic that would fit it has no educator free until the spring. Each of those is a different mechanism, with different rules, different decision-makers and a different failure mode.

The role in one line. Lead national market access for a newly NICE-approved diabetes technology: build and run account plans with Medical, Commercial and External Affairs, navigate the funding pathway, and win local and regional tenders.

What this briefing does. It follows the money from NICE publication to a device in a patient's hand, naming the mechanism, the clause or fund it sits in, the people who sign it off, and what usually goes wrong. It is written for the 2026 NHS: NHS England is being absorbed into the Department of Health and Social Care, ICBs have been reduced in number and recast as strategic commissioners, and the money is moving toward population budgets and outcome-linked payment.

> **The single most important question**
>
> Diabetes technology reaches the NHS through **four different NICE routes**, and they carry **completely different funding obligations**. A technology appraisal creates a statutory duty to fund. HealthTech guidance does not. Until you know which route your product came through, you cannot write the account plan — you do not know whether you are enforcing a mandate or building a business case from scratch. Everything in Section 1 follows from this.

Compiled 15 September 2026. Not advice — a map.

1. Which NICE route did it come through?

"NICE approved" is not one thing. For a diabetes technology there are four routes, and the funding consequence of each is different. This is the first question to settle with Medical and Regulatory.

1.1 Technology appraisal (TA) — the only route with a statutory funding duty

A NICE technology appraisal creates a legal funding requirement. The regulations require NICE to specify a compliance period that **begins on publication and ends three months later**; commissioners and providers must make the technology available within that window. NHS England can apply to vary the deadline where the **net budget impact is expected to exceed £20 million a year in any of the first three financial years** — NICE's guidance executive decides, extensions typically run to a maximum of three years, and any application must set out a **phased allocation of funding** and interim commissioning arrangements.

Diabetes technology has already used this route. **TA943 (hybrid closed loop systems for type 1 diabetes)** is a technology appraisal, and access runs through a **five-year phased rollout** in line with NHS England's implementation plan — the longest variation the system has granted for a device. If your product is a TA, the mandate is your strongest asset; if it has a phased rollout attached, your real job is being first in each ICB's annual cohort.

1.2 HealthTech guidance — no funding duty

NICE consolidated its Diagnostics Assessment, Interventional Procedures and Medical Technologies Evaluation programmes into a single **HealthTech programme** (manual PMG48). It issues HealthTech guidance across diagnostics, devices and digital technologies, with three lifecycle routes:

- **Early use** — conditional recommendation for a technology addressing an unmet NHS need, with evidence generation and reassessment
- **Routine use** — an established product assessed on clinical and cost effectiveness
- **Existing use** — guidance on technologies already in the NHS, to inform commissioning

None of this carries the TA funding requirement. A HealthTech recommendation is permission and evidence — it is not money. Local adoption is discretionary and has to be argued for, ICB by ICB, trust by trust.

1.3 MedTech Funding Mandate (MTFM) — a narrow but real obligation

The MTFM accelerates adoption of technologies that are clinically effective and **cost saving within three years**, with **total costs not exceeding £20 million**, evidenced through NICE resource impact assessments. It applies to **NICE medical technologies guidance, not technology appraisals**. The NHS Standard Contract requires both parties to comply with their obligations under MTFM guidance; commissioners fund the technology from existing allocations on a cost-and-volume basis, and the products sit as **excluded items in the NHS Payment Scheme**, paid as pass-through rather than inside core prices. A diabetes technology that is genuinely cost-saving inside three years should be tested against these criteria early — it is a far faster route than a TA.

1.4 National HealthTech Access Programme — the new national reimbursement route

Announced in **February 2026** by NICE with DHSC, NHS England, the MHRA and the Office for Life Sciences, this extends the technology appraisal framework to devices, diagnostics and digital tools: a small number of high-impact technologies will be **reimbursed and made available across the whole health service, in the same way as medicines**. First selections were capsule sponge testing for oesophageal cancer and AI tools for prostate and

breast cancer. This is the route to watch — and, for a high-impact diabetes technology, the one to lobby for through External Affairs.

Route	Funding obligation	What your account plan is really doing
Technology appraisal	Statutory — 3 months, variable to ~3 years (5 for HCL) on >£20m budget impact	Enforcing a mandate; competing for cohort places in a phased rollout
HealthTech guidance	None	Building a local business case from scratch, 36 times over
MedTech Funding Mandate	Contractual via NHS Standard Contract; pass-through payment	Holding commissioners to an existing obligation and easing cash flow
National HealthTech Access Programme	National reimbursement, medicines-style	Getting selected — an External Affairs and evidence play, not a field play

2. Who holds the money in 2026

The structure you learned five years ago has changed twice since, and the second change is still in progress.

2.1 NHS England is being abolished

The Health Bill introduced in **May 2026** ends NHS England as an independent arm's-length body and transfers its powers to the **Department of Health and Social Care** — the functions of holding and allocating funding, producing policy and guidance, and overseeing data and IT. The Bill also removes the requirement for ICBs to include GP, local authority and NHS trust representatives on their boards, removes their duty to maintain the financial health of local trusts (replacing it with spending objectives set by the Secretary of State), and — directly relevant here — gives the Secretary of State power to **set deadlines for implementing NICE decisions**. The merger has been targeted for completion around **October 2026**.

> **Why this matters to you**
> Three consequences for a national access role. First, national policy sponsorship now sits closer to ministers and further from NHS England directorates — External Affairs targets shift. Second, the people who ran national diabetes programmes are inside a redundancy and restructuring process, so institutional memory is thin and relationships are churning. Third, the Secretary of State's new power over NICE implementation deadlines means the compliance clock on your product can be moved politically, in either direction.

2.2 Fewer, bigger ICBs as strategic commissioners

From **1 April 2026**, twelve ICBs were abolished and six new ones established, with one further boundary change — taking England from 42 to **36 ICBs**. A second wave follows on **1 April 2027**. The stated purpose is coterminosity with strategic authorities and enough scale for ICBs to run resilient specialist teams within a running-cost cap.

The **Strategic Commissioning Framework** (November 2025) sets out what that means in practice. ICBs move to a four-stage cycle — understand context, build a population health strategy, deliver through resource allocation, evaluate impact — and become "intelligent healthcare payors". They are told to stop commissioning prescriptively and stop relying on activity-based contracts, and to move toward **outcomes-based specifications, value-based and capitated models**, commissioning whole pathways rather than individual services. Providers take on more: **single and multi-neighbourhood providers**, and **Integrated Health Organisations holding whole-**

population budgets. ICBs completed baseline self-assessments by March 2026, with formal assessment beginning April 2026.

> **The commercial read**
> Whole-population budgets and capitated contracts mean the buyer of a diabetes technology increasingly carries the downstream cost of not buying it. That is the best structural argument a diabetes technology has had in a decade — avoided admissions, avoided DKA, avoided retinopathy and foot disease all land in the same budget. But it also means **fewer, larger, more sophisticated negotiations**, with finance people who will want a modelled net position, not a QALY.

2.3 Where diabetes technology is actually initiated

Specialist diabetes services in acute trusts lead provision of pumps, CGM and closed-loop systems; GPs refer in for initiation and ongoing management. Simpler CGM for type 2 diabetes is increasingly a primary care prescribing decision. That split — secondary care initiation, primary care prescribing — is what makes diabetes technology funding genuinely complicated, and it is the reason the routes in Section 3 do not collapse into one.

3. The five money routes

A diabetes technology can be paid for in five distinct ways. Most products use more than one at once — the device through procurement, the consumables through the Drug Tariff. Knowing which pound is which is the core technical skill of the role.

3.1 Drug Tariff Part IX — primary care prescribing

CGM sensors, transmitters and pump consumables are **appliances**, listed in **Part IX of the Drug Tariff** and prescribable on FP10. Manufacturers apply to NHSBSA using **DT1 forms**, in scheduled **waves**, assessed under an **Enhanced Assessment Framework**, with a Part IX Drug Tariff forum secretariat handling the process. Listing is what makes a product reimbursable in primary care — without it, no GP can prescribe it.

The cost then falls on the **ICB prescribing budget**, visible in ePACT2, and is therefore governed locally by the **Area Prescribing Committee / medicines optimisation group and the local formulary**. In practice almost every ICB has a published CGM position statement setting out which brands are first-line and on what criteria. Getting listed in Part IX is necessary; getting onto 36 formularies as the preferred option is the actual job.

3.2 NHS Supply Chain — the national framework

Insulin pumps, CGM and closed-loop products are bought through the **NHS Supply Chain national framework**. For hybrid closed loop this is not optional: under NHS England's implementation strategy, ICBs may only claim reimbursement where providers **purchase from the national framework**, and suppliers must agree cost-effective prices consistent with NICE's £20,000-per-QALY threshold. NICE's own TA943 page directs pricing enquiries to NHS Supply Chain.

> **The hard gate**
> If your product is not on the relevant NHS Supply Chain framework, a trust that wants it **cannot lawfully claim the national funding for it**. Framework inclusion is therefore not a procurement detail to be delegated — it is the precondition for the entire account plan, and its renewal date is the single most important date in your calendar.

3.3 NHS Payment Scheme 2026/27 — how providers get paid

The **2026/27 NHS Payment Scheme** sets four mechanisms: **Aligned Payment and Incentive (API)** for NHS commissioner–provider relationships above £1.5m a year, combining a fixed element for non-elective work with variable payment for elective, emergency and diagnostic activity; **low volume activity block payments** below £1.5m; **activity-based payment** for non-NHS providers; and **local payment arrangements** elsewhere.

The clause that matters for devices: **high-cost devices and drugs are excluded from the core payment mechanisms**. Commissioner and provider agree the price directly, avoiding double-counting against unit prices, and where a reference price exists — set deliberately to incentivise uptake — it applies; otherwise payment is the **lowest of actual cost to the provider, the nominated supply cost, or any other applicable reference price**. **MedTech Funding Mandate products are listed in Annex A** as excluded items, with implementation costs built into the API fixed payment.

- **Read it this way:** exclusion from tariff is good news — it means the provider is not absorbing your product inside a fixed price. But the "lowest of" rule caps what they will pay, and a reference price set nationally will discipline your list price everywhere.

3.4 National top-up funding — the hybrid closed loop model

This is the most instructive precedent in the field, and worth knowing in detail. For HCL, NHS England ran a dedicated funding architecture on top of normal allocations:

- **£2.5m mobilisation fund** released December 2023 — roughly **£60,000 per ICB** for clinical time release, training, hub-and-spoke arrangements and administration
- **£14.1m in year one** via **Service Development Fund** top-up allocations (allocation letter 19 July 2024), rising annually in line with projected uptake across the five-year rollout
- **75% of estimated incremental cost** reimbursed to ICBs through quarterly SDF adjustments, against activity returns
- A **fixed maximum funding envelope per ICB per year**, calculated from National Diabetes Audit, National Pregnancy in Diabetes Audit and National Paediatric Diabetes Audit data, type 1 population size, and existing CGM and pump usage
- Conditions: purchase only from the national framework, submit baseline data, complete **quarterly audit returns**, have an approved local delivery plan, and ensure CGM provision costs are covered. **Money flows only after patient data is recorded in the national audits.**

Prioritisation ran in cohorts — children and young people regardless of HbA1c; people who are pregnant or planning pregnancy; then adults transitioning from pumps with HbA1c ≥58 mmol/mol or disabling hypoglycaemia — extending to pump-naive adults as specialist workforce capacity grew. The five-year timetable exists because of **workforce capacity, not affordability**, and a hub-and-spoke model was built so early-adopter centres could train neighbouring trusts.

> **The lesson for your account plan**
> In a phased national rollout, the binding constraint is **clinic capacity and educator time**, not the price of the device. The accounts that move fastest are the ones where you have helped solve the workforce problem — training, pathway redesign, data submission support. Also note that NICE's original £5,900–£7,500 first-year cost estimates are now regarded as out of date, with real prices significantly lower after national negotiation: never quote a NICE resource impact figure to a finance director without checking it against the framework price.

3.5 Better Care Fund — usually not your route, but name it

The **BCF for 2026/27** totals **£9,154m**: £5,791m NHS minimum contribution, £2,640m Local Authority Better Care Grant and £723m Disabled Facilities Grant, pooled by ICBs and local authorities in **section 75 pooled funds** under the NHS Act 2006, governed through health and wellbeing boards. Its three national conditions are integrated preventative care linked to neighbourhood health services, compliance with expenditure conditions (including a 4.4% uplift to the NHS minimum contribution to adult social care), and effective governance. Spending is directed at intermediate care, avoiding admissions and long-term care, hospital discharge, home adaptations and carer support.

Long-term condition management and technology-enabled care are **not** designated BCF spending categories. It is a real £9bn pool, but a diabetes technology does not normally come out of it — unless you are making a specific argument about avoided admissions in frail older people with diabetes, through a health and wellbeing board, which is a long and unusual road.

4. The levers that create local demand

Funding routes tell you where the money is. These frameworks tell you why someone in the system wakes up wanting your product. This is where account planning stops being administrative and starts being persuasive.

4.1 NHS Standard Contract 2026/27

The contract between commissioners and providers is where national policy becomes enforceable. It carries the obligation to comply with NICE technology appraisal funding requirements, and — explicitly — with obligations and recommendations under **MedTech Funding Mandate guidance**. It is also where **Service Development and Improvement Plans** live: the mechanism through which a commissioner and provider agree a phased service change, which is often the right home for a diabetes technology rollout that needs pathway redesign rather than just a purchase order.

4.2 NHS Oversight Framework 2026/27 — your metric hook

This is the framework most account managers under-use. It covers NHS trusts, foundation trusts and ICBs, with **86 metrics across seven domains**: population health and inequality; resource allocation (ICBs) or access (providers); care experience; care effectiveness; patient safety; finance and productivity; people and workforce. Organisations are placed in **segments 1 to 4**, published in **public league tables**, and a financial deficit automatically bars segments 1 and 2. Segment 3 and 4 organisations face mandated support, enforcement, restrictions on executive pay and operational freedoms, and possible intensive recovery programmes.

Three of those 86 metrics are directly diabetes-relevant:

- **Percentage of people receiving all eight diabetes care processes**
- **Cholesterol management to NICE guidance**
- **Blood pressure management compliance**

> **How to use it**
> Segmentation is public and personal. A chief executive in segment 3 has a named, published problem. If your technology can be shown to move the eight-care-processes metric — because it captures glucose data automatically, drives structured review, or brings patients into clinic contact — then you are no longer selling a device, you are selling a fix for something that sits on their board papers and in the newspapers. Always open an ICB or trust conversation having read their current segment.

4.3 Quality and Outcomes Framework 2026/27 — the primary care incentive

QOF changed materially for 2026/27 in a way that favours diabetes technology:

- **DM037 is new**: all eight NICE diabetes care processes delivered annually, worth **10 points**, thresholds 40–90%, replacing DM012. It is **all-or-nothing** — a patient missing any one of HbA1c, blood pressure, cholesterol, creatinine/eGFR, urine ACR, foot examination, BMI or weight, and smoking status does not count at all.
- **DM034** (statins, primary prevention) rises from 4 to **8 points**; **DM035** (statins, secondary prevention) rises from 2 to **8 points**
- **CHOL003** falls from 38 to **20 points**, cutting income for high-achieving practices

The all-or-nothing design of DM037 is the opening. Practices now lose the entire indicator for one missing foot check or one missing HbA1c. Any technology that reliably produces a recorded HbA1c-equivalent, or that pulls

patients into a structured annual review, has a direct financial value to a practice that can be quantified per patient — and the same metric appears in the Oversight Framework, so ICB and practice incentives point the same way for once.

4.4 Medium Term Planning Framework 2026/27 to 2028/29

The three-year planning envelope: revenue up 3% in real terms to **£226bn by 2028/29**, capital from £13.6bn to £14.6bn by 2029/30, a mandatory **2% year-on-year productivity improvement**, and a requirement to reach **break-even without deficit support funding** by the end of the period. Allocations move toward fair shares, with a Carr-Hill formula review under way for general practice. A new urgent and emergency care payment model launches in 2026/27 with a fixed element and a 20% variable payment, replacing block contracts; best-practice tariffs push day-case and outpatient shifts in line with GIRFT.

On prevention and long-term conditions it commits to new obesity service models and weight-loss treatment access for around **220,000 adults by June 2028**, **250,000 annual digital weight management referrals by March 2029**, and a **25% reduction in premature cardiovascular mortality over ten years**. On technology it mandates digital-first delivery: 95% of appointments available via the NHS App after triage by end 2028/29, full Federated Data Platform onboarding, migration of patient communications to NHS Notify, and ambient voice technology deployment.

- **The pitch that lands:** break-even without deficit support, plus 2% productivity, means every conversation is a cash conversation. A diabetes technology that reduces clinic contacts, releases educator time, or substitutes remote review for face-to-face appointments is a productivity story first and a clinical story second. Lead with the first and the second will be listened to.

4.5 Cardiovascular Disease Modern Service Framework — your best national hook

Published **7 July 2026**, this is the most useful national document a diabetes technology has in 2026. Modern Service Frameworks are the 10 Year Health Plan's successor to the old National Service Frameworks: national, time-bound delivery plans with named priorities. The CVD framework takes an explicitly integrated **cardiovascular–kidney–metabolic** approach and sets **12 priorities over three years** in the areas where evidence is strongest and performance most inconsistent, including:

- Finding people with undiagnosed or unmanaged cardiovascular-kidney-metabolic risk factors
- **Improving diabetes care processes**
- Increasing SGLT2 inhibitor use among eligible patients, hypertension management, lipid optimisation
- Optimising treatment and improving adherence; strengthening acute stroke and STEMI pathways; expanding rehabilitation

It came with a new government partnership with **Diabetes UK** on the links between type 2 diabetes and cardiovascular disease, including public campaigns and the Know Your Risk tool. Delivery accountability sits with **ICBs**, monitored by DHSC, with formal improvement plans where ambitions are not met.

> **Why this is the hook**
> "Improving diabetes care processes" is a named national priority, an ICB accountability, an Oversight Framework metric and a QOF indicator **at the same time**. That alignment is rare. If your technology touches care processes, every level of the system has a reason to say yes, and you can write one value story that works for a national policy lead, an ICB chief executive, a trust board and a GP partner.

4.6 Innovator Passport

The Innovator Passport — the MedTech Compass mutual-recognition scheme — allows an assessment done once by one NHS organisation to be recognised by others, removing repeated compliance reviews as a technology moves between trusts. For a national rollout across dozens of accounts, this is meaningful: it attacks the duplication that historically made trust-by-trust adoption so slow. Know whether your product has one, and if not, why not.

5. Tendering: what you actually have to win

5.1 Two regimes — know which applies

Getting this wrong is a visible error. There are two separate sets of rules:

Regime	Applies to	Relevance to diabetes technology
Procurement Act 2023	Goods and supplies, including medical devices and consumables	This is your regime. Framework competitions, call-offs and mini-competitions for pumps, sensors and closed-loop systems run here.
Provider Selection Regime (Health Care Services (Provider Selection Regime) Regulations 2023)	The procurement of health care **services** by NHS commissioners	Applies when an ICB commissions a diabetes **service** — a community diabetes pathway, a technology-enabled monitoring service. Relevant if your company offers a managed service wrap.

A device sale is Procurement Act. A service model with the device inside it may be PSR. If your commercial proposition is shifting toward managed services — as diabetes technology propositions increasingly are — you will meet both, and the PSR's direct-award and most-suitable-provider processes become worth understanding properly.

5.2 The practical sequence

1. **National framework.** Win or retain a place on the NHS Supply Chain framework for insulin pumps, CGM and closed-loop pathway products. Without this, national funding cannot be claimed against your product. Track the expiry date and the prior information notice that precedes re-tender.
2. **Framework price.** Agree pricing consistent with cost-effectiveness expectations — for HCL, prices consistent with NICE's £20,000-per-QALY threshold. Remember the NHS Payment Scheme "lowest of" rule will bind against any reference price set.
3. **Regional and ICB call-off.** Mini-competitions and call-offs under the framework, run by ICB or regional procurement, often with clinical scoring by a diabetes network.
4. **Local clinical approval.** For Part IX products, the **Area Prescribing Committee or medicines optimisation group** and the local formulary or CGM position statement. For trust-purchased devices, the **drug and therapeutics or medical technologies committee**, plus medical physics or clinical engineering sign-off.
5. **Business case.** ICB or trust finance, with a modelled net budget position over the planning horizon — not a QALY. Capital versus revenue treatment matters and is frequently the thing that stalls a decision.
6. **Digital and information governance.** Where the technology has an app, cloud platform or data flow: DTAC, DSPT, clinical safety case under DCB0129/0160, and a DPIA. This is the most common cause of a six-month delay after everyone has already said yes.

5.3 Where the cross-functional split falls

Function	Owns	Your interface
Medical	Evidence generation, real-world data, clinical champions, guideline and audit alignment	Supplying the clinical case that ICB and trust committees ask for; audit data support
Commercial / Tenders	Framework bids, pricing, contract terms, NHS Supply Chain relationship	Feeding local intelligence into pricing; flagging call-off timetables early
External Affairs	National policy, DHSC and Modern Service Framework delivery boards, Diabetes UK, professional societies	Aligning national narrative with what you are saying in accounts; escalating systemic blockers
You	Account plans, sequencing, decision-maker mapping, local business cases, cohort positioning	Owning the funding pathway end to end and holding the others to the plan

6. Stakeholder map

Level	Who	What they control	What they care about
National	DHSC (absorbing NHS England); NICE; NHS Supply Chain; MHRA	Guidance, funding mandate, national framework, SDF allocations	Value for money, equity of access, delivery against the Modern Service Framework
Regional	NHS England regional teams (transitional); regional procurement hubs; clinical networks	Call-off competitions, delivery plans, peer benchmarking	Variation between systems; unspent allocations
ICB	Chief executive; chief finance officer; chief pharmacist / medicines optimisation; diabetes clinical lead; Area Prescribing Committee; strategic commissioning team	Formulary, prescribing budget, funding envelope, business case approval, cohort prioritisation	Segment position, financial balance, the eight care processes, inequality of access
Provider	Diabetes consultants; diabetes specialist nurses and educators; clinical lead; D&TC / MTC; procurement; clinical engineering; digital and IG	Initiation, clinic capacity, device selection in practice, audit submission	Clinic capacity, training burden, whether the data flows into NDA returns
Primary care	GP partners; PCN clinical directors; practice pharmacists	FP10 prescribing, annual review delivery, QOF achievement	DM037 all-or-nothing achievement; workload; prescribing budget pressure
Patient	Diabetes UK; JDRF; local patient groups	Advocacy, pressure on inequity, Know Your Risk partnership	Equity — who gets the technology and who does not

7. What usually goes wrong

Treating a NICE recommendation as funding

Only a technology appraisal creates a duty, and even then it can be phased over years. HealthTech guidance creates none. Teams routinely lose a launch year assuming the mandate exists.

Missing the framework

A product off the NHS Supply Chain framework cannot attract national funding no matter how much a clinician wants it. This is discovered too late more often than it should be.

Quoting NICE resource impact figures

NICE's HCL cost estimates of £5,900–£7,500 in year one are acknowledged to be out of date, with actual prices significantly lower after national negotiation. Quoting an obsolete national figure to a finance director destroys credibility in a single meeting.

Selling the device instead of the capacity

The HCL rollout runs over five years because of workforce, not price. If you have not helped an account solve educator time, clinic slots and training, you are not in their delivery plan — whatever they said about the product.

Ignoring the audit conditions

Where funding flows on activity returns to the National Diabetes Audit and paediatric and pregnancy audits, a trust that cannot submit data cannot be reimbursed. Data submission support is a legitimate and under-used account activity.

Planning against the old map

Thirty-six ICBs, not 42; more mergers in April 2027; NHS England folding into DHSC; and a Secretary of State who can now set NICE implementation deadlines. An account plan built on last year's org chart will be addressed to people who have left.

Forgetting equity

The HCL rollout explicitly monitors inequality by age, ethnicity, deprivation and language, and the CVD framework foregrounds health inequalities. An access plan that does not address who is being missed will be challenged — and an access plan that leads with it gets heard.

8. Four questions to settle before the account plan is written

1. Which NICE route did the technology come through — appraisal, HealthTech guidance, funding mandate, or a National HealthTech Access Programme selection? And if it is an appraisal, was the funding requirement varied?
2. Are we on the NHS Supply Chain framework for this category, and when does it come up for re-tender?
3. Is there national top-up funding attached — an SDF allocation, a capped ICB envelope, audit conditions — or are ICBs being asked to fund it from core allocations?
4. Which Oversight Framework metric and which Modern Service Framework priority does this move? If the answer is none, the account plan is a materially harder piece of work and that needs saying up front.

9. A note on the devolved nations

"National" in a UK role specification usually means England, but check. NICE technology appraisals are automatically adopted in **Wales** and reviewed for **Northern Ireland**; **Scotland** runs its own route through the Scottish Medicines Consortium for medicines and the Scottish Health Technologies Group for devices. Wales adds the All Wales Therapeutics and Toxicology Centre and Health Technology Wales. Procurement, formularies and funding mechanisms all differ. If the role genuinely covers all four nations, the frameworks in this briefing — payment scheme, oversight framework, QOF variants, planning guidance — apply in modified or entirely different form outside England, and that is worth flagging as a scoping question rather than discovering in month two.

Not advice — a map.

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Sources

Every material claim above traces to one of the following. Checked 15 September 2026.

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