

How we roll

The NHS cannot govern medicines through a single budget line



South East London's published figures show a wider problem for integrated care boards: the medicines line that is easiest to spot is not the same as the full cross-setting medicines economy leaders are being asked to manage.

Medicines are one of the NHS's most powerful strategic levers, but leaders are often not looking at the same number when they talk about medicines spend.

In South East London, the ICB's 2024/25 annual report shows £254.336 million of prescribing costs and £53.281 million of pharmaceutical services, a visible medicines facing line of £307.617 million.

Yet the ICB's April 2026 board paper describes medicines as a budget of about £850 million across the system, with £256 million in primary care prescribing and £594 million in hospital spend, and around £300 million directly commissioned or managed by the ICB.

NHSBSA then offers a third cross-setting, ICB level view again, using a different methodology.

None of those lenses are necessarily wrong. The problem begins when one of them is treated as if it were the whole operating reality.

Different numbers, different purposes

That matters because annual accounts, board papers and national data sets are built for different purposes.

Annual accounts are there to present audited cost lines. Board papers are there to support management judgement and decision-making. National data sets are there to provide attributed visibility and comparison across systems.

All three matter. But leadership weakens when the easiest figure to find becomes the default figure for governance, especially in an area as operationally complex as medicines.

This is no longer a narrow pharmacy issue. South East London's own board paper describes medicines as one of the NHS's largest, most volatile and most influential system levers.

It says that creating headroom for new NICE approved innovation depends on delivering £22–£25 million of medicines efficiencies in 2026/27, underpinned by aligned commissioning, finance and planning.

It also makes the broader strategic point: moving from cost to value improves outcomes and system productivity. That is the language of pathway redesign, operational performance and strategic commissioning, not just of procurement.

Why framing really matters

Once medicines are understood in that way, narrow framing becomes dangerous. A visible line of £307.6 million can make medicines look like a contained budget issue.

A wider system view of around £850 million makes them look like what they really are: a cross-setting challenge touching primary care, hospitals, specialised services, neighbourhood delivery, workforce, safety, prevention and innovation adoption.

The denominator changes what feels material, which opportunities attract senior attention and who is expected to act. That is not semantics. It shapes management behaviour.

This is not an accusation of bad accounting. Nor is it a claim that a national attributed data set is somehow 'truer' than local audited accounts.

NHSBSA is explicit that its Prescribing Costs in Hospitals and the Community release covers medicines, appliances, dressings and medical devices, combines different cost measures across settings and cannot be used as a final figure for total NHS cost.

That caveat should not weaken the argument; it should sharpen it. The point is precisely that cross-setting medicines governance is currently spread across several legitimate but partial official views. Leaders still have to reconcile them.

Strategic pressure increases

The timing makes this more than a technical irritation. NHS England's draft Model ICB Blueprint said integrated care boards were expected to move towards strategic commissioning and cut operating costs by roughly 50% to an £18.76 per head envelope.

NHS England's later 2025/26 pay awards guidance raised that envelope to £19.00 per head but kept the same direction of travel. Separate NHS England guidance also set out mergers and boundary changes taking effect from 1 April 2026.

In other words, systems are being asked to think more strategically with less management slack. In that environment, fragmented visibility is not a reporting curiosity. It becomes an execution risk.

South East London is a useful case study precisely because this is not a story about an obviously weak system.

NHS England's 2024/25 annual assessment said the ICB had demonstrated a robust approach to governance and management, with effective structures and positive partner feedback.

At the same time, South East London's digital strategy openly states that there is no ICS-wide single digital solution to support multi-organisational care teams.

That combination matters. It suggests the issue is structural, not personal. Even relatively mature systems can still end up managing medicines through multiple official views and disconnected operational environments.

South East London's own medicines paper is also instructive about what good

looks like. It points to strategic commissioning pharmacy leadership, population health management using prescribing and outcomes data, stronger contractual levers and financial accountability for medicines value and safety, and greater investment in data and analytics.

That is the right ambition. But it also exposes the scale of the challenge.

To get there, systems need more than descriptive reporting. They need one shared cross-setting operating frame for medicines, one that makes it clear which figure is being used for which decision and why.

‘A wider system view makes medicines look like a cross-setting challenge touching every part of care’

What needs to change

So, what should follow? Not another round of abstract rhetoric about optimisation.

What integrated care boards need is a disciplined cross-setting medicines view brought routinely into executive and board discussion, with each number clearly labelled for what it is: an audited ICB cost line, a wider local management view or a national attributed view with methodological limits.

They also need medicines priorities judged consistently against patient benefit, unwarranted variation, affordability and practical deliverability, with joint ownership across pharmacy, finance and commissioning.

That is not glamorous. But it is what serious governance now requires. The deeper lesson is simple. Public reporting and operational management are not the same thing.

Annual accounts matter. Board papers matter. National data sets matter. But no single lens is enough on its own in a cross-setting NHS.

South East London’s published material shows both sides of the truth: serious strategic intent, but also a genuinely difficult denominator problem.

Until the service addresses that more explicitly, it will keep describing

medicines as one of its biggest levers while still governing them through several different windows at once.

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