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Who Pays for CVD Secondary Prevention

The commissioning, funding and procurement map behind national adoption of a new lipid-lowering therapy in England — traced through the eight policy instruments that now govern it, and the inclisiran agreement that shows how the money actually moves.

Compiled 10 September 2026 · Steve Meadows · Sourced throughout · Not advice — a map.

The question

A pharmaceutical company has a new secondary prevention therapy for cardiovascular disease. NICE has said yes. What happens next — who commissions it, whose budget the cost lands on, which committee lists it, what gets tendered locally, and what actually determines whether any of that becomes treated patients?

Since July 2026 that question has a sharper answer than it did, because the accountability for CVD secondary prevention is now written into a specific, findable metric that appears — with the same definition — in four separate national documents. Finding that chain is most of the work of this briefing. The rest is the money.

The worked example throughout is inclisiran (Leqvio). It is the most instructive precedent in the therapy area because NHS England did something unusual with it: a population health agreement struck before the NICE appraisal concluded, central funding, and a Drug Tariff listing that put a specialist injectable into the hands of general practice. Five years on there is enough public evidence to say what that bought, and what it did not.

THE SHORT ANSWER

- **One number now runs through four documents.** The proportion of people with recorded CVD whose most recent LDL-C is ≤2.0 mmol/L or non-HDL-C is ≤2.6 mmol/L is simultaneously the CVD Modern Service Framework's priority 7 metric, QOF indicator CHOL004, a scoring metric in the NHS Oversight Framework 2026/27, and a CVDPREVENT audit indicator. Build the commercial case on that number and it lands in every conversation in the building.
- **QOF moved the money from prescribing to achieving.** For 2026/27 CHOL003 (is the patient on a lipid-lowering therapy?) fell from 38 points to 20. CHOL004 (is the patient at target?) carries 44 points at thresholds of 20 to 50 per cent. That is a structural shift in favour of any therapy that closes the residual gap.
- **The clause that compels a formulary listing binds trusts, not GPs.** NHS Standard Contract SC27.1.2 requires a provider's formulary to reflect all relevant positive NICE Technology Appraisals. General practice does not hold that contract. In a therapy area delivered in primary care, that asymmetry is the whole game.
- **The framework carries no new money.** The CVD MSF was explicitly built around interventions "deliverable within existing system resources, recognising the absence of additional funding

within the CVD MSF". Every pitch has to answer where the capacity comes from, not just whether the intervention works.

- **What is tendered locally is almost never the drug.** Medicines are goods under the Procurement Act 2023; clinical services run under the Provider Selection Regime. The procurement that decides your volume is usually a service tender for prescriber capacity or case-finding.
- **Two structural changes are in flight.** ICBs are consolidating from 42 to around 26, and the Single National Formulary begins replacing local formulary categorisation from December 2026. Lipids is not in its first phase — but NHS England chooses the next therapy areas at the end of 2026.

1. The eight instruments, and what each one does

The documents below are not interchangeable. Each does exactly one job — compel, fund, plan, measure, or pay — and a market access argument that cites the wrong one for the job at hand simply does not land. This table is the map; the sections after it are the detail.

Instrument	Published	What it does	Why it matters here
CVD Modern Service Framework (and its technical annex)	7 July 2026	Sets the outcome goal — a 25% reduction in premature deaths from heart disease and stroke within a decade — and 12 priorities, each with a metric, a baseline, a 3-year ambition, a 10-year ambition and an equity metric.	Priority 7 is secondary prevention. It defines the number everything else measures.
Strategic Commissioning Framework	4 November 2025	Redefines the ICB as a strategic commissioner: understand the population, set a 5-year health strategy, act as payor, evaluate impact. Adds payment reform options — best practice tariffs, year of care tariffs, local payment agreements, risk-share models.	It tells you what an ICB is now trying to buy: outcomes and allocative efficiency, not activity.
Medium Term Planning Framework 2026/27 to 2028/29	24 October 2025 (updated 8 December 2025)	Three-year operational planning: waiting times, urgent care, primary care access, mental health, workforce. Requires break-even without deficit funding and a 2% annual productivity ambition. Commits to a Single National Formulary within two years.	It is the reason your ICB has no headroom, and the origin of the formulary change coming down the track.
NHS Oversight Framework 2026/27	11 June 2026 (updated 29 July 2026)	86 metrics across 7 domains; segments 1 to 4; quarterly delivery segmentation, annual capability assessment, a published quarterly league table. A financial deficit caps an organisation at segment 3.	Cholesterol management in people with CVD is a scoring ICB metric. This is where the CVD MSF gets teeth.
NHS Standard Contract 2026/27	November 2025 (for 1 April 2026)	The contract between commissioners and NHS providers. SC2.1.6 requires compliance with NICE TAs. SC27.1.2 and SC27.1.3 require the formulary to reflect positive TAs and the	The only genuine formulary compulsion in the system — and it stops at the trust boundary.

Instrument	Published	What it does	Why it matters here
		treatments to be made available. Schedule 6A carries drug reporting requirements.	
2026/27 NHS Payment Scheme	In force 1 April 2026	Aligned Payment and Incentive for trust contracts over £1.5m. High-cost drugs, devices and listed procedures excluded from core prices and paid at the lowest of actual cost, nominated supply cost or applicable reference price, with no cost uplift or efficiency factor.	How a tariff-excluded injectable is actually reimbursed in secondary care.
QOF guidance for 2026/27	March 2026	The primary care incentive. CHOL003 at 20 points (70–95% thresholds); CHOL004 at 44 points (20–50% thresholds). CHD015, CHD016, STIA014 and STIA015 retired and replaced by CD001 and CD002.	The only instrument that puts money directly in front of the prescriber — and it now pays for target attainment.
Better Care Fund framework 2026 to 2027	17 February 2026	£9,154m pooled under Section 75 between ICBs and local authorities: £5,791m NHS minimum contribution, £2,640m Local Authority Better Care Grant, £723m Disabled Facilities Grant. Three national conditions, tied to neighbourhood health plans.	The one large pooled fund adjacent to this pathway — and the one most often misread as a source of drug funding. It is not.

> *Compel, fund, plan, measure, pay. Five verbs, eight documents. Almost every failed access argument in this therapy area is a fund argument made to a measure audience, or a compel argument made to someone the clause does not bind.*

2. The system you are selling into, as at September 2026

NHS England is being abolished, and the Bill is mid-passage

The Health Bill 2026-27 abolishes NHS England as a separate arm's-length body and transfers its functions to the Department of Health and Social Care and the Secretary of State. Second reading was 1 June 2026; committee stage finished 16 July 2026; report stage was scheduled for 7 September 2026. It has not received Royal Assent, and most provisions will commence on days specified by the Secretary of State in regulations.

Three clauses matter commercially. Clause 11 lets the Secretary of State direct integrated care boards even where they are performing well. Clause 33 caps NHS trust spending on operational costs. Clause 58 would let the Secretary of State set deadlines for implementing NICE decisions — which, if enacted, becomes a second statutory lever alongside the existing NICE funding requirement.

ICBs are consolidating from 42 to around 26

New ICB footprints take effect on 1 April 2026 and 1 April 2027. Merged ICBs continue as strategic commissioners with delegated responsibility for primary care and an agreed set of specialised services, operating at a scale that supports specialist teams inside a running-costs cap. GP practice mapping issues must be resolved by 30 September of the preceding year. The Strategic Commissioning Framework describes the end state as approximately 26 organisations.

The practical consequence for a launch team: a positive formulary position held in a legacy ICB does not automatically travel into the merged footprint. Area prescribing and integrated medicines optimisation committees consolidate, memberships change, and a new committee will often re-run a position it inherited rather than adopt it. An account plan built on named individuals in 2024 is, across most of England, now naming the wrong people.

What the Strategic Commissioning Framework asks ICBs to become

Published on 4 November 2025, the framework defines strategic commissioning as "a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term" and structures it in four stages: understand the population, develop a long-term population health strategy, deliver through the payor function and resource allocation, and evaluate impact. Seven enablers sit underneath, including intelligent healthcare payor capability — health economics, contracting expertise and market management — and data and analytics with the NHS Federated Data Platform as the default tool.

Two features change how a commercial conversation should be framed. First, ICBs are directed towards allocative efficiency: putting resource into clinically appropriate, cost-effective activity, with decommissioning explicitly in scope. Second, the framework opens the door to payment forms beyond activity — best practice tariffs, year of care tariffs, local payment agreements and risk-share models across primary, community, secondary, social care and the voluntary sector.

Milestone	Date
Strategic Commissioning Framework published	4 November 2025
Strategic commissioning capability toolkit issued	January 2026
ICB five-year strategies and population health improvement plans approved	January 2026
Integrated needs assessments complete; ICB baseline self-assessment	March 2026
Strategic commissioning development programme launches	April 2026
Formal adoption begins	2026/27 planning cycle
Intelligence functions operational; evaluation approaches formalised	March 2027

And what the Medium Term Planning Framework asks them to deliver

The Medium Term Planning Framework 2026/27 to 2028/29, published 24 October 2025 and updated 8 December 2025, is the operational counterweight. It sets three-year objectives across elective care (at least 92% of patients waiting 18 weeks or less by 2028/29), cancer, diagnostics, urgent and emergency care (85% four-hour performance by 2028/29), primary care (90% same-day urgent appointments), community services, mental health and workforce (agency spend down 30% in 2026/27). Every ICB and trust must plan to break even or better without deficit funding, against a 2% annual productivity ambition.

It also carries the commitment to introduce a Single National Formulary within two years, with 2026/27 savings prioritised on direct-acting oral anticoagulants and SGLT-2 medicines, and confirms that the first modern service frameworks cover CVD, serious mental illness and sepsis.

> *Read the two frameworks together and the tension is obvious. The Strategic Commissioning Framework asks ICBs to think in five and ten-year population health horizons. The Medium Term Planning Framework asks them to break even this year against constitutional standards. A therapy whose benefit lands in year five needs an argument that survives that tension, not one that pretends it away.*

3. What compels, what pays, what measures

This is the distinction that decides how a plan is written. A policy that persuades produces enthusiasm; a clause that compels produces a listing; a metric that scores produces a phone call from the regional director. All three matter, and they are not substitutes.

Instrument	What it says	Effect
NICE TA733 and the NICE funding requirement	Commissioners have a statutory responsibility to fund NICE-recommended technologies, beginning no later than 90 calendar days after publication (30 days for EAMS products or Fast Track Appraisals), unless the guidance specifies otherwise.	**Compels.** Binds the commissioner. The hardest lever available.
NHS Standard Contract 2026/27, SC2.1.6	Providers must comply, where applicable, with the recommendations in NICE Technology Appraisals and have regard to other NICE guidance.	**Compels providers.** No timeframe stated in the clause itself.
NHS Standard Contract 2026/27, SC27.1.2 and SC27.1.3	The provider must ensure its formulary reflects all relevant positive NICE Technology Appraisals, and must make the recommended treatments available to service users. Applies to acute, ambulance, cancer/radiotherapy and mental health services.	**Compels a formulary listing.** Does not reach general practice.
NHS Oversight Framework 2026/27	"Number of patients with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance" — a scoring metric in the Effectiveness of care domain, applied to ICBs. Segments 1 to 4, quarterly, published.	**Measures, publicly.** Poor segmentation costs freedoms, capital access and executive pay flexibility.
QOF 2026/27, CHOL004	Percentage of patients on the CHD, PAD or Stroke/TIA register whose most recent cholesterol in the preceding 12 months is ≤2.0 mmol/L (LDL) or ≤2.6 mmol/L (non-HDL). 44 points, thresholds 20–50%.	**Pays the prescriber.** The single largest cholesterol incentive in the contract.
QOF 2026/27, CHOL003	Percentage of patients on the CHD, PAD, Stroke/TIA or CKD register currently prescribed a statin, or another lipid-lowering therapy where a statin is declined or clinically unsuitable. 20 points, thresholds 70–95%.	**Pays, but less than it did.** Down from 38 points for consistency with the target indicator.
CVD Modern Service Framework	Twelve priorities with baselines, 3-year and 10-year ambitions and equity metrics. ICBs must actively manage performance across providers, neighbourhoods and practices and flag unacceptable performance.	**Directs.** No statutory force, but it sets the metric the Oversight Framework scores.

Instrument	What it says	Effect
NICE NG238 and the NHS England lipid optimisation pathway	Clinical guidance on risk assessment, LDL-C and non-HDL-C targets, and escalation from high-intensity statins through ezetimibe to injectable therapies.	**Persuades.** Shapes the formulary argument rather than settling it.
Health Bill 2026-27, Clause 58	Would let the Secretary of State set deadlines for implementing NICE decisions.	**Not yet in force.** Report stage September 2026.

4. The measurement chain: one number, four documents

This is the most useful single thing in the briefing, so it gets its own section.

The CVD Modern Service Framework's technical annex defines the population for priority 7 in a footnote: patients with GP-recorded CVD (narrow definition) whose most recent LDL-cholesterol is less than or equal to 2.0 mmol/L, or non-HDL cholesterol less than or equal to 2.6 mmol/L, in the preceding 12 months. Baseline prevalence was calculated from CVDPREVENT audit data using patients with CVD, excluding heart failure, in 2025.

That is, to the decimal place, the definition of QOF indicator CHOL004. It is also what the NHS Oversight Framework 2026/27 scores ICBs on, and what CVDPREVENT publishes quarterly.

Where it appears	As what	Who is accountable
CVD Modern Service Framework, priority 7	National standard with a baseline, a 3-year ambition, a 10-year ambition and an equity metric	ICBs, with a designated clinical CVKM lead
NHS Oversight Framework 2026/27	Scoring metric, Effectiveness of care domain: "Number of patients with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance"	ICB board, quarterly, published in a league table
QOF 2026/27	CHOL004 — 44 points, thresholds 20–50%	The individual practice, financially
CVDPREVENT audit	Published indicator, updated quarterly, broken down by ICB, practice, deprivation and ethnicity	Everyone, visibly

> *One measure, four accountabilities: a national standard, a published performance score, a payment to the practice, and a quarterly public benchmark. A therapy that moves this number has an argument for the ICB medical director, the finance director, the practice, and the CVKM clinical lead — using the same slide.*

Where that number currently sits

Measure	Figure	Source and period
People with CVD meeting NICE cholesterol targets	48.3%	CVDPREVENT fifth annual report, audit period to March 2025
People with CVD not to target, or with no record of treatment	51.7% — 1,474,280 people	CVDPREVENT fifth annual report

Measure	Figure	Source and period
Range of achievement across ICBs	37.5% to 57.2% (a 19.7 percentage point spread)	CVDPREVENT fifth annual report
Achievement by ethnicity	37.5% Black; 48.5% White; 53.3% Asian	CVDPREVENT fifth annual report
QOF CHOL004 payment thresholds for 2026/27	Lower 20%, upper 50%	QOF guidance for 2026/27
Adults with CVD on lipid-lowering therapy	86%	NHS England, as at March 2025
Events prevented if that reaches 90% over three years	nearly 14,000 heart attacks, strokes and deaths	NHS England modelling
Events prevented if that reaches 95%	around 22,000	NHS England modelling

Note the gap between the QOF upper threshold and the clinical ambition. A practice earns full CHOL004 points at 50 per cent attainment; the national average is already 48.3 per cent. The incentive is calibrated to the current distribution, not to the framework's ambition — which means QOF alone will not deliver priority 7, and the ICB knows it.

5. The CVD Modern Service Framework in detail

Published on 7 July 2026 by DHSC and NHS England, led by clinical co-chairs Dr Jessica Randall-Carrick and Sir Andrew F Goddard, with the 12 priorities endorsed by the National Quality Board and ministers. Stakeholder engagement ran from September 2025 to April 2026 and explicitly included industry.

The framing: cardiovascular–kidney–metabolic

The framework reorganises the field around CVKM risk on the basis that hypertension, high cholesterol, atrial fibrillation, high blood sugar and chronic kidney disease cluster together, share risk factors and compound one another. Priority 2 states the strategic case plainly: "the single greatest opportunity to reduce premature mortality from heart disease and stroke lies in tackling CVKM risk factors". The 12 priorities sit under four themes — finding the missing millions, driving treatment to target, ensuring timely equitable high-quality acute care, and living with CVD and expanding access to rehabilitation.

The outcome goal and what it requires

A 25 per cent reduction in premature mortality from heart disease and stroke within a decade, tracked through a nationally published metric on the mortality profile and updated annually. The annex sets out what that means arithmetically: on a no-change scenario, England's ageing population alone would add approximately 4,000 deaths by 2034, so around 9,000 fewer premature deaths than expected are needed — 5,000 fewer than the 2024 number plus the 4,000 from ageing. On an alternative scenario where mortality in those aged 70 to 74 continues its historical decline, around 7,400 premature deaths need to be prevented.

What priority 7 is modelled to deliver

Priority 7 is "blood pressure and cholesterol optimisation for people with CVD". The modelling counts lipid management only — the annex notes that blood pressure and lipid management in CVD patients are

not additive, that quantifying the multiplicative relationship is unclear, and that lipid management showed the larger mortality risk reduction, so only lipid impacts were included. Heart failure patients are excluded to avoid overlap with priority 8.

Priority 7 modelled impact (lipid management only)	Over 3 years	Over 10 years
CVD events prevented	over 3,800	up to 9,500
Additional years of full-time work	140	more than 1,600
Increase in earnings	£6 million	£56.7 million
Fiscal impact (reduced benefits, increased tax)	£3.2 million	£36.5 million

The relative risks come from the economic analysis published with NICE NG238, applied to a baseline drawn from CVDPREVENT 2025 data, with the eligible cohort increasing linearly to meet the 3-year ambition and then held flat to year 10. The effect is applied for five years per starting cohort. Ten-year figures assume the 3-year ambition is reached and maintained, with no further improvement — a deliberately conservative construction.

The combined picture, and a number worth understanding

Table 1 of the annex aggregates the priorities into components, with overlaps stripped out.

Component	Deaths avoided, year 3	Deaths avoided, year 10
Case finding (priority 2 minus 10%)	100	1,000
Management of at-risk patients (priorities 4 and 5, modelled together)	260	710
Management of patients with CVD (priorities 7 and 8)	**800**	**470**
Acute stroke interventions (priority 9 minus 10%, and priority 10)	380	760
Acute intervention for STEMI (priority 11)	150	180
Cardiac rehabilitation (priority 12)	Not available	770
SGLT2i and diabetes care (priority 3 minus 20% of priorities 4 and 5, and priority 6 minus 50%)	810	1,000
Low end combined estimate	**1,600**	**3,850**
High end combined estimate	**2,400**	**4,900**

> *Secondary prevention is the largest single contributor at year 3 — 800 of a 1,600 to 2,400 total — and falls to 470 by year 10 as case-finding and rehabilitation overtake it. That shape is the commercial argument and the commercial risk in one line: this is where the fast wins are, and the system knows the fast wins are here.*

Three features that should shape an account plan directly

- **Every ICB designates a clinical CVKM lead.** A named decision-maker created by national policy — the most useful new entry in a stakeholder map since ICBs were formed.
- **Equity metrics attach to every standard,** focused on improving performance in the areas performing worst, to narrow the gap. Failing to narrow it counts as delivery failure regardless of the national average. Guiding principles for equitable implementation were developed by the Health Equity Evidence Centre at Queen Mary University of London.
- **There is no new money.** Stakeholders asked for a framework focused on "interventions that are deliverable within existing system resources, recognising the absence of additional funding within the CVD MSF". A pitch that assumes new investment is answering a question nobody asked.

The commercial door the annex leaves open

The final page of the technical annex describes a strategic partnerships programme. Phase 1 launched with a webinar in February 2026 and a market engagement notice inviting proposals around prevention, engagement and community-based delivery. Phase 2 follows publication of the framework and focuses on clinical management and treatment of CVD risk factors, CVD, and acute care. Five innovation themes frame the work: digital transformation, pharmaceutical advances, genomics and precision medicines, service model redesign, and medical technology.

For a company with a secondary prevention therapy, phase 2 is the named national route in — and it is a partnership conversation, not a tender. A detailed delivery plan for the framework was promised for the autumn of 2026.

6. Whose budget it lands on — the inclisiran worked example

NICE recommended inclisiran in TA733 for adults with primary hypercholesterolaemia or mixed dyslipidaemia who have a history of a cardiovascular event — acute coronary syndrome, coronary or other arterial revascularisation, coronary heart disease, ischaemic stroke or peripheral arterial disease — and whose LDL-C is persistently 2.6 mmol/L or more on maximum tolerated statins with or without other lipid-lowering therapy, or on other therapy where statins are not tolerated. NHS England puts the eligible population at approximately 600,000 people.

What makes it worth studying is not the recommendation. It is the money underneath it.

Primary care: Drug Tariff Part VIIIC

- **Purchase price:** £45 per syringe, a nominal charge, supplied through the wholesaler AAH. Community pharmacies and general practices buy at this price.
- **Reimbursement:** £60 per injection via Drug Tariff Part VIIIC from 1 April 2025, up from £50. No discount deduction — clawback — has applied since 1 October 2024.
- **Administration:** it can be given as a personally administered item, so the administering practice does not need dispensing status.
- **Who pays:** NHS England states that "the cost to the ICB and primary care prescribing budget will be the reimbursement amount of £60" and that this "will be charged to the local ICB drugs budget". There is no local offset.

- **The central top-up:** because the £45 nominal charge sits below the confidential contract price agreed with Novartis, "a separate payment will be made to Novartis from a central NHS budget for the difference between the two. This will not impact on local budget."

Secondary care: tariff-excluded and centrally reimbursed

- Inclisiran has been on the Payment by Results excluded drugs list since 1 April 2022 and is reimbursed centrally by NHS England.
- Reimbursement runs through the cost and volume process, and the NHS Standard Contract Schedule 6A reporting requirements for drugs apply — in practice, Drugs Patient Level Contract Monitoring submissions.
- Trusts purchase at confidential contract prices via the CAP portal, supplied directly by Novartis.
- Prior approval for secondary care — the Blueteq form — was removed in the March 2025 guidance, aligning the primary and secondary care arrangements.

The cliff

> **31 December 2027.** NHS England has agreed to continue funding inclisiran centrally for all patients initiated on treatment before that date. The commercial arrangement is reassessed at that point, and any revised terms apply only to new patients from 1 January 2028.
>
> Any account plan whose horizon runs past 2027 needs a written assumption about 1 January 2028, and a view on whether local systems will initiate ahead of the cliff or hold back until terms are known. Both behaviours are rational, and they have opposite implications for a forecast.

How a tariff-excluded drug is paid for under the 2026/27 NHS Payment Scheme

The scheme took effect on 1 April 2026. Aligned Payment and Incentive applies to almost all NHS trust and foundation trust relationships worth more than £1.5 million a year, combining a fixed element with variable payments for elective, diagnostic, emergency, radiotherapy and genomic activity. High-cost drugs, devices, listed procedures and MedTech products are excluded from core prices and handled separately: commissioner and provider agree a price reflecting "actual cost to the provider, or the nominated supply cost, or any other applicable reference price, whichever is lowest", with no cost uplift or efficiency factor applied. For 2026/27 the cost uplift is 3.24% and the efficiency factor 2.0%. Several high-cost homecare drugs moved into core prices for 2026/27 — a structural change worth checking against any product with a homecare route.

What the Better Care Fund is, and is not

The Better Care Fund framework 2026 to 2027, published 17 February 2026, pools £9,154 million between ICBs and local authorities under Section 75 agreements: a £5,791 million NHS minimum contribution, a £2,640 million Local Authority Better Care Grant and a £723 million Disabled Facilities Grant. Three national conditions apply, requiring integrated and preventative delivery linked to neighbourhood health plans, compliance with grant conditions including a 4.4% uplift in NHS contributions to adult social care, and effective joint governance. Metrics centre on non-elective admissions in people aged 65 and over, discharge delays, long-term care home admissions and reablement.

> *The BCF is a genuine pooled fund adjacent to this pathway — intermediate care, reablement, discharge support, neighbourhood delivery. It is not a source of drug funding, and proposing it as one is a reliable way to lose credibility in an ICB finance meeting. Where it is relevant is the wrap-around: the community capacity that gets a discharged patient reviewed, titrated and kept on therapy.*

The national pricing backdrop

Two changes in 2026 alter the economics above every local pathway. The VPAG payment rate for newer medicines fell from 22.9 per cent in 2025 to 14.5 per cent in 2026, with companies contributing an additional 1 per cent to support clinical trials and manufacturing. And NICE raised its cost-effectiveness thresholds to £25,000 to £35,000 per quality-adjusted life year — applied immediately to both new and ongoing evaluations, and expected to allow an additional three to five medicines or indications to be recommended each year. DHSC estimates the combined effect will raise NHS medicines spending by around £1.5 billion over three years, from 0.3 to 0.35 per cent of GDP by the end of 2028, with no additional NHS funding to cover it: the money comes from existing Spending Review allocations.

That last sentence is the one to carry into a local meeting. A more generous national threshold and a lower scheme payment do not arrive with new money attached at ICB level. They arrive as more approved medicines competing for the same prescribing budget.

7. What "local and regional tendering" actually means

This is the part of a job description that most often gets misread. Two procurement regimes run side by side in the NHS, and the line between them is drawn around the thing being bought, not the buyer.

Regime	In force	What it covers	What that means here
Provider Selection Regime	1 Jan 2024	Health care services procured by NHS England, ICBs, trusts and local authorities. Direct Award Processes A, B and C; the most suitable provider process (14-day notice); or a competitive process the authority may design as it chooses.	The lipid clinic, the prescriber capacity, the community pharmacy pathway.
Procurement Act 2023	24 Feb 2025	Goods, including medicines. Open procedure and competitive flexible procedure. "Most advantageous tender" replaces "most economically advantageous tender". Frameworks may run to eight years, with open frameworks allowing new suppliers to join mid-term. Transparency notices via the Central Digital Platform and Find a Tender.	The molecule.

Three tiers of buying

1. **National.** DHSC and NHS England commercial agreements — the inclisiran route — plus the Drug Tariff, the Medicines Procurement and Supply Chain (MPSC) frameworks and NHS Supply Chain. For a therapy with a population health case, this is where the value is won or lost.
2. **Regional.** Nine collaborative purchasing organisations cover England: the North East and Yorkshire Pharmacy Procurement Consortium, East Midlands Pharmacy Collaborative, Health Trust Europe

(West Midlands), East of England Collaborative Procurement Hub, South East Pharmacy Procurement Service, NHS London Procurement Partnership, Peninsular Purchasing and Supplies Alliance, North of England Commercial Procurement Collaborative, and NHS Commercial Solutions. They procure what national frameworks do not cover — including compounding and homecare services, which is the tier that matters for an injectable.

3. **Local.** Trust-level contracts, and — for CVD secondary prevention — service tenders run by ICBs.

A real local tender, and why it is the one that matters

NHS Norfolk and Waveney ICB ran a procurement titled "Provision of Hypertension and Lipids Optimisation Project", published on Find a Tender, with the deadline extended to 28 April 2025. The successful bidder supplies clinical prescribers to work alongside the ICB's Protect NoW team and general practices, initiating medicines and managing treatment to defined criteria, using a population health management approach to case-finding.

> *No product is being bought. Capacity is being bought — the clinical hours that turn an eligible patient list into a prescription. For a primary-care-administered secondary prevention therapy, this is the procurement that determines volume, and it runs under the PSR on a timetable that has nothing to do with the drug.*

The practical instruction: monitor Find a Tender for lipid optimisation, hypertension case-finding, CVD prevention and clinical pharmacist capacity notices across your ICBs, and engage during preliminary market engagement rather than after the notice publishes. A company that watches only for drug tenders in this therapy area will see almost nothing and conclude, wrongly, that there is nothing to influence.

The gate that is coming: the Single National Formulary

The Single National Formulary replaces local formulary categorisation with one evidence-based national source of prescribing guidance, delivered as a digital product inside clinical workflows. NHS England's case for it is variation: at least 51 different categorisation systems exist across local formularies, and uptake of treatments for common conditions varies by more than 50 per cent between systems.

Stage	Date
13 early adopter ICBs move to the new formulary categories	December 2026
NHS England decides which therapy areas come next	End of 2026
Remaining 13 ICBs transition; first digital SNF product launches covering 8–12 therapy areas	July 2027
Expansion to further therapeutic areas	Late 2027 to mid-2030

The first phase covers chronic heart failure, type 2 diabetes in adults, ophthalmology and asthma — chosen for large populations, significant service burden and inconsistent access to innovation. Lipid management is not among them. That is a reprieve and an opportunity in equal measure: the decision on the next tranche is taken at the end of 2026, and a therapy area with a national metric, a QOF indicator and an Oversight Framework score attached to it is an obvious candidate. Anyone with a secondary prevention product should have a considered position on whether they want lipids in phase 2, and be able to say why.

8. What an account plan for this therapy has to answer

Six questions. If a plan cannot answer all six with a named mechanism, a named person and a date, it is a call plan wearing an account plan's clothes.

4. **Which funding route is the product on, and when does it expire?** Drug Tariff Part VIIIC, tariff-excluded high-cost drug, core price, or a national commercial agreement — and the review date. For inclisiran: 31 December 2027.
5. **Whose budget line does the whole pathway cost fall into?** Not just the drug. Prescriber time, phlebotomy, recall and search, administration, and the follow-up lipid profile. Those costs usually land on a different budget from the medicine, and the person holding that budget is often not in the room.
6. **Which committee lists it, under which clause, and has it merged?** Area prescribing or integrated medicines optimisation committee, and whether the position you hold predates the April 2026 or April 2027 footprint. Regional Medicines Optimisation Committees have been superseded by regional chief pharmacists and ICS-level integrated medicines optimisation committees.
7. **What is being tendered in the next twelve months that touches this pathway, and under which regime?** PSR for services, Procurement Act for goods — and preliminary market engagement is the point of influence, not the tender itself. Add the CVD MSF strategic partnerships phase 2 to the same list.
8. **Where does this ICB sit on the CVDPREVENT distribution, what is its Oversight Framework segment, and who is the CVKM clinical lead?** The gap to the national figure is the argument; the segment is the urgency; the lead is the audience.
9. **What is the cross-functional split?** Medical owns the evidence and the unsolicited-request boundary; External Affairs owns the framework, the delivery plan and the strategic partnership conversation; Commercial owns the funding route, the formulary, the tender and the pathway economics. The failure mode is not conflict — it is three functions independently briefing the same ICB pharmacist in the same fortnight.

9. What usually goes wrong

- **Winning the formulary and losing the patients.** A listing is permission, not capacity. With 1.47 million people with CVD not to target, the binding constraint is clinical time, not clinical agreement.
- **Building the account map before the merger.** Footprints changed on 1 April 2026 and change again on 1 April 2027, consolidating 42 ICBs to around 26. Committees consolidate and often re-run inherited positions.
- **Treating a national agreement as a finished job.** Inclisiran was centrally funded, tariff-listed, clawback-free and stripped of prior approval — and uptake was still publicly described as slower than expected. Central funding removes the price objection. It does not remove the workload objection, and the workload objection is the one that decides.
- **Pitching new investment into a framework built on its absence.** The CVD MSF is explicitly scoped to what is deliverable within existing resources, and the Medium Term Planning Framework requires break-even without deficit support. The winning argument is substitution or capacity release, not addition.

- **Watching the wrong procurement.** The drug tender being monitored is not the tender that determines volume. The Norfolk and Waveney prescriber-capacity contract is the shape to look for.
- **Pitching the enthusiast.** Equity metrics attach to every CVD MSF standard and are focused on the worst-performing areas. Resource follows the bottom quartile, not the site already at 57.2 per cent.
- **Building a workload argument on the wrong QOF indicator.** CHOL003 fell from 38 points to 20. If the practice-level case rested on the prescribing indicator, it lost roughly half its value in April; the case now has to be built on CHOL004 and on the ICB's Oversight Framework exposure.
- **Forgetting what happens above the pathway.** A 14.5 per cent VPAG rate and a higher NICE threshold sit behind every net price conversation — and the higher threshold brings more approved medicines competing for the same unchanged local budget.

10. Dates to diarise

Date	What happens
1 April 2022	Inclisiran added to the PbR excluded drugs list — the origin of the secondary care route.
1 January 2024	Provider Selection Regime in force for health care services.
1 October 2024	Discount deduction (clawback) ceases to apply to inclisiran.
24 February 2025	Procurement Act 2023 in force for goods, including medicines.
1 April 2025	Inclisiran reimbursement rises from £50 to £60; Blueteq prior approval removed in secondary care.
24 October 2025	Medium Term Planning Framework 2026/27 to 2028/29 published (updated 8 December 2025).
4 November 2025	Strategic Commissioning Framework published.
17 February 2026	Better Care Fund framework 2026 to 2027 published.
March 2026	QOF guidance for 2026/27 published; ICB integrated needs assessments and baseline self-assessments due.
1 April 2026	First wave of ICB mergers. 2026/27 NHS Payment Scheme, NHS Standard Contract 2026/27 and QOF 2026/27 take effect. NICE cost-effectiveness thresholds rise to £25,000–£35,000 per QALY.
11 June 2026	NHS Oversight Framework 2026/27 published (updated 29 July 2026).
7 July 2026	CVD Modern Service Framework and technical annex published.
7 September 2026	Health Bill 2026-27 report stage.
Autumn 2026	CVD MSF detailed delivery plan expected. Strategic partnerships phase 2 opens on clinical management and treatment.
December 2026	13 early adopter ICBs move to Single National Formulary categories. NHS England decides the next SNF therapy areas.
1 April 2027	Second wave of ICB mergers and boundary changes.

Date	What happens
July 2027	Remaining ICBs adopt SNF categories; first digital SNF product covering 8–12 therapy areas.
31 December 2027	Last date for initiation under the current inclisiran central funding agreement.
1 January 2028	Any revised inclisiran terms apply to new patients.

11. What I could not verify

Everything above traces to a primary source listed below. These points do not, and are flagged rather than smoothed over.

- The specific baseline, 3-year and 10-year ambition figures for priority 7. The technical annex states that baselines and ambitions are set out in tables 1 to 15 of the main CVD MSF document, and that the annex "has not assessed the feasibility of ambitions in relation to resource or historic performance". The 71-page policy paper could not be parsed in this session. Read those tables directly before any plan cites a target percentage.
- Whether the CVD MSF detailed delivery plan has been published as at 10 September 2026, and whether strategic partnerships phase 2 has formally opened.
- The Health Bill's Lords stages, Royal Assent date, and the commencement regulations for Clause 58.
- The precise scoring construction and thresholds for the Oversight Framework cholesterol metric — the metric wording and its scoring status are sourced from Annex B, but the technical metric specification was not retrieved.
- Whether the higher NICE threshold applies any change to the severity modifier, and the detail of the linked EQ-5D value set update.
- Whether the Lipid Management Rapid Uptake Product programme remains separately resourced, and how it now sits alongside the Modern Service Framework.

Sources

All URLs accessed 10 September 2026. The CVD MSF technical annex was read in full from the published PDF.

The CVD Modern Service Framework

- DHSC and NHS England, Cardiovascular disease modern service framework (7 July 2026) — https://www.gov.uk/government/collections/cardiovascular-disease-modern-service-framework
- DHSC and NHS England, Technical annex: cardiovascular disease modern service framework — https://assets.publishing.service.gov.uk/media/6a4cdc077abea59ac13fd2d1/CVD-MSF-technical-annex.pdf
- Pulse, GPs to be monitored by ICBs on meeting priorities for cardiovascular disease prevention — https://www.pulsetoday.co.uk/news/clinical-areas/cardiovascular/gps-to-be-monitored-by-icbs-on-meeting-priorities-for-cardiovascular-disease-prevention/

Commissioning, planning and oversight

- NHS England, Strategic commissioning framework — https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

- NHS England, Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 — https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/
- NHS England, NHS Oversight Framework 2026/27 — https://www.england.nhs.uk/long-read/nhs-oversight-framework-2026-27/
- NHS England, NHS Oversight Framework 2026/27 methodology manual — https://www.england.nhs.uk/long-read/nhs-oversight-framework-2026-27-methodology-manual/
- NHS England, Implementing integrated care board mergers and boundary changes for April 2026 and 2027 — https://www.england.nhs.uk/long-read/implementing-integrated-care-board-mergers-and-boundary-changes-to-take-effect-in-april-2026-and-2027/
- NHS England, Regional arrangements for medicines optimisation in the NHS in England — https://www.england.nhs.uk/long-read/regional-arrangements-for-medicines-optimisation-in-the-nhs-in-england/

Contract, payment and incentives

- NHS England, 2026/27 NHS Standard Contract Service Conditions (full length) — https://www.england.nhs.uk/wp-content/uploads/2025/11/03-nhssc-26-27-full-length-service-conditions.pdf
- NHS England, 2026/27 NHS Payment Scheme — https://www.england.nhs.uk/long-read/2026-27-nhs-payment-scheme/
- NHS England, Quality and Outcomes Framework guidance for 2026/27 — https://www.england.nhs.uk/wp-content/uploads/2026/03/PRN02356-quality-and-outcomes-framework-guidance-26-27.pdf
- DHSC and MHCLG, Better Care Fund framework 2026 to 2027 — https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027

Funding and supply of the therapy

- NHS England, Funding and supply of inclisiran (Leqvio) — https://www.england.nhs.uk/long-read/funding-supply-inclisiran-leqvio/
- NHS England, Cardiovascular disease prevention: lipid management including access to inclisiran — https://www.england.nhs.uk/long-read/cvd-disease-prevention-lipid-management-inclisiran/
- NICE TA733, Inclisiran — recommendations — https://www.nice.org.uk/guidance/ta733/chapter/1-Recommendations
- NICE, Compliance with NICE-approved medicines or treatments (the funding requirement) — https://www.nice.org.uk/what-nice-does/our-guidance/about-technology-appraisal-guidance/compliance-with-nice-approved-medicines-or-treatments
- NICE NG238, Cardiovascular disease: risk assessment and reduction, including lipid modification — https://www.nice.org.uk/guidance/ng238
- NHS England, Lipid optimisation pathway: secondary prevention in primary care and the community — https://www.england.nhs.uk/long-read/lipid-optimisation-pathway-secondary-prevention-in-primary-care-and-the-community/

National pricing and formulary policy

- NICE, Changes to NICE's cost-effectiveness thresholds take effect — https://www.nice.org.uk/news/articles/changes-to-nice-s-cost-effectiveness-thresholds-take-effect
- ABPI, VPAG payment rate for newer medicines will be 14.5% in 2026 — https://www.abpi.org.uk/media/news/2025/december/vpag-payment-rate-for-newer-medicines-will-be-145-in-2026/
- NHS Confederation, Changes to medicines policy: what you need to know — https://thenhsalliance.org/resources/changes-to-medicines-policy-what-you-need-to-know
- NHS England, Fairer, faster access to medicines for NHS patients: delivering the Single National Formulary — https://www.england.nhs.uk/blog/fairer-faster-access-to-medicines-for-nhs-patients-delivering-the-single-national-formulary/
- The Pharmaceutical Journal, Single national formulary pilot sites announced — https://pharmaceutical-journal.com/article/news/single-national-formulary-pilot-sites-announced

The gap

- HQIP, CVDPREVENT fifth annual report (audit period to March 2025) — https://www.hqip.org.uk/wp-content/uploads/2025/12/Ref.-690-CVDPREVENT-Fifth-Annual-Report-FINAL.pdf

- NHS England, Closing in on cholesterol: delivering cardiovascular prevention across the NHS — https://www.england.nhs.uk/blog/closing-in-on-cholesterol-delivering-cardiovascular-prevention-across-nhs/
- NHS Accelerated Access Collaborative, Lipid Management Rapid Uptake Product — https://www.england.nhs.uk/aac/what-we-do/innovation-for-healthcare-inequalities-programme/rapid-uptake-products/lipid-management/

Procurement

- NHS England, Provider Selection Regime: frequently asked questions — https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/nhs-provider-selection-regime/provider-selection-regime-frequently-asked-questions/
- Arnold & Porter, UK public procurement landscape transformed: what does it mean for medicines? — https://www.arnoldporter.com/en/perspectives/advisories/2025/03/uk-public-procurement-landscape-transformed
- NHS Specialist Pharmacy Service, Regional procurement of pharmacy products and services in England — https://www.sps.nhs.uk/articles/regional-procurement-of-pharmacy-products-and-services-in-england/
- Find a Tender, NHS Norfolk and Waveney ICB — Provision of Hypertension and Lipids Optimisation Project — https://www.find-tender.service.gov.uk/Notice/014194-2025

System change

- House of Commons Library, Health Bill 2026-27: progress of the bill — https://commonslibrary.parliament.uk/research-briefings/cbp-11078/
- Nuffield Trust, What's in the new Health Bill? — https://www.nuffieldtrust.org.uk/resource/whats-in-the-new-health-bill

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