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Who Pays for a NICE-Approved Cardiomyopathy Therapy?

NHS management, funding and tendering to commercialise an approved cardiomyopathy medicine in England

Compiled 15 September 2026. Every material claim is traced to a primary source, linked at the end.

This briefing takes one question and answers it end to end: when a cardiomyopathy therapy has a positive NICE technology appraisal, who is obliged to pay for it, out of which budget, under which clause, on whose signature — and where, in practice, the money and the patients get stuck. It is written for the person who has to build an account plan against that answer, working across Medical, Commercial and External Affairs.

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1. The short answer

A positive NICE technology appraisal creates a legal funding obligation on NHS England and integrated care boards (ICBs), normally within three months of publication. That obligation is real, and it is enforceable through the NHS Standard Contract. It is also the least of your problems.

What it does not do is create a service. For a cardiomyopathy therapy, the binding constraints are diagnostic capacity (echocardiography, cardiac MRI, bone scintigraphy, genomics), the small number of centres competent to initiate and monitor, the local high-cost-drug approval gate, and the fact that in 2026/27 every ICB is planning to break even against a three-year envelope while being judged on metrics your product does not touch. The funding requirement gets you onto the formulary. Everything after that is capacity, pathway and permission.

2. What "a NICE-approved cardiomyopathy product" now means

Two distinct commercial situations sit under the same word, and they behave differently in the system.

Obstructive hypertrophic cardiomyopathy (HCM)

- Mavacamten (TA913) is recommended for symptomatic obstructive HCM in adults in NYHA class 2 to 3, as an add-on to optimised standard care (a beta-blocker, a non-dihydropyridine calcium-channel blocker, or disopyramide), and only with the company's commercial arrangement in place. The recommendation is narrower than the marketing authorisation — that gap is where local approval forms are written.
- Aficamten (TA1181) received final NICE guidance on 30 July 2026 for obstructive HCM, with NHS availability expected in late 2026. Its echocardiography schedule is more flexible than mavacamten's, which matters more than it sounds: monitoring burden, not drug cost, is the practical rate-limiter on cardiac myosin inhibitor uptake in most trusts.

Transthyretin amyloid cardiomyopathy (ATTR-CM)

- Acoramidis (TA1121) was recommended on 14 January 2026 for adults with wild-type or hereditary ATTR-CM. Notably, NHS England and ICBs agreed to fund it within 30 days of publication rather than the standard three months — an accelerated funding commitment, and a useful precedent to cite when you are negotiating your own implementation timetable.

If you are commercialising in HCM, your pathway runs through cardiology and inherited cardiac conditions (ICC) services. If you are in ATTR-CM, it runs through amyloidosis centres, nuclear medicine and an older, multi-morbid population with a heart failure phenotype. The funding architecture below is common to both; the bottlenecks are not.

3. The obligation: what NICE approval actually buys you

The funding requirement

The funding requirement obliges commissioners to make funding available so that a recommended technology can be prescribed within a period beginning on the date NICE publishes the recommendation and ending three months later. This is the mechanism people loosely call the "NICE mandate".

It can be varied. Where NHS England expects the net budget impact to exceed £20 million a year in any of the first three financial years of NHS use, it can apply to NICE for a variation of the funding requirement — normally for up to three years, exceptionally longer. An application must set out the duration and justification, any commercial arrangement, the interim commissioning policy for phased access, the equity impact on patients whose treatment is delayed, and how funding will be phased. For a cardiomyopathy asset this is a live risk in ATTR-CM, where prevalence is being revised upwards as diagnosis improves; it is less likely, but not impossible, in obstructive HCM.

Where the obligation bites: the 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.
- **SC27 (Formulary)** — formularies must reflect all relevant positive NICE technology appraisals, and providers must make available to service users all relevant treatments recommended in them. This is the clause to quote, politely, when a trust formulary committee schedules your product for "review in the next cycle".
- **SC20 (Service Development and Improvement Plan)** — an SDIP is agreed between the co-ordinating commissioner and the provider and appended at Schedule 6C. If your product needs a service change to land — a monitoring clinic, a specialist nurse, a diagnostic pathway — the SDIP is the contractual vehicle for it, and it is chronically under-used by industry.
- **Prior approval schemes** — referenced at SC6.13.1, SC8.5 and SC29.4.1. In practice this is Blueteq or an equivalent high-cost-drug approval system: a form, with criteria, that a named clinician completes before the trust can be reimbursed. The form is written locally or regionally from the NICE wording, and getting it written accurately and quickly is one of the highest-return activities in the first 90 days of a launch.

4. Who holds the money

Cardiology sits mostly in ICB-commissioned acute care, but the boundary with specialised commissioning matters for inherited and rare cardiac conditions, and it has moved.

- 70 specialised services, worth around £14 billion, are delegated to ICBs; 104 services worth around £2 billion are retained by NHS England, including all 79 highly specialised services (those serving roughly 500 patients a year or fewer).
- NHS England remains the accountable commissioner for all specialised services even where they are delegated, and continues to set national service specifications and clinical commissioning policies. Delegation changed who writes the cheque, not who sets the rules.
- Delegated services are funded through population-based allocations to individual ICBs rather than historical spend. High-cost drugs, devices and national programmes are handled separately from those figures.
- From 2027/28, seven Offices for Pan-ICB Commissioning (OPICs) — one per NHS region — will hold the complex functions, including specialised services. Expect your access decisions to consolidate upwards into those seven bodies over the plan period.

Practically: identify early whether your indication is commissioned by the ICB, by a lead ICB acting across a footprint, or by NHS England directly, and whether the drug appears on the NHS England high cost drugs

commissioning list (version 21.1, updated 31 July 2026). That single fact determines whose budget is hit, which approval form applies, and who you should be talking to.

5. How the money moves: the 2026/27 NHS Payment Scheme

The NHS Payment Scheme (NHSPS) in force from 1 April 2026 sets the default payment rules between commissioners and providers.

- **Aligned Payment and Incentive (API)** applies to almost all commissioner–provider relationships expected to exceed £1.5 million a year: a fixed element covering non-elective services plus variable payment for elective, emergency and diagnostic activity against agreed activity levels. Under API, doing more of an activity does not automatically bring more money — which is why "this will increase your outpatient activity" is an argument against you unless you can show what it displaces.
- **High-cost drugs and devices are excluded** from those core payment mechanisms and reimbursed under the excluded items pricing rule: the provider is paid the lowest of the actual cost to the provider, the nominated supply cost, or any other applicable reference price. The provider is therefore financially neutral on the drug itself — but not on the staff, clinic slots and echoes needed to use it.
- **Some high-cost drugs were moved into prices for 2026/27.** Check your product's status annually. A drug that moves from the excluded list into a national price stops being cost-neutral to the trust overnight, and pharmacy will notice before you do.
- **Specialised services top-up payments** continue for eligible inpatient providers, and OPCS-4.11 procedure codes take effect from 1 April 2026.
- **Treatment costs relating to certain NICE decisions** (the scheme cites CAR-T) sit outside standard API and require separate local arrangements — the same logic applies to any therapy with an unusual delivery or monitoring cost structure.

6. The planning cycle you are selling into

Medium Term Planning Framework 2026/27 to 2028/29

Published 24 October 2025 and updated in December 2025, the MTPF replaced the annual planning round with three-year plans covering 2026/27 to 2028/29. Systems are expected to deliver around 2% annual productivity improvement and to break even without deficit support, alongside the shift to prevention, integration, and digital (full EPR coverage and NHS App adoption across the period).

Two consequences for market access. First, a three-year envelope means a three-year investment case; a business case that only works in year one now reads as a deficit. Second, "break even without deficit support" means that in most systems, new spend has to be matched by an identified release elsewhere. Your economic case should name the displaced cost — septal reduction therapy, heart failure admissions, monitoring in the wrong setting — not merely assert cost-effectiveness that NICE has already accepted.

The Strategic Commissioning Framework

Published on 4 November 2025, the Strategic Commissioning Framework recasts the ICB as a strategic commissioner and payor rather than a manager of providers. It sets a sequence of deadlines: five-year strategies and population health improvement plans approved by January 2026; integrated needs assessments by March 2026, updated annually; intelligence functions, co-production methods and evaluation frameworks by March 2027. Regional NHS teams took lead responsibility for provider trust performance from April 2026, and national bodies hold specialised services and ambulance commissioning through pan-ICB commissioning offices.

The framework explicitly encourages outcomes-based contracts, lead provider arrangements, best practice tariffs and year-of-care payment models, and expects ICBs to work in terms of cost per patient per year using population segmentation, risk stratification and predictive modelling on the Federated Data Platform.

This is the single most useful document for how you should frame a cardiomyopathy proposition. An ICB that is being told to segment its population, model risk and buy outcomes is an ICB that can hear a case built on an identified, under-diagnosed cohort with a measurable trajectory. It is much less able to hear a product-first message.

7. The policy tailwind — and its limits

The Cardiovascular Disease Modern Service Framework

Published on 7 July 2026, the CVD Modern Service Framework is the government's ten-year strategic vision and delivery model for heart disease and stroke in England, with a headline ambition to cut premature deaths under 75 from heart disease and stroke by a quarter within a decade. Its organising idea is a cardiovascular–kidney–metabolic (CVKM) approach, managing blood pressure, cholesterol, blood sugar, obesity, kidney disease, atrial fibrillation and smoking together rather than through separate pathways. It sets 12 priorities under four themes — finding the missing millions, driving treatment to target, timely and equitable acute care, and expanding cardiac rehabilitation — each with baseline data, three-year targets and ten-year ambitions.

Delivery runs through named clinical CVKM leads in every ICB, a national oversight board and regional teams, with variation metrics requiring the gap between best and worst performers to close, and explicit linkage to 2026/27 incentive schemes and payment models. Failing to close that gap can count as a delivery failure whatever the headline numbers.

The honest caveat: the CVD MSF's centre of gravity is population-level prevention and risk-factor management. Cardiomyopathy — inherited, infiltrative or otherwise — is not one of its 12 priorities. Claiming your therapy "delivers the Modern Service Framework" in front of a CVKM clinical lead who has read it will cost you credibility. The defensible move is narrower and stronger: attach to the framework's equity and variation language, and to its named ICB clinical leadership, as the route in — then make the cardiomyopathy case on its own evidence.

8. What the system is actually measured on

NHS Oversight Framework 2026/27

The Oversight Framework segments trusts, foundation trusts and ICBs from 1 (strong) to 4 (significantly below average), with public league tables by segment and by individual metric. A financial deficit override prevents placement in segments 1 or 2 until the deficit is resolved. Segment 1–2 organisations get lighter oversight, capital flexibilities and eligibility for advanced foundation trust status; segments 3–4 get intensive oversight, mandated support, enforcement action and senior manager pay restrictions.

Its domains cover population health, access and resource allocation, experience, effectiveness, safety, finance and productivity, and people. Cardiovascular disease appears in exactly two measures: the deprivation gap in CVD management, and cholesterol management in people with recorded cardiovascular disease.

Read that carefully, because it is the core commercial insight in this briefing. Nothing a cardiomyopathy therapy does moves an oversight metric. It will not shorten a diagnostic wait that is counted, improve a cancer pathway, or fix a deficit. So the account plan cannot be built on "this helps you hit your targets" — it must be built on legal obligation (the funding requirement and SC27), on clinical leadership and specialist advocacy, and on displacing identifiable costs. Where you can borrow an oversight metric, borrow the deprivation gap: inequity of access to specialist cardiac diagnosis and treatment is a defensible, evidenced argument that maps onto something an ICB is scored on.

9. Primary care and the diagnostic funnel: QOF 2026/27

The Quality and Outcomes Framework pays general practices for managing defined clinical cohorts. For 2026/27 the cardiovascular picture changed in ways worth knowing:

- HF009 is a new indicator rewarding four-pillar therapy in heart failure with reduced ejection fraction (12 points).
- CHOL003 (cholesterol management) survives but its points fall from 38 to 20.
- AF006 (atrial fibrillation) keeps its 12 points but the upper achievement threshold rises from 90% to 95%.
- HYP010 and HYP011 (hypertension) continue at 38 and 14 points with frailty cohorts removed.
- Blood pressure control indicators CD001 and CD002 consolidate elements previously held separately.

No QOF indicator rewards identifying cardiomyopathy. That is the point. QOF pays practices to manage risk factors and to optimise HFrEF therapy; it does not pay anyone to ask why a 58-year-old has unexplained left ventricular hypertrophy, or to look for red flags for cardiac amyloidosis in a patient with heart failure with preserved ejection fraction, carpal tunnel syndrome and lumbar stenosis. Case-finding in cardiomyopathy is therefore unfunded work sitting upstream of your product, and no amount of NICE approval will make it happen on its own. The new HF009 four-pillar indicator is nevertheless useful to you: it pulls HFrEF patients into structured review, and structured review is where an undiagnosed cardiomyopathy is most likely to be noticed.

10. Better Care Fund — and why it is mostly not your fund

The Better Care Fund pools NHS and local government money to integrate health and social care, principally around admission avoidance, discharge and independence at home. NHS England published minimum NHS contributions from ICBs for 2026/27 to 2028/29 in November 2025, updated in December 2025, alongside a refreshed policy framework and reformed Disabled Facilities Grant allocations.

For a specialist cardiac medicine, the BCF is a peripheral instrument, and over-claiming it is a recognisable tell that a market access plan was written from a template. Where it is genuinely relevant is at the margins that matter in ATTR-CM and advanced heart failure: supported discharge, community heart failure teams, falls and frailty services, and the domiciliary support that keeps an elderly patient on a monitored therapy. If your proposition touches those, name the specific BCF-funded service; otherwise leave it out.

11. Price, rebate and the national deal

Above all of the local machinery sits the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG). The payment rate for newer medicines was set at 14.5% for 2026, with a parallel statutory scheme for non-members and an ongoing VPAG review. Two implications for the launch: the effective net price of your product is materially below list before any local discount is discussed, and any commercial arrangement agreed with NICE (both mavacamten and the newer entrants carry one) sits on top of that. Know what your net-net position is before a regional procurement conversation starts, and be clear internally about what is actually left to give.

12. Tendering: what is actually tendered

"Local and regional tendering" in a cardiomyopathy launch usually means one of four things, and they have different buyers:

- **National medicines framework agreements.** NHS England's Medicines Procurement and Supply Chain (MPSC) frameworks set terms under which eligible "purchasing points" — NHS trusts and foundation trusts and certain NHS-contracted providers — buy medicines. Purchasing points commit to buying from an MPSC framework where one exists and a clinically appropriate medicine is available, must submit monthly

purchasing data, and are bound by strict pricing confidentiality. Private hospitals, wholly-owned NHS subsidiaries, homecare providers and outsourced pharmacies cannot register as purchasing points.

- **Regional collaborative procurement.** Regional hubs run tenders and mini-competitions on behalf of groups of trusts. For a single-source branded product these are usually about terms, service wrap and data rather than unit price.
- **Homecare medicines services.** Homecare provision is separately contracted — the East of England Collaborative Procurement Hub runs framework arrangements for homecare medicines services used nationally. For an oral cardiomyopathy therapy requiring scheduled echocardiography, a homecare wrap can be the difference between a pathway that works and one that silently rations itself on clinic capacity. It is also a cost the trust does not have to find, which is why it is often the most persuasive thing you bring.
- **Service-level tendering.** Under the Strategic Commissioning Framework's push towards outcomes-based and lead provider contracts, whole pathways — diagnostics, monitoring, specialist review — are increasingly bought as services rather than components. Watch for these: they are where a cardiomyopathy pathway either gets designed in or designed out for the next three years.

13. The account plan, mechanism by mechanism

The table below maps each mechanism to the decision it governs, and to the function best placed to work it.

Mechanism	What it decides	Who works it, and how
NICE funding requirement (3 months; variation if >£20m/yr)	Whether and by when the ICB must fund	Market Access: agree the implementation date in writing with the ICB medicines team; cite the 30-day precedent set for acoramidis
NHS Standard Contract SC2.1.6 and SC27	Formulary listing and availability to patients	Medical and Market Access: supply the evidence pack to the DTC/APC in the format the committee actually uses
Prior approval / Blueteq (SC6.13.1, SC8.5, SC29.4.1)	Whether an individual patient is reimbursed	Market Access: get the approval form drafted from the NICE wording, not narrower; audit it for drift at 6 months
NHSPS excluded items pricing rule	Whether the drug is cost-neutral to the trust	Market Access and Finance: confirm listing on the NHS England high cost drugs commissioning list and re-check annually
SC20 Service Development and Improvement Plan (Schedule 6C)	Whether a monitoring or diagnostic pathway gets built	Market Access with Medical: propose the SDIP text; this is the most under-used lever available to industry
Strategic Commissioning Framework (Nov 2025)	How the ICB frames need, risk and value	External Affairs: engage at needs-assessment and five-year-strategy level, not at product level
CVD Modern Service Framework (Jul 2026)	Where clinical leadership attention sits	External Affairs and Medical: work through the ICB's named CVKM clinical lead; use equity and variation language honestly
NHS Oversight Framework 2026/27	What the system is scored and ranked on	Market Access: borrow the CVD deprivation-gap metric where the data supports it; do not overreach
QOF 2026/27 (HF009, CHOL003, AF006)	Primary care behaviour upstream of diagnosis	Medical: case-finding education around structured HFrEF review

Mechanism	What it decides	Who works it, and how
MPSC / regional / homecare tendering	Supply terms and the service wrap	Commercial: prepare the homecare and monitoring-support offer before the tender, not after
VPAG (14.5% newer medicines rate, 2026)	True net price and remaining commercial headroom	Commercial and Market Access: agree the net-net floor internally before local negotiation

14. What usually goes wrong

- The funding requirement is treated as the finish line. It is a starting gun with a three-month fuse; the pathway work should be complete before the clock starts, not begun when it does.
- The local approval form is written narrower than the NICE recommendation. Nobody notices for two quarters, by which time it is custom and practice. Read the form the week it appears, and read it again at six months.
- The business case is built on drug cost-effectiveness that NICE has already settled, and is silent on the thing the trust actually cannot afford: echo slots, clinic capacity and specialist nurse time. Under API, that capacity is not separately funded.
- Engagement is aimed at the ICB medicines optimisation team alone. Since April 2026 provider performance sits with regional teams, specialised commissioning increasingly sits above the individual ICB, and from 2027/28 it consolidates into seven pan-ICB offices. Map the decision, then map the person.
- The Modern Service Framework is over-claimed. Cardiomyopathy is not among its 12 priorities, and clinicians who have read it will know that within a sentence.
- The Better Care Fund, QOF and the Oversight Framework are cited generically to demonstrate system literacy. Cite them only where they carry a specific, checkable claim — an indicator, a fund, a metric — or leave them out.
- Diagnosis is assumed. In both HCM and ATTR-CM the prevalent, undiagnosed population is the commercial opportunity and the operational constraint at the same time. Nothing in the 2026/27 architecture funds finding those patients. Whoever solves that, with the specialist centres, wins the pathway.

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Not advice — a map.

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