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A free briefing series from Healthcare Acumen Ltd on how the NHS commissions, funds and pays for specialist medicines and technologies

Learning from the Who Pays Series

Commissioning architecture, funding flows, contracting levers and tendering routes in England — compiled 17 September 2026

Scope

Seven Who Pays briefings were compiled between 10 and 16 September 2026, each answering the same question for a different product type: a CVD secondary prevention therapy, a NICE-approved diabetes technology, a cardiomyopathy therapy, an oncology medicine, an obesity product, a digital mental health product, and a medical device. This entry reads across all seven. It sets out what held every time, what changed by product type, and where the argument that works in one therapy area actively costs you credibility in another. England only; the devolved nations run parallel but distinct machinery.

Health warning. The seven entries were written into the same twelve months of structural change, and they do not agree with each other on every number — the ICB consolidation figure alone appears as 42 to 36, to around 30, and to around 26, because the answer moved while the series was being written. That disagreement is itself a finding, and it is treated as one below rather than smoothed over. The mechanisms and the logic in these briefings will outlast the names, boundaries, contacts and prices in them.

Executive summary

Seven products, one architecture. The same eight instruments govern the money in every entry, and the differences between a stem cell therapy, a glucose sensor and a talking therapies app are differences in which instrument bites, not in which instruments exist.

Approval is a permission, and the strength of that permission is the single most consequential fact about a product. A technology appraisal compels; HealthTech guidance does not; an early value assessment buys deployment sites on condition you collect data. Settle which door the product came through before writing a word of the account plan.

Even the strongest mandate is weaker than it looks. Obesity is the clearest case in England of a positive recommendation that did not convert into funded access: 3.4 million eligible adults, a three-year phased rollout, roughly 220,000 people funded by June 2028. The gap is not a forecasting error. It is the policy.

The binding constraint is almost never the drug. Across all seven it was aseptic minutes, echo slots, educator time, therapist hours, wraparound dietetic capacity, or 62-day pathway headroom — things the product cannot buy and someone else is being performance-managed on.

The money is never where the product is. Reimbursement protects the drug or device cost and excludes preparation, delivery, homecare and clinic time, so a value case denominated in price and clinical outcome speaks to nobody in the room.

What is tendered is usually not the product. In CVD it was prescriber capacity; in obesity, weight management services; in mental health, a subcontracted pathway. A team watching only for product tenders will see almost nothing and conclude, wrongly, that there is nothing to influence.

The NHS Oversight Framework is the most under-used asset in the system, and it is public. Eighty-six metrics, four segments, published league tables: a pre-qualified list of every account's failing metrics, and a direct read on whether they have the headroom to say yes.

And the account map has a shelf life measured in months. Two waves of ICB mergers, NHS England folding into DHSC, seven pan-ICB commissioning offices from 2027/28, and a Single National Formulary arriving from December 2026.

The series so far

Each entry took one product type and followed the money end to end. The right-hand column is what that entry added that the others could not.

Entry	Compiled	The question it answered	The layer it added
Who Pays for CVD Secondary Prevention	10 Sep 2026	Who funds a new lipid-lowering therapy, traced through the inclisiran precedent	One metric running through four documents, and a national agreement that removed the price objection but not the workload objection
Who Pays for a NICE-Approved Diabetes Technology?	15 Sep 2026	Which pound pays when the pump is bought nationally and the sensors are prescribed locally	Four NICE routes with four different funding obligations, and framework listing as a precondition of national money
Who Pays for a NICE-Approved Cardiomyopathy Therapy?	15 Sep 2026	Who pays for an approved cardiomyopathy medicine, out of which budget, on whose signature	The local approval form as a second, narrower label; the undiagnosed population as opportunity and constraint at once
Who Pays for a NICE-Approved Obesity Product?	15 Sep 2026	Why eligible patients still wait behind a mandatory funding requirement	A funding variation, phased cohorts, and mandated wraparound capacity as the real rate-limiter
Who Pays for a NICE-Approved Oncology Medicine?	16 Sep 2026	Who pays when funding is the easy part	Interim funding, the Blueteq form, and aseptic capacity as the bottleneck the launch curve actually hits
Who Pays for a NICE-Approved Digital Mental Health Product?	16 Sep 2026	How money reaches a product with no tariff and no mandate	A fixed payment envelope with no marginal income, and assurance gates — DTAC, DET, DCB0129 — that matter more than NICE status
Who Pays for a Medical Device?	16 Sep 2026	Who pays when NICE guidance carries no funding requirement at all	Four national funding designations ranked by realism, and a procurement regime where price can no longer win

Why these seven: the fastest-growing NHS disease areas

The products were not picked for variety. Each entry sits in a disease area where demand is growing fastest and where national policy attention has concentrated — because those are the areas where a funding pathway is being rewritten, and therefore where the map is worth drawing.

The Health Foundation projects 2.5 million more people in England living with major illness by 2040 than in 2019, a 37% increase against working-age population growth of 4%. Nineteen of the twenty conditions studied are projected to rise, with growth of more than 30% in cancer, diabetes and kidney disease, and much of the overall increase coming from anxiety and depression, chronic pain and diabetes. NICE's strategic priorities for 2026/27 name four high-priority guideline suites — cancer, cardiometabolic disease, mental health, and women's and reproductive health — alongside cardiovascular disease, described as the largest single contributor to preventable mortality.

Entry	Disease area	Why it qualified
CVD secondary prevention	Cardiovascular	The largest single contributor to preventable mortality; first Modern Service Framework, published July 2026, with a 25% premature mortality reduction target
Cardiomyopathy therapy	Cardiovascular, specialist end	The same policy weather, but rare, under-diagnosed and commissioned differently — a deliberate test of whether the architecture holds at the specialist end
Diabetes technology	Diabetes	Projected growth of more than 30% by 2040, and one of NICE's cardiometabolic priority suites
Obesity product	Obesity and cardiometabolic	The upstream driver of the CVKM cluster; new QOF indicators for 2026/27 and a published commitment to treat roughly 220,000 adults by June 2028
Oncology medicine	Cancer	Projected growth of more than 30% by 2040; a National Cancer Plan with £200m of ring-fenced funding
Digital mental health product	Mental health	Anxiety and depression named among the main drivers of projected illness growth; a Severe Mental Illness Modern Service Framework in development
Medical device	Cross-cutting	Diagnostics and technology serve every area above, and the Medium Term Planning Framework's digital mandates make them a condition of delivery rather than an option

The rule also names what is missing. Dementia and frailty, chronic kidney disease, respiratory disease, end of life care, and children and young people's health all meet the same test and have no entry yet — dementia and frailty are next in the Modern Service Framework queue, and kidney disease carries one of the three named growth rates above. Those are the obvious next questions for the series, alongside the flagship still to come: who pays for a first-in-class stem cell therapy.

1. "NICE approved" is four or five different things, and only one of them is money

Every entry in the series opened on the same question, because every entry found the same trap. "NICE approved" is not one status. It is a family of statuses with completely different funding consequences, and teams routinely lose a launch year assuming they hold the strongest one.

Route	What it creates	Where it appeared in the series
Technology appraisal, routine commissioning	Statutory funding requirement, normally within three months of final guidance	Cardiomyopathy, oncology, obesity, CVD
Technology appraisal with a varied funding requirement	The same duty, phased over up to three years — five for hybrid closed loop	Obesity (tirzepatide), diabetes technology
Managed access (Cancer Drugs Fund, Innovative Medicines Fund)	Funded, with a dated evidence-generation obligation and a re-appraisal at exit	Oncology
MedTech Funding Mandate	Contractual duty via the NHS Standard Contract, pass-through payment, no new money	Devices, digital, diabetes technology

Route	What it creates	Where it appeared in the series
HealthTech guidance and early value assessment	No funding duty at all. Permission and evidence	Devices, digital mental health, diabetes technology
National HealthTech Access Programme	National reimbursement, medicines-style — deliberately narrow	Devices, diabetes technology

Three things follow. First, the difference between a technology appraisal and HealthTech guidance is the difference between enforcing a mandate and building a local business case thirty-six times over; that is not a nuance, it is a different job with a different headcount. Second, a mandate can be varied, and in the two highest-volume cases in the series it was — so "we have a funding requirement" and "our patients will be treated this year" are separate claims. Third, the same molecule can reach patients on different terms depending on which appraisal the prescription sits under: semaglutide under TA875 goes through specialist weight management services, and under TA1152 carries an ordinary 90-day requirement with no phasing and no setting specified.

The sentence the device entry offered generalises across the series: for medicines, NICE approval triggers funding; for everything else, NICE approval triggers a conversation. The job is to make that conversation short.

2. The eight instruments held for all seven products

The series was built on a hypothesis that turned out to be right: the same eight documents govern the money whatever is being sold. What changes is which of them carries the argument. Five verbs sit under the eight — compel, fund, plan, measure, pay — and most failed access arguments are a fund argument made to a measure audience, or a compel argument made to someone the clause does not bind.

Instrument	What it controls	The lever, across products
NHS Payment Scheme 2026/27	Statutory prices and payment rules; what is excluded from unit prices and reimbursed separately	Get outside the tariff, or attach to a better-paying currency. A one-year bridge scheme, with a full price recalculation expected for 2027/28
Strategic Commissioning Framework	What an ICB is for: population health strategies, payor function, market shaping, outcomes-based contracting	Get evidence into the integrated needs assessment, not the specification. By the time a spec is written the decision is largely made
NHS Standard Contract 2026/27	Binding commissioner–provider terms; where national policy becomes an enforceable local duty	SC27 formulary clauses, a local quality requirement, an SDIP, or a variation. The escalation route of last resort, not an opening argument
Medium Term Planning Framework 2026/27–28/29	Three-year delivery expectations and the financial envelope	The value-proposition dictionary. Quote the specific target the product moves, in the framework's own numbers
Better Care Fund	£9.15bn pooled with local government under section 75, via Health and Wellbeing Boards	Real money for community equipment, telecare and adaptations. For medicines, know it well enough to rule it out credibly in front of a finance director
Quality and Outcomes Framework	The GP incentive scheme; the most direct lever on general practice behaviour	Map to the specific indicator a practice is missing, and quantify the points and the pounds

Instrument	What it controls	The lever, across products
NHS Oversight Framework 2026/27	86 metrics, seven domains, four segments, public league tables, deficit override	Read each account's failing metrics. It tells you what to sell and who is receptive
Modern Service Frameworks	National standards of care by clinical priority area; CVD and sepsis published July 2026	National pull where the product is named or implied. Where the framework is still in development, influence it now

The honest caveat the cardiomyopathy entry supplied applies to the whole set: cite these only where they carry a specific, checkable claim — an indicator, a fund, a clause, a metric. Citing them generically to demonstrate system literacy is transparent, and a clinician who has read the framework will know within a sentence.

3. Funding routes rank the same way every time

Every entry ended up ranking its funding routes, and the shape of the ranking was identical across all seven: the strongest route is the hardest to reach, and the default route is the one with no obligation at all.

1. **A national obligation.** A technology appraisal funding requirement, the Cancer Drugs Fund, the National HealthTech Access Programme. Strongest force, narrowest gate.
2. **A contractual obligation.** The MedTech Funding Mandate, enforced through the NHS Standard Contract and monitored via the Quarterly Assurance Reporting Tool. Real, but the mandate has taken no new products for 2026/27 while it is reviewed.
3. **A national supply route.** High cost tariff-excluded drugs and devices, the Drug Tariff, NHS Supply Chain category towers. This is a procurement contest rather than a commissioning one, and winning it is a specification exercise.
4. **A commissioner's discretionary budget.** ICB allocation, provider operational or capital budget, a pooled section 75 fund. No legal obligation. This is the default, and it is where launches stall: trust-by-trust business cases against competing pressures, repeated at every site.
5. **Non-recurrent money.** Transformation awards, Cancer Alliance service development funding, Health Innovation Network adoption funding, pilot cohorts. Easy to win, hard to convert — only take it with a written recurrent-funding decision point and an evidence plan attached.

Two observations that only appear when the entries are read together. First, the non-drug money is often the most useful money: the £200m of ring-fenced Cancer Alliance funding will not buy your medicine, and that is exactly why it can fund the diagnostic step or pathway capacity your medicine depends on. The same logic runs through the Better Care Fund for community technology and the CVD strategic partnerships programme for prevention.

Second, a route that exists is not a route that is open. The MedTech Funding Mandate supported one new device in 2025/26 and is closed for 2026/27; the National HealthTech Access Programme started with capsule sponge testing and two AI cancer detection tools. Assume you are out of scope unless you have a credible case for NHS-wide transformation, and plan for route four while arguing for route one.

4. Funding and procurement are separate problems — and what is tendered is rarely the product

A commissioner can agree it wants the product and still be unable to buy it, because it is not on a compliant route to market. The legal split is drawn around the thing being bought, not the buyer: the

Procurement Act 2023, in force 24 February 2025, covers goods — medicines, devices, consumables, software licences. The Provider Selection Regime, in force January 2024, covers healthcare services, with direct award routes, a most suitable provider process and a competitive process.

The finding that recurred across the series is that the procurement determining your volume is usually a service tender, under the Provider Selection Regime, with a timetable that has nothing to do with your product.

Entry	What was actually being tendered
CVD secondary prevention	Clinical prescriber capacity. NHS Norfolk and Waveney ICB bought clinical hours to turn an eligible patient list into prescriptions — no product was purchased
Obesity	Weight management and digital weight management services, procured under the PSR
Digital mental health	The product as a subcontracted clinical service inside a talking therapies pathway, or as licensed software — two different regimes for the same offer
Oncology	Homecare delivery, outreach and community SACT clinics; competitive tendering on the molecule only bites at biosimilar entry
Cardiomyopathy	Whole pathways — diagnostics, monitoring, specialist review — bought as services under lead provider arrangements
Diabetes technology	The NHS Supply Chain framework place, without which national funding cannot be claimed against your product
Medical device	Framework call-offs and national category tower tenders, plus a managed service structure that can sit under the PSR instead

Three practical consequences. The same offer can fall under either regime depending on how it is packaged — decide that deliberately with Legal and Commercial rather than letting whichever NHS department picks up the phone decide it. Preliminary market engagement, not the tender response, is the point of influence; presence before the specification is drafted counts for more than a strong response after publication. And under DHSC's Value Based Procurement guidance the five non-price value domains must carry a minimum 60% of evaluation criteria, social value a minimum 10%, and whole life cost cannot exceed 40% — price alone can no longer win a medtech tender.

5. What actually changes by product type

The common architecture sits underneath all seven. What sits on top of it is a product-specific layer, and importing the wrong one is the commonest cause of a plan that reads plausibly and fails in the room.

Product type	The layer on top	The binding constraint
Specialist medicine	Tariff-exclusion status, the high cost drugs commissioning list, and a local prior approval form — Blueteq or equivalent — that is in practice a second, narrower label	Diagnostic capacity, specialist centres, clinic and monitoring time
Oncology medicine	Interim funding ahead of routine commissioning, managed access with a dated evidence-generation obligation, SACT data completeness as a condition of payment	Aseptic compounding minutes, chair time, genomic test turnaround, 62-day headroom

Product type	The layer on top	The binding constraint
Primary-care medicine	The Drug Tariff, the ICB prescribing budget, QOF indicators, and a Single National Formulary arriving from December 2026	Prescriber hours, case-finding, and mandated wraparound support
Medical device	MHRA/UKCA and the draft 2026 pre-market regulations, NICE HealthTech routes, and four funding designations of which three are effectively closed	Capital cycles, procurement route, EPR integration, pathway redesign
Digital product	DTAC, DCB0129/0160, the DSP Toolkit, and for talking therapies the NHS Talking Therapies digitally enabled therapies criteria	Therapist adoption — most digital pilots fail on adoption, not on software
Diabetes and community technology	National framework listing as a precondition of national money, plus audit returns that funding flows against	Educator time, clinic slots, training, and audit data submission

The device entry put the weighting plainly: roughly two thirds of a device market access plan is trust and ICB work, which is the opposite weighting to a specialty medicine. For a digital product the centre of gravity moves again, to national assurance cleared once so that local conversations are about money and workforce rather than paperwork. And for a hospital-administered oncology medicine, pitching QOF signals that you have learned framework names rather than how money moves.

One warning generalises from the cardiomyopathy entry and is worth stating on its own. Do not over-claim a policy framework. Cardiomyopathy is not among the CVD Modern Service Framework's twelve priorities; there is no cancer Modern Service Framework at all, and the National Cancer Plan fills that space instead. Claiming a framework endorses your product in front of someone who has read it costs more credibility than the claim was ever going to buy.

6. The same six questions, and the same two weak layers

Seven entries produced the same account plan architecture, almost question for question. A plan that cannot answer these six with a named mechanism, a named person and a date is a call plan wearing an account plan's clothes.

6. **Where does the money come from?** Name the budget line — tariff-excluded, pass-through, prescribing budget, provider revenue, capital, a section 75 pool — and the person who controls it.
7. **What problem does this account have that we solve?** From its Oversight Framework segment and failing metrics, its planning trajectory, its waiting list position. In their numbers, not ours.
8. **Who decides, who influences, who blocks?** And, after two waves of mergers, which organisation this actually now is.
9. **What is the compliant route to buy?** Existing framework, catalogue listing, tender due when, or a PSR-compliant service structure.
10. **What has to change in the pathway?** Referral criteria, workflow, EPR build, training, capacity — and who inside the organisation owns each.
11. **What is the evidence and reporting commitment?** What we collect, what we report back, and what that buys us at review.

Layers three and five — decision rights and the funding route — were identified as the weakest layers in the oncology and digital mental health entries independently, and the pattern holds across the series. A stalled account almost always turns out to have failed at one of those two.

The cross-functional split settled into the same shape every time. Medical owns clinical evidence, evidence-generation plans and guideline or framework influence. Commercial owns account relationships, pricing architecture and pull-through. External Affairs owns policy engagement while the window is open — NICE topic selection, Modern Service Framework development, framework consultations. Market Access is the integrating function: the one that turns clinical evidence into a paid-for pathway. Where it breaks down, the cause is sequencing — Commercial pushing for usage before a funding route exists, or Medical building evidence that answers a question no commissioner is asking. The CVD entry named the sharpest version: the failure mode is not conflict, it is three functions independently briefing the same ICB pharmacist in the same fortnight.

The planning calendar is also common. Autumn is when consultations run and commissioning intentions are drafted; September to December is the window for getting into local plans; January to March is contract round and sign-off, after which anything arriving waits a year; April is when the new Payment Scheme, Standard Contract and plans take effect and the account map has to be re-based; June to July is when the Oversight Framework publishes and the territory should be re-prioritised.

7. Where the flux is, and what it does to a plan

The seven entries were compiled within seven days of each other and still disagree on the ICB consolidation figure: 42 to 36, to around 30, and to around 26, depending on whether the entry counted the April 2026 wave, the April 2027 wave, or the Strategic Commissioning Framework's stated end state. That is not an error to be tidied away. It is the most useful single illustration in the series of why an account map has a shelf life.

Change	Timing	What it does to an access plan
ICB mergers and boundary changes	1 April 2026 and 1 April 2027	A formulary position held in a legacy ICB does not travel. Committees consolidate and often re-run inherited positions
NHS England abolished, functions to DHSC	Health Bill laid 13 May 2026; merger targeted around October 2026	National sponsorship moves closer to ministers; institutional memory is thin and relationships are churning
Secretary of State power over NICE implementation deadlines	Health Bill clause 58, not yet in force	The compliance clock on a product can be moved politically, in either direction
Ministerial power to direct NICE's cost-effectiveness threshold	NICE (Amendment) Regulations 2026, in force 24 March 2026	A threshold that can be directed is a threshold that can move
Pan-ICB commissioning offices	Seven, from 2027/28	Specialised access decisions consolidate upwards into seven bodies
Single National Formulary	First 13 ICBs December 2026; next therapy areas chosen end of 2026	Local formulary categorisation stops being the game. Have a position on whether you want your area in phase 2
NHS Payment Scheme recalculation	Expected 2027/28	2026/27 is explicitly a one-year bridge. Anything built on current prices needs a stated assumption
Reimbursement of high cost tariff-excluded items moves to DHSC	April 2027	The counterparty changes for the products most dependent on that route

Three structural facts sit underneath all of it and shape every argument. Systems must break even without deficit support, against a minimum 2% annual productivity requirement — so new spend has to be matched by an identified release elsewhere. Revenue grows around 3% in real terms to roughly £226bn by 2028/29, but a higher NICE threshold and a lower VPAG rate arrive with no new money attached at ICB level, only more approved medicines competing for the same budget. And 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, not annual rollovers.

8. The failure modes that recurred

The house method commits each briefing to say what usually goes wrong. Read together, the same eight failures appear under different names.

12. **Treating the recommendation as funding.** Only a technology appraisal creates a duty, and even then it can be phased over years. Teams lose a launch year to this.
13. **Winning the permission and losing the patients.** A formulary listing is permission, not capacity. With 1.47 million people with CVD not to target, the binding constraint is clinical time, not clinical agreement.
14. **Arguing the thing that is already settled.** Business cases built on cost-effectiveness NICE has accepted, and silent on the echo slots, aseptic minutes or therapist hours the organisation actually cannot afford.
15. **Planning against the old map.** Account plans naming people who have left, in organisations that have merged.
16. **Watching the wrong procurement.** Monitoring product tenders in a market where capacity and services are what get bought.
17. **Pitching the enthusiast.** Equity metrics attach to the worst-performing areas, so resource follows the bottom quartile, not the site already performing well.
18. **Over-claiming a framework.** Citing a Modern Service Framework, the Better Care Fund or QOF generically, to someone who has read it.
19. **Taking non-recurrent money without a conversion plan.** Pilots are easy to win and hard to convert; without a written recurrent-funding decision point, the pilot is the ceiling.

The common root is sequencing. Almost every one of these is an argument made to the right organisation at the wrong stage, or to the right person about the wrong constraint.

9. What the method taught us

The series was also a test of a way of working: AI does retrieval and first draft, every material claim is traced to a primary source and linked, and the framing, judgement and warnings are the author's. Seven entries in, three things about that division of labour are clear.

The question is the scarce input. AI is very good at answering. It does not know what to ask. "Who pays for this?" is a useful question only because it forces a chain — the named mechanism, the clause or fund it sits in, the people who sign it off, and what usually goes wrong — and that chain came from knowing how a launch fails, not from retrieval.

The judgement calls are the value. Deciding that the Better Care Fund is not a drug funding route and saying so plainly; deciding that cardiomyopathy is not a CVD framework priority and that claiming otherwise costs credibility; noticing that the QOF upper threshold for CHOL004 sits at 50% when the national average is already 48.3%, so the incentive is calibrated to the current distribution rather than to the framework's ambition. None of those are retrieval. All of them are what a reader is actually paying attention for.

And the limits have to be published. The CVD entry carried a section listing six things it could not verify, including the priority 7 baseline and ambition figures, the Health Bill's Lords stages, and the precise scoring construction of the Oversight Framework cholesterol metric. Flagging those rather than smoothing them over is what makes the rest of the document usable in a board paper. The same discipline explains why this entry names the ICB figures that disagree instead of picking one.

Not advice — a map.

Compiled 17 September 2026 from the seven Who Pays briefings listed below. Framing and judgement are the author's.

The series

Entry	Compiled
Who Pays for CVD Secondary Prevention	10 September 2026
Who Pays for a NICE-Approved Diabetes Technology?	15 September 2026
Who Pays for a NICE-Approved Cardiomyopathy Therapy?	15 September 2026
Who Pays for a NICE-Approved Obesity Product?	15 September 2026
Who Pays for a NICE-Approved Oncology Medicine?	16 September 2026
Who Pays for a NICE-Approved Digital Mental Health Product?	16 September 2026
Who Pays for a Medical Device?	16 September 2026

Primary sources common to the series

Each entry carries its own full sources list. These are the documents every entry drew on.

— 2026/27 NHS Payment Scheme — NHS England
https://www.england.nhs.uk/long-read/2026-27-nhs-payment-scheme/

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

— 2026/27 NHS Standard Contract — NHS England
https://www.england.nhs.uk/nhs-standard-contract/26-27/

— Medium Term Planning Framework 2026/27 to 2028/29 — NHS England
https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/

— NHS Oversight Framework 2026/27 — NHS England
https://www.england.nhs.uk/long-read/nhs-oversight-framework-2026-27/

— Better Care Fund framework 2026 to 2027 — DHSC and MHCLG
https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027

— Quality and Outcomes Framework guidance for 2026/27 — NHS England
https://www.england.nhs.uk/gp/investment/gp-contract/quality-on-outcomes-framework-qof-changes/

— Cardiovascular disease modern service framework — DHSC and NHS England
https://www.gov.uk/government/collections/cardiovascular-disease-modern-service-framework

— Implementing integrated care board mergers and boundary changes, April 2026 and 2027 — NHS England
https://www.england.nhs.uk/long-read/implementing-integrated-care-board-mergers-and-boundary-changes-to-take-effect-in-april-2026-and-2027/

— Provider Selection Regime: statutory guidance — NHS England

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— Health in 2040: projected patterns of illness in England — The Health Foundation
https://www.health.org.uk/reports-and-analysis/reports/health-in-2040-projected-patterns-of-illness-in-england

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https://www.nice.org.uk/what-nice-does/our-guidance/prioritising-our-guidance-topics/nices-strategic-priorities-in-2026-to-2027

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