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Who Pays for a NICE-Approved Digital Mental Health Product?

Commissioning architecture, funding flows, contracting levers and tendering routes in England — compiled 16 September 2026

This reference covers the eight NHS financial and planning instruments that govern commissioning and funding decisions in England and, for each, sets out the mechanics, how money actually reaches a digital mental health product, and the levers available to an access lead working cross-functionally with Medical, Commercial and External Affairs. England only; devolved nations operate different machinery.

Health warning: NHS financial architecture is in unusually rapid flux — ICB mergers, the Strategic Commissioning Framework, the first Modern Service Frameworks and a weakened Mental Health Investment Standard have all landed inside twelve months. Figures and dates below are sourced and dated; confirm against the live documents before relying on them in a business case, board paper or tender response.

Executive summary

For a NICE-approved digital mental health product, NICE endorsement is a licence to be considered, not a route to money. Unlike a medicine with a Technology Appraisal, which carries a statutory funding requirement inside 90 days, a digital therapeutic typically reaches NICE through an early value assessment that is explicitly conditional and carries no mandate and no new funding. Every pound therefore has to be won locally, and won from inside an envelope that is already fixed.

That envelope is the central commercial fact. Under the NHS Payment Scheme, mental health sits in the fixed element of the Aligned Payment and Incentive: there is no tariff, no unit price and no marginal income for a provider that adopts your technology. A proposition built on new revenue will fail. A proposition built on released therapist hours, completed courses of treatment against the national target, waiting-time movement and displaced agency, out-of-area or independent-sector spend is one both the provider and the commissioner can act on.

The eight instruments in this reference do four different jobs, and confusing them is the commonest error in an access plan:

- Price and paper — the NHS Payment Scheme sets how money moves and what flexibility exists (local variation, pass-through, neighbourhood pilots); the NHS Standard Contract is the legal vehicle that turns an adoption decision into an enforceable obligation, via a local quality requirement, a service development and improvement plan, or a variation.
- Who decides — the Strategic Commissioning Framework recasts ICBs as strategic commissioners with an “intelligent payor” function and allows commissioning to be delegated to neighbourhood providers and integrated health organisations; the NHS Oversight Framework defines what those organisations are judged on, and therefore what they will buy.
- What the system is trying to achieve — the Medium Term Planning Framework sets the three-year targets and the financial regime (2% annual productivity, deficit support gone, 915,000 talking therapies courses); the Modern Service Frameworks, including the Severe Mental Illness framework now in

development, will set the clinical standards that migrate into planning guidance, oversight metrics and contracts.

- Adjacent money and behaviour — the Better Care Fund pools health and social care money but is oriented to frailty, discharge and older people, so it is a narrow fit; the Quality and Outcomes Framework will not pay for your product but shapes case-finding and referral in primary care, and added no new mental health indicators for 2026/27.

Three changes in the last twelve months alter the playing field. The Mental Health Investment Standard was weakened in November 2025 to an inflation-linked commitment rather than one that grows with overall NHS funding, so mental health growth money is scarcer and more contested. ICB mergers and boundary changes took effect in April 2026, concentrating buying into fewer, larger commissioners with new decision-makers, while existing contracts continue under transfer schemes. And the first Modern Service Frameworks — cardiovascular disease, severe mental illness and sepsis — are being written now, against three shifts that include digital over analogue.

The practical conclusions for an access lead are these. Clear the assurance gates nationally once — DTAC, clinical safety, information governance and, for anxiety and depression products, "fully compliant" status under the NHS Talking Therapies digitally enabled therapies criteria — so that local conversations are about money and workforce rather than paperwork. Decide deliberately, with Commercial and Legal, whether the product is sold as a subcontracted clinical service under the Provider Selection Regime or as licensed software under the Procurement Act 2023, because that choice governs process, timescales and challenge risk. Enter the commissioning cycle at the needs-assessment and planning stage, not the specification stage. Run a Medical-owned evidence-generation plan with dates, because converting conditional NICE status into full guidance is the only route to mandate eligibility. And use External Affairs to get evidence into the Severe Mental Illness Modern Service Framework, which is the highest-leverage policy engagement available in this category over the next eighteen months.

At a glance

Instrument	What it controls	Your principal lever
NHS Payment Scheme 2026/27	How commissioners pay providers; mental health inside the API fixed element; MTFM exclusions.	Locally agreed price, pass-through, or local variation with NHSE approval — particularly under a neighbourhood pilot.
Strategic Commissioning Framework	The ICB's commissioning cycle, payor function and ability to delegate to providers; appetite for outcomes-based and risk-share contracting.	Get evidence into the integrated needs assessment and population health improvement plan; sell a proposition that carries measurable risk.
NHS Standard Contract 2026/27	The contractual form, including duties to comply with NICE TA funding requirements and MTFM guidance; local variation of quality requirements.	Insert via an SDIP, a local quality requirement, or a contract variation.
Medium Term Planning Framework 2026/27–28/29	Three-year national targets, the financial regime and the digital architecture providers must adopt.	Denominate value in courses completed, capacity released and productivity; ask for multi-year terms.
Better Care Fund 2026/27–28/29	£9.154bn pooled under section 75, signed off by Health and Wellbeing Boards, measured on admissions, discharge, care home entry and reablement.	Only where mental health meets older people, dementia, discharge or crisis-related non-elective activity.

Instrument	What it controls	Your principal lever
Quality and Outcomes Framework 2026/27	Primary care incentives, registers and review activity — no new mental health indicators this round.	Case-finding and referral flow; workload relief for practices and PCNs as a neighbourhood argument.
NHS Oversight Framework	Provider segmentation 1–5 across six domains, published quarterly.	Target the metrics that move an organisation's segment; sequence accounts by segment.
Modern Service Frameworks	National clinical standards and targets; SMI framework in development by NHSE and DHSC.	Policy engagement now; map evidence to the standards the week they publish.

1. Starting position: what “NICE approved” does and does not buy you

The single most important commercial fact about a digital mental health product is that NICE endorsement almost never carries a statutory funding requirement. The 90-day statutory funding mandate attaches to Technology Appraisals and Highly Specialised Technologies — overwhelmingly medicines. Digital therapeutics reach NICE through different doors, and each door has a different funding consequence.

NICE route	What it delivers	Funding consequence
Early Value Assessment / HealthTech guidance (HTE)	Conditional recommendation for use while evidence is generated — e.g. digitally enabled therapies for adults with depression (HTE8) and anxiety disorders (HTE9), published December 2023 with a three-year evidence-generation period; digital front-door technologies for NHS Talking Therapies (HTE30).	No mandate, no new money. Adoption is entirely discretionary and locally funded. Conditional status is also the commonest objection you will meet from finance directors.
Medical technologies / diagnostics guidance (MTG, DG)	Full positive guidance following a completed assessment.	Opens eligibility for the MedTech Funding Mandate if the other tests are met (below).
Technology Appraisal	Rare for software-only products.	Statutory funding requirement within 90 days — the only genuinely mandated route.
NICE guideline / quality standard citation	Named within a clinical guideline or QS.	No funding force, but strong currency in business cases and tender scoring.

1.1 The MedTech Funding Mandate test

The MTFM covers devices, diagnostics and digital products, but sets four cumulative tests: published NICE medical technology or diagnostics guidance; cost-saving within three years on NICE's resource impact assessment; total cost below £20m in any of the first three years; and demonstrated clinical effectiveness. Support runs roughly three years across onboarding, adoption/spread and graduation, after which the technology must be business as usual.

Two points matter commercially. First, the MTFM provides no additional funding — ICBs fund it from existing allocations, and commissioners reimburse providers through pass-through payments based on actual cost and volume. Second, MTFM products sit outside core NHS Payment Scheme mechanisms, subject to local arrangements, so the money still has to be negotiated locally. An EVA-stage product is not MTFM-eligible; getting there requires converting conditional guidance into full guidance.

1.2 The parallel assurance gates

For a digital mental health product, NICE is one of five or six gates, and the others are frequently the ones that stall a deal:

- Regulatory: UKCA marking and MHRA classification as software as a medical device; the class drives the evidence and conformity route.
- DTAC (Digital Technology Assessment Criteria): the baseline national assurance set — clinical safety, data protection, technical security, interoperability, usability and accessibility. Almost universally required before a trust or ICB will contract.
- Clinical safety: DCB0129 (manufacturer) and DCB0160 (implementing organisation) — a named clinical safety officer and a hazard log on both sides.
- Information governance: Data Security and Protection Toolkit submission, DPIA, data processing agreement, NHS-hosted or UK-resident data, Cyber Essentials Plus and/or ISO 27001.
- NHS Talking Therapies Digitally Enabled Therapies (DET) assessment criteria: the service-specific gate for anxiety and depression products. Two clinical assessors test the product, a ratification panel decides, and products are published as fully compliant, partially compliant or not compliant on NHS Futures. Requirements include delivering a NICE-recommended intervention for one of the 13 covered conditions, adult (18+) use, alignment to Step 2 (low-intensity) or Step 3 (high-intensity) protocols, therapist-assisted use, defined clinician training, evidence of outcomes at least as good as the non-digital equivalent, and harms/drop-out data.
- Interoperability and adoption plumbing: FHIR UK Core, SNOMED CT coding, NHS login, outcome-measure flow into IAPTus/PCMIS and the Mental Health Services Data Set. If your outcomes do not land in MHSDS, they do not exist for oversight or payment purposes.

Access implication: "Fully compliant" DET status plus DTAC is closer to a licence to trade than NICE conditional status is. Build the account plan around clearing all gates nationally once, so local conversations are about money and workforce, not assurance.

2. Who holds the money

Funding for a digital mental health product can sit in at least six places, and misdiagnosing which one is the classic cause of a stalled pilot.

Budget holder	What they hold	How they buy
Integrated care board	The population allocation, including the mental health programme budget; commissions mental health, LD and autism services for all ages.	Strategic commissioning (see §3.2); contracts via the NHS Standard Contract; increasingly at larger scale following the April 2026 ICB mergers and boundary changes.
Mental health provider trust / NHS Talking Therapies service	An agreed fixed payment envelope under the Aligned Payment and Incentive rules — mental health sits in the fixed element.	Operational budget, capital/digital budget, or displacement of existing spend. Most digital therapy contracts are provider-held, not commissioner-held.
Provider collaboratives / lead providers	Delegated budgets for specialised mental health (adult secure, CAMHS Tier 4, eating disorders) and, increasingly, whole pathways.	Lead-provider subcontracting; pathway redesign money; risk/gain share.

Budget holder	What they hold	How they buy
Primary care and neighbourhood	Core GP contract, Additional Roles funding, Mental Health Support Teams, neighbourhood health budgets and emerging Single/Multi-Neighbourhood Provider and Integrated Health Organisation models.	Local enhanced services, PCN-level agreements, neighbourhood pilots (which the Payment Scheme explicitly allows local variation for).
Local authority / Better Care Fund	Pooled health and social care money under section 75 agreements; public health grant.	BCF plans signed off by Health and Wellbeing Boards; joint commissioning where mental health intersects discharge, older people or housing.
National / regional NHSE and transformation	Programme and transformation funding, Modern Service Framework implementation support, Health Innovation Network adoption funding, NIHR and evidence-generation money.	National call-offs, pilot cohorts, evidence-generation partnerships — typically non-recurrent and the hardest to convert into recurrent spend.

The structural problem to solve in every account: under the Payment Scheme, mental health income is fixed. Adopting your product does not increase a provider's revenue, and it may not save the commissioner cash in-year either. So the value case must be denominated in the currency that both parties actually need — released therapist hours, waiting-list and waiting-time movement, completed courses of treatment against the national target, reduced DNA and drop-out, step-down from Step 3 to Step 2, and avoided crisis or out-of-area activity.

3. The eight instruments

3.1 NHS Payment Scheme (2026/27)

What it is: the statutory rules governing how commissioners pay providers for NHS-funded care, issued annually by NHS England after consultation.

Mechanics that matter

- Aligned Payment and Incentive (API) remains the primary approach: a fixed element covering mental health, community, maternity, ambulance and outpatient follow-ups, plus a variable element for elective activity at national unit prices.
- New blended models for urgent and emergency care (fixed payment based on planned activity plus a 20% variable element for deviations, with negotiated “break glass” clauses), radiotherapy and genomics.
- Mental health stays inside the API fixed payment. The 2026/27 proposals expand guidance on mental health currencies to give more granularity on care setting and complexity.
- Activity-based payment continues for non-NHS providers at the same unit prices — relevant if your product is delivered through an independent-sector talking therapies provider.
- Local variation to API arrangements is permitted with NHS England approval, and is explicitly flagged for neighbourhood health service pilots. Genomics allows locally agreed variable percentages.
- MedTech Funding Mandate products remain excluded from core payment mechanisms, subject to local arrangements.

Access implications

- There is no tariff, no unit price and no marginal income for a digital mental health intervention. Anyone who tells you they are waiting for “the tariff” has misunderstood the scheme.

- Your realistic payment routes are: inclusion in the provider's fixed-envelope cost base; a pass-through or locally agreed price negotiated between ICB and provider; a local variation (particularly under a neighbourhood pilot); or a non-recurrent transformation award that you then have to convert.
- Expanded mental health currencies are an opportunity: they make it easier to describe where in the pathway your product sits and what complexity of patient it serves, which is the language a contract variation needs.
- Price architecture options to discuss with Commercial: per-licence, per-completed-course-of-treatment (aligns with the NHS Talking Therapies national metric), banded population licence, or an outcomes/capacity-release risk share. The Strategic Commissioning Framework's explicit encouragement of risk-share mechanisms makes the last of these more saleable than it was two years ago.

3.2 Strategic Commissioning Framework (published November 2025)

What it is: NHS England's redefinition of the ICB role — from transactional purchaser to strategic commissioner accountable for "creating the best value for the public from their NHS budget", aligned to the 10 Year Health Plan.

Mechanics that matter

- A four-stage commissioning cycle: understand context (population data and needs); develop strategy (long-term population health improvement plans); deliver through the payor function (allocate resources, manage contracts, shape provider markets); evaluate impact.
- Implementation timeline: integrated needs assessments, strategies and population health improvement plans approved January 2026; baseline assessments March 2026; development programme from April 2026; formal assessment of ICB commissioning capability during 2026/27.
- Enablers include an "intelligent payor" function — market shaping and contracting expertise — plus data and analytics capability and clinical governance.
- Substantial devolution: Single Neighbourhood Providers, Multi-Neighbourhood Providers and Integrated Health Organisations can take on commissioning roles, with ICBs able to delegate commissioning to providers and to use outcomes-based contracts that give providers freedom over service design against population health accountability.
- Explicit support for exploring capitated, population-based payment and risk-share mechanisms, best-practice tariffs and year-of-care models.

Access implications

- Timing is everything: get your evidence and population-impact modelling into the integrated needs assessment and population health improvement plan stage, not the procurement stage. By the time a specification is written, the decision is largely made.
- Map and target the payor function specifically — director of strategy/commissioning, mental health programme director, ICB finance business partner, chief data/analytics officer — not only clinical leads.
- Where an ICB has delegated to an IHO or neighbourhood provider, the buying decision has moved. Refresh your stakeholder map after every delegation.
- Outcomes-based contracting genuinely favours a digital product that can evidence throughput and outcomes at population level. Bring a proposition that carries measurable risk — e.g. payment contingent on recovery rate or on courses completed.
- April 2026 ICB mergers: contracts transfer under statutory transfer schemes rather than requiring novation, so existing agreements continue with the successor ICB — but decision-makers, thresholds and procurement policies change. Re-baseline the account, and check whether contracts expiring around transfer were renewed or re-procured early.

3.3 NHS Standard Contract (2026/27)

What it is: the mandated contractual form for all NHS-funded healthcare services other than primary care — the legal vehicle through which any adopted technology becomes an enforceable obligation.

Mechanics that matter

- Service Conditions and General Conditions include obligations to comply with NICE Technology Appraisal funding requirements and with MedTech Funding Mandate guidance — the mechanism by which national policy becomes a local contractual duty.
- 2026/27 strengthens activity management: commissioners must now comply with (not merely have regard to) the technical guidance when setting Individual Activity Plans and Activity Management Plans, and the window for setting an AMP falls to the next operational day where agreement fails or a provider does not attend. The proposed removal of the escalation process was dropped after consultation.
- Commissioners may now set local variations to National Quality Requirements where different targets align with annual planning agreements; those local standards take precedence over national ones.
- Standard machinery that matters for digital: information and data requirements, information governance and data protection clauses, subcontracting provisions, service development and improvement plans (SDIPs), and contract variation.

Access implications

- The three practical insertion points for a digital product are: a local quality requirement, a service development and improvement plan, and a contract variation. An SDIP is often the least contested route — it commits the provider to a delivery milestone without renegotiating the envelope.
- Understand whether you are contracted directly with a commissioner, subcontracted by a provider, or supplied as software under a licence — this determines both the procurement regime (§5) and who carries the clinical safety and IG obligations.
- Local variation of quality requirements cuts both ways: an ICB can write a local access or recovery standard that your product helps deliver, which is a strong lever if you get in early enough to influence the planning agreement.

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

What it is: the replacement for annual operational planning guidance — a three-year framework setting national objectives, the financial regime and the delivery trajectory implementing the 10 Year Health Plan.

Mechanics and the numbers to quote

- Financial regime: around 3% real-terms revenue growth to roughly £226bn by 2028/29; capital of £13.6–14.6bn a year; a minimum 2% annual productivity improvement; elimination of deficit support funding by the end of the period; multi-year planning replacing the annual cycle.
- Mental health commitments: 915,000 courses of NHS Talking Therapies and 73,500 people accessing Individual Placement and Support; 94% Mental Health Support Team coverage in schools and colleges by 2029; elimination of inappropriate out-of-area placements; 10% year-on-year reduction in reliance on inpatient care for people with a learning disability and autistic people.
- Digital commitments by 2028/29: 95% of appointments available through the NHS App after triage; full Federated Data Platform adoption; migration to NHS Notify for direct patient communication; Electronic Prescription Service and e-Referral APIs; ambient voice technology deployment.

- Neighbourhood health from April 2026: decompressing over-capacity GP practices, integrated neighbourhood teams for frail and vulnerable populations, minimum 12-hour daily community urgent care, digital-first urgent and emergency care.
- Modern Service Frameworks launching for cardiovascular disease, severe mental illness and sepsis in 2026, with dementia and frailty to follow.

Access implications

- The talking therapies course volume and the productivity requirement are the two numbers your value proposition should be denominated in. A capacity-release argument — therapist hours released per 1,000 patients treated — maps directly onto both.
- Multi-year planning makes multi-year contracting defensible for the first time in years. Ask for three-year terms with break clauses tied to outcome thresholds rather than annual rollovers.
- The digital commitments create a coherence test: a product that sits outside the NHS App, does not flow data to the FDP or MHSDS, and communicates outside NHS Notify will look like a workaround rather than part of the target architecture.
- Deficit-support elimination means many systems are in cash-release mode. Frame the first year as cost-neutral or self-funding via displaced spend (agency therapist hours, out-of-area placements, independent-sector overflow) wherever the data supports it.

3.5 Better Care Fund 2026/27 to 2028/29

What it is: the mandatory pooled budget between ICBs and local authorities under section 75, signed off by Health and Wellbeing Boards — the main formal integration money.

Mechanics that matter

- Total commitment of £9.154bn for 2026/27: NHS minimum contribution £5,791m, local authority Better Care Grant £2,640m, Disabled Facilities Grant £723m. The NHS contribution to adult social care rises 4.4%; the remaining ICB allocation rises 2.1%. Indicative funding now visible to 2028/29.
- Three national conditions: joint plans for more integrated and preventative care linked to neighbourhood health; compliance with grant conditions, maintenance of NHS minimum contributions to adult social care and pooling into section 75 funds; compliance with planning requirements and assurance. Section 75 agreements to be finalised by 30 September 2026.
- Four metrics: non-elective admissions for over-65s per 100,000; discharge delays measured against Discharge Ready Date; long-term residential and nursing admissions for over-65s per 100,000; reablement outcomes measured by community tenure after discharge.

Access implications

- Be honest about fit: the BCF is oriented to frailty, discharge and older people's care, not to working-age mental health. For most digital mental health products it is a secondary route at best.
- Where it does work: older adults' mental health and dementia support, mental health contributions to discharge and admission avoidance, crisis alternatives that reduce non-elective activity, carer support, and anything that intersects with housing or the Disabled Facilities Grant.
- If you pursue it, the decision-making body is the Health and Wellbeing Board, the money sits in a section 75 pool, and the business case has to be written against the four metrics above — not against recovery rates.

- The 2026/27 alignment of BCF spend to neighbourhood health is the more useful hook: a neighbourhood-level mental health offer can be positioned inside both the BCF plan and the Payment Scheme's neighbourhood local-variation flexibility.

3.6 Quality and Outcomes Framework (2026/27 GP contract)

What it is: the voluntary incentive scheme within the GP contract that pays practices for achievement against clinical and organisational indicators — the main lever on primary care behaviour, and therefore on referral and case-finding.

Mechanics that matter

- 2026/27 settlement: a 3.6% cash uplift worth around £485m, plus around £292m repurposed from the Capacity and Access Payment into a practice-level reimbursement scheme averaging roughly £47,000 per practice.
- An additional 18 QOF points worth around £25m, focused on childhood vaccinations, diabetes, obesity and heart failure. Sliding-scale achievement is introduced for childhood vaccination thresholds, replacing all-or-nothing scoring.
- The Obesity Enhanced Service is retired into QOF indicators; the Advice and Guidance Enhanced Service is embedded in core funding; several indicators are consolidated. The Additional Roles Reimbursement Scheme expands, removing restrictions on employing GPs.
- No new mental health indicators were added in this round. Mental health's QOF footprint remains the established registers and review activity — verify the exact current indicator set for depression and severe mental illness physical health checks before citing it.

Access implications

- QOF will not pay for your product. Its relevance is as a demand and case-finding lever: what GPs are incentivised to record and review determines who gets identified and referred into talking therapies and community mental health.
- Where an SMI or depression register review is incentivised, a digital self-referral or triage offer can be positioned as workload relief for practices and PCNs — this is a route into neighbourhood budgets rather than QOF money.
- The absence of new mental health incentives is itself an External Affairs argument: primary care mental health is comparatively under-incentivised at a point when the Severe Mental Illness Modern Service Framework is being written.

3.7 NHS Oversight Framework

What it is: how NHS England segments and performance-manages providers and ICBs, and what is published about them — in practice, the definition of what a chief executive is judged on.

Mechanics that matter

- Providers are placed in segments 1 to 5, 1 being high-performing and 5 the most challenged and requiring intensive support. ICBs were not segmented in 2025/26 because of the scale of organisational change; expect that to change as merged ICBs bed in and as commissioning capability assessments run through 2026/27.
- Six domains: access to services (including mental health); effectiveness and experience of care; patient safety; people and workforce; finance and productivity; and improving health and reducing inequality (contextual, non-scoring).

- NHS England publishes a quarterly public dashboard with individual metric scores, domain scores and organisational delivery scores — the “league table” in practice.
- Mental health metrics include year-on-year change in children and young people accessing services and the proportion of people in crisis receiving face-to-face contact within 24 hours. The Medium Term Planning Framework confirms oversight will track access, quality, finance, workforce and productivity through standardised metrics with public league tables.

Access implications

- Write the account plan against the specific metrics that move an organisation's segment. For a mental health trust, that is typically access and waiting times, crisis response, CYP access growth, workforce and productivity.
- Segment drives buying behaviour. Segment 4–5 organisations have acute pain and national attention but very constrained discretionary spend and a turnaround director scrutinising every commitment; segment 1–2 organisations have more autonomy and are the better sites for first adoption and reference-site evidence.
- Publicly available segmentation and dashboard data is free, high-quality account intelligence. Use it for targeting and sequencing rather than treating every account as equivalent.

3.8 Modern Service Frameworks

What it is: the 10 Year Health Plan's revival of the National Service Framework concept — national standards for high-quality, evidence-based care in a defined condition area, with measurable targets and implementation support. The first wave is cardiovascular disease, severe mental illness and sepsis in 2026, with dementia and frailty to follow.

Mechanics that matter

- The Severe Mental Illness Modern Service Framework is being developed jointly by NHS England and DHSC, with a stated vision that by 2035 people with severe mental illness live longer, healthier and more fulfilling lives through integrated and equitable care.
- It is explicitly framed against the three shifts — prevention over sickness, community over hospital, and digital over analogue — which is unusually favourable positioning for a digital mental health product.
- Development has run through a national call for proposals inviting interventions and initiatives across mental health support, health inequalities, housing, employment, justice, social care, lived experience and system transformation, with submissions closing 28 May 2026.
- Sepsis was first out of the gate as a published framework; expect the SMI framework to follow the same shape — standards, measurable targets and implementation support — and for its metrics to migrate into planning guidance, the Oversight Framework and, eventually, contracts.

Access implications

- This is the highest-leverage policy engagement available to a digital mental health product over the next 18 months. Standards written into a Modern Service Framework become planning requirements, then oversight metrics, then contractual expectations.
- Note the scope mismatch to manage: an SMI framework addresses psychosis, bipolar disorder and complex needs. If your product serves common mental health conditions through talking therapies, your policy hooks are the talking therapies and neighbourhood commitments in the Medium Term Planning Framework, and you should track whether a broader mental health strategy or a subsequent framework picks up common mental illness.

- External Affairs actions: submit and track evidence into framework development, align with VCSE and royal college coalitions, brief the relevant national clinical director, and be ready to map your evidence against the framework's standards the week it publishes.

4. Funding routes, ranked by realism

Route	How it works	Realism / what it needs
Provider operational budget	The talking therapies or community mental health service buys licences from its fixed API envelope, displacing agency, overtime or independent-sector overflow spend.	Highest volume route. Needs a credible capacity-release and displacement model, and a service manager with delegated spend.
ICB mental health programme budget	Commissioner-held funding, now growing broadly in line with inflation rather than in line with overall NHS growth following the November 2025 change to the Mental Health Investment Standard.	Realistic but more competitive than before. Needs alignment to the ICB's population health improvement plan and mental health priorities.
Local variation / locally agreed price	Agreed between commissioner and provider under the NHS Payment Scheme, with NHS England approval; explicitly available for neighbourhood health pilots.	Underused. Best route for a defined pathway redesign. Needs ICB finance sponsorship and a clear currency.
Non-recurrent transformation or pilot funding	National programme, regional, Health Innovation Network adoption funding, or ICB transformation reserve.	Easy to win, hard to convert. Only take it with a written recurrent-funding decision point and evidence plan attached.
Outcomes or risk-share agreement	Payment tied to completed courses, recovery rate, waiting-time movement or capacity released; supported in principle by the Strategic Commissioning Framework.	Increasingly viable. Needs robust MHSDS-linked data and Commercial/Legal appetite to carry risk.
MedTech Funding Mandate	ICB-funded from allocation with pass-through payment to providers; contractual duty via the NHS Standard Contract.	Only if you convert to full NICE medical technology or diagnostics guidance and pass the cost-saving, affordability and effectiveness tests.
Better Care Fund / section 75 pool	Pooled ICB and local authority money, Health and Wellbeing Board sign-off.	Narrow fit — older adults, dementia, discharge, admission avoidance, carers.
Evidence-generation partnerships	NIHR, research collaborations, real-world evidence generation aligned to the NICE EVA evidence-generation plan.	Not revenue, but it is the route out of conditional status and into mandate eligibility.

5. Tendering and procurement

5.1 Which regime applies

The first question in any tender is which legal regime governs it, because it determines process, timescales and challenge risk.

- Provider Selection Regime (PSR, in force January 2024) applies where the NHS is procuring healthcare services. Processes are direct award (processes A, B and C), the most suitable provider process, and the competitive process. Decisions are assessed against the PSR key criteria — quality and innovation; value;

integration, collaboration and service sustainability; improving access, reducing health inequalities and facilitating choice — with published transparency notices and a standstill period.

- Procurement Act 2023 (in force February 2025) applies where the NHS is buying goods or software rather than a healthcare service. A software licence for a digital therapeutic bought by a trust IT or digital function is usually here, with competitive flexible procedures, Find a Tender publication and its own transparency regime.
- The same product can fall under either regime depending on how it is packaged — as a subcontracted clinical service inside a talking therapies pathway (PSR) or as licensed software (Procurement Act). Decide deliberately with Legal and Commercial; do not let it be decided by whichever NHS department picks up the phone.

5.2 Routes to market

- Frameworks and dynamic purchasing systems are frequently a practical prerequisite: Crown Commercial Service G-Cloud for cloud software, NHS Shared Business Services, NOE CPC, Health Trust Europe, and Spark DPS for innovative technologies. Being on the right vehicle can convert a six-month tender into a call-off.
- National assurance lists matter as much as frameworks in this category: DET-assessed status for talking therapies, DTAC compliance, and any ICB digital formulary or ORCHA-style local assessment.
- ICB mergers from April 2026 concentrate buying: fewer, larger commissioners, more standardised procurement policies, larger lot sizes and more regional aggregation. Contracts held by predecessor ICBs continue under transfer schemes without novation, but re-procurement timing may have shifted.

5.3 What wins the paperwork

- Assurance pack ready to submit on day one: DTAC, DSPT, DCB0129 safety case and hazard log, DPIA and data processing agreement, ISO 27001 / Cyber Essentials Plus, UKCA and MHRA classification, accessibility (WCAG 2.2) and equality analysis.
- Health inequalities: PSR criteria, the Oversight Framework's inequalities domain and Core20PLUS5 all pull the same way. Evidence uptake, completion and outcomes by deprivation decile, ethnicity and age, and have a digital-exclusion mitigation plan. This is scored, not decorative.
- Social value: typically a minimum 10% weighting under public procurement policy, plus the NHS net zero supplier roadmap and evergreen supplier assessment. Prepare local employment, carbon and community commitments in advance.
- Mobilisation credibility: training and supervision model for therapists, caseload management, data flows into the local clinical system and MHSDS, information governance sign-off route, and a named implementation lead. Most digital pilots fail on therapist adoption, not on software.

6. Cross-functional operating model

Function	Owns	Access lead's ask
Medical	Evidence generation plan against the NICE EVA conditions; real-world evidence with adopter sites; publications; clinical safety case; KOL and clinical reference network.	A dated plan to convert conditional NICE status into full guidance, and reference-site data in the currencies commissioners buy on.
Commercial	Pricing architecture, contracting models, risk share, framework positions,	Price structures that survive a fixed-envelope conversation — per completed

Function	Owns	Access lead's ask
	forecasting and revenue recognition against non-standard deal shapes.	course, banded population licence, capacity-release guarantee.
External Affairs / Policy	Modern Service Framework engagement, NHS England and DHSC relationships, VCSE and royal college coalitions, national data and standards bodies.	Evidence into the SMI Modern Service Framework and mental health strategy development; alignment with the digital-over-analogue shift.
Market Access (you)	Account plans, funding pathway navigation, value dossier and budget impact model, tender leadership, system stakeholder map, local variation and contract negotiation.	One nationally reusable value case, locally instantiated with each system's own data.

7. Account plan architecture

A defensible account plan for this product type has six layers. Layers 3 and 5 — decision rights and the funding route — are where most plans are weakest, and where a stalled account usually turns out to have failed.

- 1. System diagnosis: population mental health need, talking therapies waiting times and recovery rates, CYP access, crisis performance, out-of-area placements, oversight segment and financial position.
- 2. Money map: where the mental health budget sits, what is delegated to providers or collaboratives, the ICB's planning round timetable, and whether any neighbourhood pilot flexibility is in play.
- 3. Stakeholder map by decision right: who specifies (clinical lead, service manager), who assures (CCIO, clinical safety officer, IG/DPO), who pays (ICB finance, provider finance), who signs (chief operating officer, chief finance officer), who can block (procurement, digital, staff side).
- 4. Value case: capacity released, courses completed against the 915,000 national commitment, waiting-time movement, displacement of agency or independent-sector spend, inequality impact — modelled with the system's own numbers, not national averages.
- 5. Funding and contracting route: which of the eight routes in §4 you are pursuing, the contractual insertion point (SDIP, local quality requirement, variation, subcontract or licence), and the procurement regime that follows.
- 6. Evidence and expansion: agreed metrics, data flow, review points, publication plan, and a pre-agreed decision point for recurrent funding.

7.1 Planning calendar to work to

Period	What is happening	Access action
Summer	Systems model next-year financial position; Modern Service Framework and national policy development.	Get the value case and budget impact model into early planning assumptions; submit policy evidence.
Autumn	NHS Payment Scheme and Standard Contract consultations; capital and delegated limits issued; planning guidance lands.	Respond to consultations; test local variation appetite with ICB finance.
January to March	Plan submission, contract negotiation and sign-off; section 75 and BCF plan agreement.	Close contract variations and SDIP commitments before the year-end freeze.

Period	What is happening	Access action
April onwards	Plans go live; oversight metrics publish quarterly; commissioning capability assessment activity.	Mobilise, collect outcome data, build the reference case for the next cycle.

8. Objections you will meet, and the answer shape

Objection	Why it is being raised	Answer shape
“NICE only recommends it conditionally.”	Finance and clinical governance want mandate-level cover that EVA does not provide.	Concede the status, then move the argument to DET compliance, the evidence-generation plan with dates, and a contract that carries review points and exit.
“There is no money — mental health is in the fixed envelope.”	Correct under the Payment Scheme. Adoption generates no marginal income.	Displacement and capacity release modelled in the provider's own cost lines; local variation or pass-through as the mechanism; phased or risk-share pricing for year one.
“We already piloted something like this.”	Digital mental health has a long tail of stalled pilots, usually failing on therapist adoption.	Lead with the implementation model — training, supervision, caseload integration, data flow — not the product. Bring a comparable site's adoption curve.
“It will widen digital exclusion.”	A scored criterion under PSR and a live board-level concern.	Uptake and outcome data by deprivation, ethnicity and age; blended offer; mitigation plan; positioning as capacity release that protects face-to-face slots for those who need them.
“We are in segment 4 and in turnaround.”	Discretionary spend is frozen.	Cash-releasing or cost-neutral year one, tied to the specific oversight metrics driving their segment.

Not advice — a map.

Compiled 16 September 2026. Every material claim is traced to a primary source and linked below.

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