



The role of medicines in neighbourhood health

Policy roundtable report with ICB leaders

Table of contents

Page 3 - Introduction

Page 4 - Neighbourhood Health: What is it and why does it matter?

Page 5 - What neighbourhood health will do?

Page 6 - The role of ICBs in neighbourhood health

Page 7 - Off-patent medicines overview

Page 8 - Neighbourhood Health: Patent Expiry Visibility and System Readiness

Page 9 - How Neighbourhood Health Will Change Savings Flow

Page 10 - Learning from NHSE's Best Value Biologics Programme

Page 11 - Next steps and roundtable participants

Integrated Care Boards (ICBs) have a critical function in how healthcare services are delivered to patients in England through their extended strategic commissioning role. There are 42 legally established ICBs, although NHS England is operating them in 26 clusters to reduce running costs, and future mergers may reduce the number further. However, bigger scale creates greater opportunities for partnership working and commercial partnerships.

Their remit is to strategically plan, fund, and integrate NHS services across local systems - including enabling neighbourhood-level, preventative, community-based care.

The NHS 10 Year Plan identifies a shift towards more community-delivered care and a stronger emphasis on prevention and early intervention. ICBs are central to delivering this vision and ensuring its success and neighbourhoods are seen as the key service delivery platform of the future.

Medicines UK is the trade body which represents manufacturers and suppliers of nine out of 10 NHS patient prescriptions. Every day, around 3 million packs of off-patent generic and biosimilar medicines are dispensed to patients.

Off-patent medicines enter the market following the end of an originator product's patent period and the competition they provide drives down prices paid by the NHS typically by as much as 90%. As a result, the UK benefits from the lowest medicine prices in Europe. This allows the NHS to make substantial savings on its medicine spending and more patients to access the treatments they need, often earlier in their pathway. Medicines will of course be crucial to the success of neighbourhood health and central to new models of procurement and dispensing in communities. Despite clear recognition from central government and NHS England, the value of off-patent medicines is not always fully realised at local system level. Therefore, greater clarity and consistency of uptake is important for local communities to benefit from the neighbourhood health approach and for ICB's to realise the savings off-patent medicines deliver. We know that there is still significant variation in treatments despite well established generic competition.

Analysis by Medicines UK from July 2026, shows that from 2027 to 2030, an average of 57 medicine patents will expire annually. This represents £69m per ICB of protected drugs losing exclusivity each year. By embracing generics and biosimilars as strategic levers for both financial sustainability and enabling wider patient access, ICBs can deliver real value to their communities while freeing up crucial resources to be deployed elsewhere.

Medicines UK has convened a series of roundtable discussions with ICB leaders and those who will be key to implementing care targeted towards local community needs. These conversations have developed a platform where healthcare professionals can meet with industry suppliers to look at areas for improvement, collaboration and partnership and forge consensus across key themes.

Facilitated and supported by Conclusio Limited, the latest discussion focussed on the concept of Neighbourhood Health and what it will mean for system reconfiguration and delivery and to discuss the implications in terms of new points of engagement and partnership working for the industry. Specific topics around the role of medicines were tabled and this paper summarises some of the key points and provides a practical solution which can help realise the full potential of Neighbourhood Health.

Medicines UK sees this as a vital forum in which to discuss ideas and share best practice and further themed sessions will take place in the coming months. We would like to thank all those who attended the session and provided their insight and expertise. A full list of attendees is available at the back of this document.

Neighbourhood Health: What is it and why does it matter?

Neighbourhood Health is an approach to organising care so that people can access the support they need closer to home, in ways that are convenient, coordinated, and genuinely centred on their lives. It is also an approach which prioritises the specific needs of local populations and assembles services and pathways to meet those requirements. It has the potential to embody all three key shifts left of the 10-year health plan namely:

From hospital to community - more care delivered closer to home - in neighbourhoods, primary care, and people's own homes - rather than relying on hospitals as the default.

From analogue to digital - a digitally-led NHS where technology reduces administration, improves access, and makes managing care as simple as online banking.

From sickness to prevention - a shift towards catching illness earlier, preventing it wherever possible, and making healthy choices easier.

Arguably, it also reflects what staff want. Professionals across health and social care want to work together without organisational barriers getting in the way. They see the frustration people experience when services feel fragmented or inconsistent, and they want a system that enables them to deliver the kind of seamless, proactive support the NHS should be known for.

Why change is needed

For years, the NHS and wider care system have struggled to create the conditions in which local services can truly work together. Despite strong ambition, it has been difficult to coordinate care, align funding, and deliver a service which moves treatment from hospitals to the community in a scalable way. Indeed, it will be interesting to see if the payment structures and tariffs within the NHS, largely provided for one discipline to offer an appointment, make a diagnosis or dispense a prescription, still prove to be a major stumbling block.

Each ICB has its own compelling population health case for change which highlights a range of challenges in terms of disease incidence, increasing number of comorbidities and chronic condition and a growing gap in terms of healthy life expectancy.



What neighbourhood health will do?

Neighbourhood Health will create local, collaborative teams that bring together the NHS, local authorities, and wider partners. It builds on successful pilots and pockets of this approach across the country and aims to make these models standard practice.

This joint endeavour combines:

- The NHS's responsibility for health services.
- Local authorities' responsibility for adult and children's social care and public health.
- The strengths of voluntary, community, and wider partners.

Together, these teams will support people earlier, closer to home, and in ways that reflect local needs. The goal is a genuine partnership that delivers the left shifts of the 10-year plan.

How the system will enable neighbourhood health

The medium-term planning framework published by the Government earlier this year sets out four key changes to make neighbourhood health possible:

- Clear governance structures ("archetypes") so local systems know how to organise neighbourhood teams.
- An established contractual footprint with neighbourhoods typically managing circa 30-50,000 residents with opportunities to scale to populations of circa 250,000 + through multi -neighbourhood contracts that are currently being consulted on.
- A common description and shared outcomes so everyone understands what neighbourhood health is and how success will be measured.
- Early financial incentives to help local systems accelerate change.
- A new model of joint working between NHS and local government leaders, including more collaborative strategic commissioning.

These changes will be supported by integrated care boards (ICBs) evolving into strategic commissioners and working more closely with local authorities. Neighbourhoods could work across ICBs, as well as within them.

The intention is not to impose a rigid national model. Instead, the framework aims to create the conditions in which local leaders can succeed - providing consistency where it helps but allowing flexibility so neighbourhood health can reflect local circumstances.

Where strong neighbourhood models already exist, this approach builds on them. Where they are scarce, it gives local leaders the tools to accelerate development.

With Andy Burnham now Prime Minister, it will be interesting to see if his Government does indeed propose significant changes to social care, and whether it chooses to further devolve health.

The role of ICBs in neighbourhood health

ICBs are central to making Neighbourhood Health work. Their role is to create the conditions, set the strategy, and enable the partnerships that allow neighbourhood-level teams to deliver joined-up, preventative, community-based care.

Neighbourhood Health is not something neighbourhoods can deliver alone - it requires system-level leadership, alignment, and commissioning. Their role includes the following key areas.

1. ICBs act as strategic commissioners

The Government's framework explicitly states that ICBs will develop into strategic commissioners. This means:

- Setting the overall direction for population health.
- Aligning NHS resources with local authority priorities.
- Ensuring neighbourhood teams have the funding, governance, and support they need.
- Commissioning in a way that hard-wires collaboration between health and social care.
- Neighbourhood Health becomes the local delivery arm of the ICB's strategic commissioning.

2. ICBs create the governance structures ("archetypes") and will enable new contractual models

One of the four national changes is to provide archetypes - standardised governance models that local systems can adopt.

ICBs are responsible for:

- Choosing and adapting the right archetype for their area.
- Ensuring neighbourhoods have clear accountability.
- Making sure NHS and local authority partners can work together without friction.
- This gives neighbourhood teams clarity, legitimacy, and a stable operating model.

3. ICBs define the common outcomes and metrics

Neighbourhood Health must be consistent enough to be measurable. ICBs will:

- Adopt the national description of neighbourhood health.
- Use the common outcomes and metrics.
- Monitor performance across neighbourhoods.
- Support improvement where provision is weak or inconsistent.
- This is intended to ensure that neighbourhood health is not a patchwork of pilots but a coherent, scalable model.

4. ICBs enable financial incentives and resource alignment

The Government will introduce early financial incentives to accelerate neighbourhood health. ICBs will:

- Deploy these incentives locally.
- Align NHS budgets with local authority investment.
- Support neighbourhood teams to shift care from hospital to community.
- Remove financial barriers that currently block integration.
- This is crucial for achieving the left shift as laid out in the 10-year plan.

Off-patent medicines overview

The NHS depends on off-patent medicines – whether chemical-based generics or biologically derived biosimilars. Nearly 90% of prescriptions for NHS patients are fulfilled by these products. It is a simple but highly effective system. Originator companies research and develop new medicines to meet unmet patient needs. Their products must pass rigorous regulatory hurdles to ensure safety and efficacy. To reward innovation, pharmaceutical companies are granted exclusive patent periods during which they alone can promote and sell a medicine to the NHS. Once this period ends, competition enters the market, and the NHS moves from having a single supplier to having many.

Generic medicines contain the same active ingredients as originator pharmaceuticals and act in the same way on patients. Equivalent generic medicines may contain different non-active ingredients (such as colourings, starches, sugars, etc.) and they may differ in size, colour or shape, but none of these have any impact on the therapeutic effect, i.e. the way they work in the patient's body.

Generic medicines must comply with exactly the same standards of quality, safety and efficacy as all medicinal products. They are produced in inspected plants under what is known as Good Manufacturing Practice (GMP). And, just like originator products, once a generic or biosimilar medicine is sold on the market, it must be monitored by the manufacturer in case any adverse reactions are reported.

The impact is dramatic: prices typically fall by up to 90% as companies compete for market share. Generic and biosimilar competition saves the NHS around £20 billion each year – equivalent to around 10% of its operating budget in England. These market fundamentals mean the UK enjoys the lowest average medicine prices in Europe. The off-patent industry thrives on simplicity and efficiency, combining high volumes with low margins. Yet sustained downward pressure on prices has stretched and globalised supply chains as companies seek ever greater efficiencies to remain viable. Today, the average generic medicine costs the NHS less than £4, nearly half of which covers pharmacy and distribution margins ^[1].

Indeed, around 60% of these medicines cost under £1 for a month's supply of life saving or life-enhancing treatment ^[2]. When supply becomes constrained, the government allows reimbursement prices to rise, enabling pharmacies to cover increased costs and maintain dispensing margins.

In recent years, shortages have become increasingly common. The drivers are many and varied, but sustainability of pricing has undoubtedly been a significant factor. The UK needs to compete globally for allocations of medicines, and therefore the commercial environment must be conducive to ensure adequate supplies are available. This delicate balance between affordability and sustainability underpins the resilience of the NHS medicines supply. Protecting it must remain a strategic priority.

An often-overlooked fact is that one in four prescription medicines used by the NHS are manufactured in the UK. From Barnstaple to Runcorn and Wrexham to Grangemouth, more than 20 facilities anchor this sector, supporting thousands of jobs across manufacturing, packaging, logistics, and corporate offices. Most of these plants produce finished medicines – the tablets, capsules, and injections patients receive when items are dispensed. Some are dedicated to packing drugs. With an economic model built on high volumes and razor-thin margins, companies have been driven to internationalise production to contain costs. As a result, global supply chains have grown longer over time. The active pharmaceutical ingredients (APIs) that give medicines their therapeutic effect are typically sourced from Europe, India, and China. Their creation depends on key starting materials, the majority of which originate in China. This reliance on extended supply chains erodes resilience and has contributed to medicine shortages particularly when exacerbated by globally impacting crises.

[1] Prescription Cost Analysis – England 2025/26 | NHSBSA

[2] IQVIA, June 2026.

Neighbourhood Health: Patent Expiry Visibility and System Readiness

Key Themes from the Roundtable

During our roundtable, ICB leaders highlighted a clear interest as part of neighbourhood health discussions - for more proactive, systematic visibility of upcoming patent expiries for high spend medicines. These achievable savings provide an opportunity for a form of shift left through reinvestment of money back into prevention and neighbourhood development. As neighbourhood health models evolve, understanding when major products lose exclusivity will become increasingly important for planning, budgeting, and maximising savings.

Why Patent Expiry Matters

When an originator medicine is approved, it typically benefits from a period of market exclusivity - often around 10-15 years - during which it is the sole supplier to the NHS. The manufacturer sets the list price, with NICE determining cost-effectiveness, and effectively holds a monopoly position. Once exclusivity ends, generic or biosimilar competition enters the market. This competition rapidly drives down prices, delivering substantial savings to NHS budgets. It also increases supply resilience, as multiple manufacturers begin producing the medicine.

How Primary Care Currently Realises Savings

In traditional primary care pathways, a GP prescribes using the International Non-proprietary Name (INN) of a medicine. The pharmacist then dispenses either a generic or the originator brand, depending on patent status. Because INN prescribing and reimbursement incentives favour lower-cost products, the generic market forms automatically without the need for formal switching programmes. Patients typically remain unaware of the change, as off-patent medicines must meet the same standards of quality, safety and efficacy as branded equivalents. (Note that products in some treatment areas should be prescribed by brand to maintain a patient on a single manufacturer's brand).





How Neighbourhood Health Will Change Savings Flow

Neighbourhood health models will reshape where and how patients access medicines. As prescribing and dispensing move beyond traditional GP-pharmacy pathways, the need for local health systems to plan for upcoming patent expiries grows. Systems will need to understand when major products are due to lose exclusivity so they can prepare local infrastructure, align incentives, and ensure savings are realised as early as possible.

A major structural shift is already underway. From later this year, newly qualified pharmacists will be able to prescribe independently from the moment they join the register. This change will make access to medicines quicker and more convenient for patients and will alter prescribing patterns across neighbourhoods.

Pharmacy First is another significant development. By enabling pharmacists to diagnose, treat and dispense for a growing range of conditions, it reduces GP workload and expands pharmacy-led care. As the programme grows and additional prescribing pathways are introduced, the role of pharmacy in neighbourhood health will deepen further.

Why Patent-Expiry Visibility Matters for Neighbourhood Health

Roundtable participants agreed that knowing when major patent expiries will occur would help ICBs anticipate when savings could be realised and prepare local systems accordingly. Early visibility would support:

- Aligned incentive agreements.
- Workforce and infrastructure planning.
- Readiness to maximise off-patent competition savings.
- Clearer financial forecasting across neighbourhoods.

It would also send a positive signal to manufacturers that the UK is a priority market, helping ensure strong supply levels at the point of patent expiry.

Learning from NHSE's Best Value Biologics Programme

NHS England has already demonstrated the value of structured, advance planning through its Best Value Biologics Programme. This national strategy ensures the NHS uses the clinically appropriate, lowest-cost biological medicine - including biosimilars - as early and widely as possible.

The programme provides commissioning and implementation guidance designed to maximise savings, reduce unwarranted variation, and accelerate biosimilar uptake.

NHSE identified five high-spend biologics and worked with hospital trusts and manufacturers months ahead of patent expiry to prepare for switching. As a result, uptake of biosimilars such as ustekinumab and aflibercept has been among the fastest in Europe.

A key success factor has been strong central guidance combined with effective local and regional execution.

Applying a Similar Model in Primary Care

A comparable approach could be adapted for primary care. Government could identify major expected patent expiries for primary-care medicines over the next five years and support systems to prepare in advance.

The dynamics differ from secondary care:

- Primary care relies on INN prescribing and reimbursement incentives rather than tendering.
- Patients do not need proactive switching; the generic market forms automatically (where there is no clinical reason to maintain a patient on a single manufacturer's brand).

However, neighbourhood health may impact prescribing and dispensing routes, and therefore how savings are to be planned for and potentially flow. Advance notice and structured preparation would still be highly valuable. For example the UK patent expiry of Semaglutide for weight loss management does not occur until 2031 but will need careful advanced management.

Building a Reliable Source of Patent-Expiry Information

Patent expiry dates are not always straightforward, particularly where legal challenges occur. A system-wide approach to horizon scanning would need to combine:

- Robust data analysis.
- Structured dialogue with industry.
- Clear national guidance.

Roundtable participants also discussed whether the Single National Formulary could help signal future loss-of-exclusivity events.

While its primary function is to drive consistency in first-line treatment guidance, it could potentially carry information on upcoming patent expiries to support coherent knowledge-sharing across health networks.

Next steps

The ideas shared in this paper are intended as a platform for further discussion and collaboration. Medicines UK see this as an opportunity to evolve and explore ideas to see how they could accelerate the benefits of neighbourhood health for local systems and communities. If you are interested in finding out more, please contact jeremy.durrant@medicinesuk.com

Participants

We would like to thank the following people who gave of their time and insights freely to facilitate greater understanding and partnership between industry and healthcare leaders.

- Jessica Patel, Brand Manager UK, Luye.
- Andy Mooney, Head of External Affairs, Viatris.
- Iain Chalmers, National Market Access Manager, Thornton & Ross/Stada.
- Maja Gkiokas, Associate Director, Health System and Payer Strategy Market Access, Teva.
- Ian De'Ath, Business Unit Director, Lupin.
- Janet Maclean, Head of Marketing, Rosemont.
- James Roach, Managing Director, Conclusio, Director of Neighbourhood Health NHS Hampshire and Isle of Wight.
- Dr Tom Bertram, Clinical Director, Neighbourhood Health and Deputy Chief Medical Officer, NHS Hampshire and Isle of Wight.
- Dr Alex Ward, Clinical Peer Ambassador, NHS England.
- Will Huxter, Director of Commissioning, NHS England London Region.
- Dr Ameet Bakhai, Consultant Cardiologist and Research Director, Royal Free Hospital London.
- Rezina Hakim, Senior Policy Advisor, Life Sciences and Digital, NHS Alliance.
- Ron Shields, Provider Chief Executive, NHS South East Region.
- Ankur Trivedi, Prescribing Lead, Primary Eyecare, Gloucestershire, Herefordshire and Worcestershire ICBs.
- Raj Matharu, Chairman, Pharmacy London.
- Luvjit Kandula, Director of Strategy and Transformation/ Chief Officer Community Pharmacy, Greater Manchester, Chair Primary Care Provider Collaborative Board Greater Manchester ICB.
- Mark Samuels CEO, Medicines UK.
- Robert Russell-Pavier, Director of Policy & Economics, Medicines UK,
- Jeremy Durrant, Director of Communication & External Engagement, Medicines UK.
- Jackson Lynn, Programme Director, Medicines UK.

Medicines UK represents the interests of UK-based manufacturers and suppliers of generic and biosimilar medicines. We promote the development and understanding of this vital sector, which supplies four out of five NHS prescription medicines. Find out more at www.medicinesuk.com or contact us at info@medicinesuk.com