

Medicines Optimisation Centricity

What is the value of medicines
in the patient pathway?

A review by **HSJ Advisory**
in partnership with **Aspire Pharma Limited**

Initiated and funded by Aspire Pharma Ltd which had no input to the content and were able to review in advance of publication for factual accuracy and compliance checks only.



Medicines optimisation is a tool - however sometimes we need to remind ourselves of its purpose. If it doesn't service our patients well - does it need refining?



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Foreword



Denis Gizzi

Former Chief Accountable
Officer, NHS

As the healthcare landscape continues to evolve, so too must our approach to medicines. The value of medicines cannot be fully realised without looking beyond cost and clinical efficacy to the patient experience, their outcomes, access, and ability to manage their health in partnership with healthcare organisations, clinical practitioners and industry partners.

This white paper captures the insights of a rich and timely conversation between professionals deeply embedded in our healthcare system, from pharmacists and prescribers to system leaders and policy connections. What unites us is a shared recognition that medicines optimisation must now move from the margins to the mainstream of healthcare transformation. In this sense, there really is no substitution for long term, value adding partnerships.

Too often, medicines are managed as a transactional cost centre rather than a strategic enabler of long-term wellbeing and system efficiency. At a time when NHS resources are under more pressure than ever, and health inequalities remain stubbornly persistent, we must use every tool at our disposal to deliver care that is more integrated, preventative, and patient-driven.

Medicines optimisation is one of those tools, but only if we are willing to rethink how it is structured, commissioned, and delivered. That requires courageous leadership, smarter use of data, bolder collaboration with industry, and most importantly, a renewed focus on the person behind every prescription (both those in receipt and those who prescribe). For too long the value of medicines has been measured in cost

terms, rather than the contribution to patient wellbeing over their years of care. Furthermore, the placement of medicines in the patient pathway requires much more strategic alignment with the impact on programme budgeting for the related care system.

I am grateful to all contributors who took part in the roundtable and to HSJ Advisory and Aspire Pharma for creating the space to have this conversation. I hope the reflections and recommendations in this paper act as both a provocation and a practical guide for those of us committed to shaping a better future for medicines in the NHS.

Contributors

The roundtable event was chaired by **Denis Gizzi**, CEO SmartSight Consulting, former Chief Accountable Officer. **Jyotika Singh**, Senior Principal Consultant at HSJ Advisory, acted as facilitator, with support from **Kieran Brown**, Senior Healthcare Consultant at HSJ Advisory, and **Jemma Carter**, Independent Medical Writer.

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Executive Summary

Purpose

This white paper explores the pivotal role of medicines within the patient pathway and challenges the current system to become more patient-centric, integrated, and outcome-driven. It synthesises findings from a 2025 expert roundtable facilitated by HSJ Advisory and sponsored by Aspire Pharma, drawing on experiences across primary care, secondary care, community pharmacy, and industry.

Key insights

Medicines optimisation is often used as a financial lever rather than a patient-facing intervention.

Patients with long-term conditions face fragmented systems not designed for their needs.

The NHS remains overly bureaucratic and focused on short-term metrics over long-term outcomes.

The current system is incompatible with the NHS 10 year health plan, as it doesn't yet consider the sizeable opportunities presented by NHS anchor organisations (e.g. Foundation Trusts) collaborating in wider provider partnerships to re-design care systems and take on responsibility for delegated programme budgets.

Generic systemic barriers identified

Digital and system interoperability

Administrative complexity

Short-term financial planning

Commissioning misalignment

Patient access inequities

Workforce training gaps

Cultural resistance to industry collaboration

Strategic recommendations

Patient-centric approaches

System improvements

Collaborative care models

Education and workforce development

Technology and AI enablement

Mature industry partnerships

Aspirations

A future NHS where medicines optimisation is fully integrated into holistic, value-based care; pharmacy is empowered as a clinical partner; and NHS–industry collaboration shifts towards pragmatic problem-solving, driving innovation and equity.

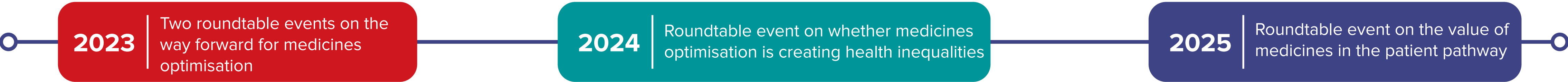
Call to Action

This paper calls on NHS leaders and industry stakeholders to co-design and scale integrated solutions that ensure medicines deliver better health outcomes and greater patient empowerment.

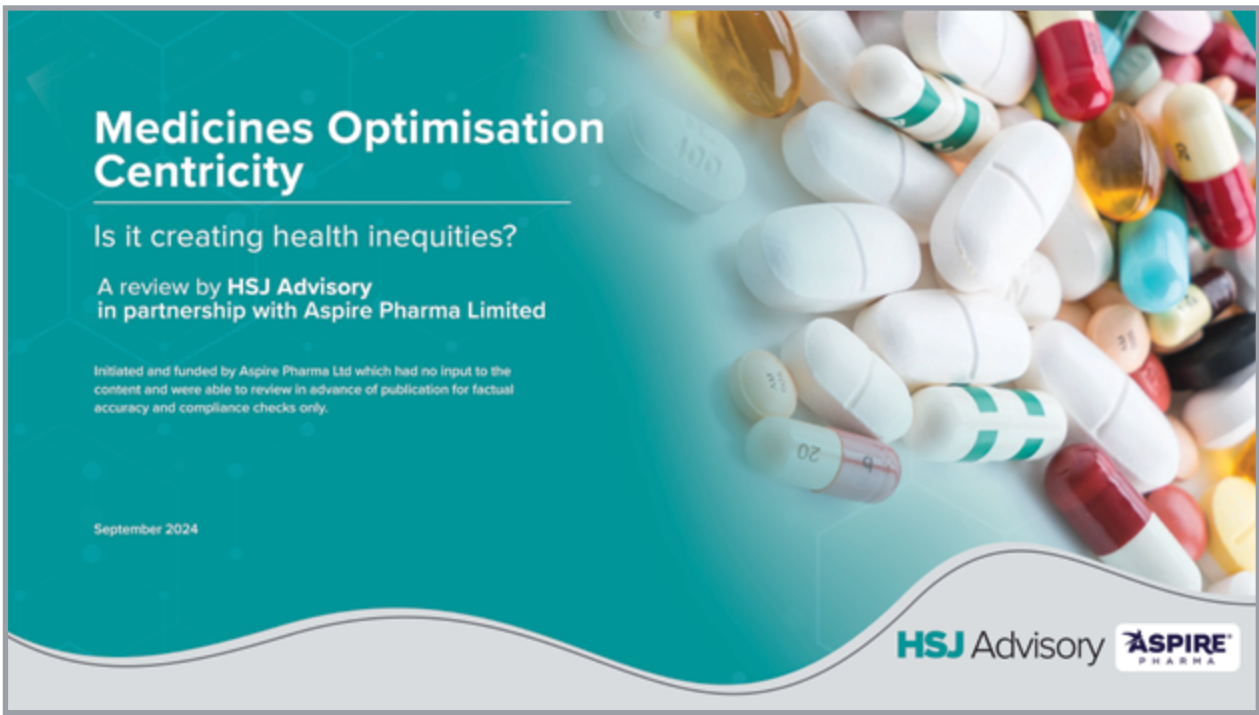
Background

HSJ Advisory has partnered with Aspire Pharma to support Aspire to drive transformative change in patient care by:

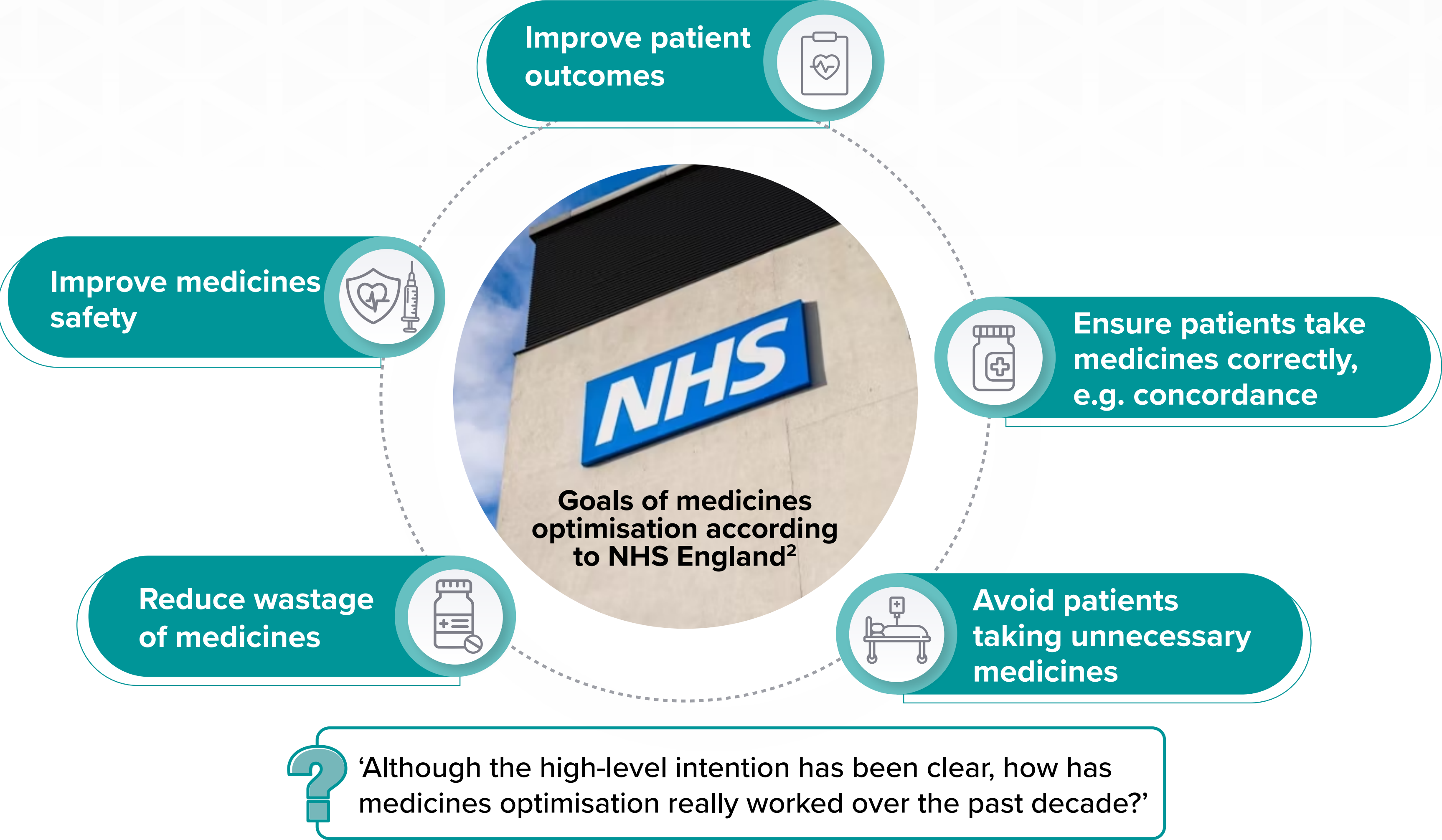
- placing patients at the core of every decision, ensuring their voices shape Aspire’s mission and actions
- developing and supplying innovative products and medicines throughout the world
- deeply understanding the real-world experiences of both patients and the healthcare professionals (HCPs) who support them
- partnering with healthcare systems like the NHS to implement practical, outcomes-focused solutions that elevate health across communities.



Advisors in pharmacy clinical leadership roles, which involve issues such as workforce and resilience of pharmacy services across the system, and pharmacy teams involved in medicines optimisation on the ground.



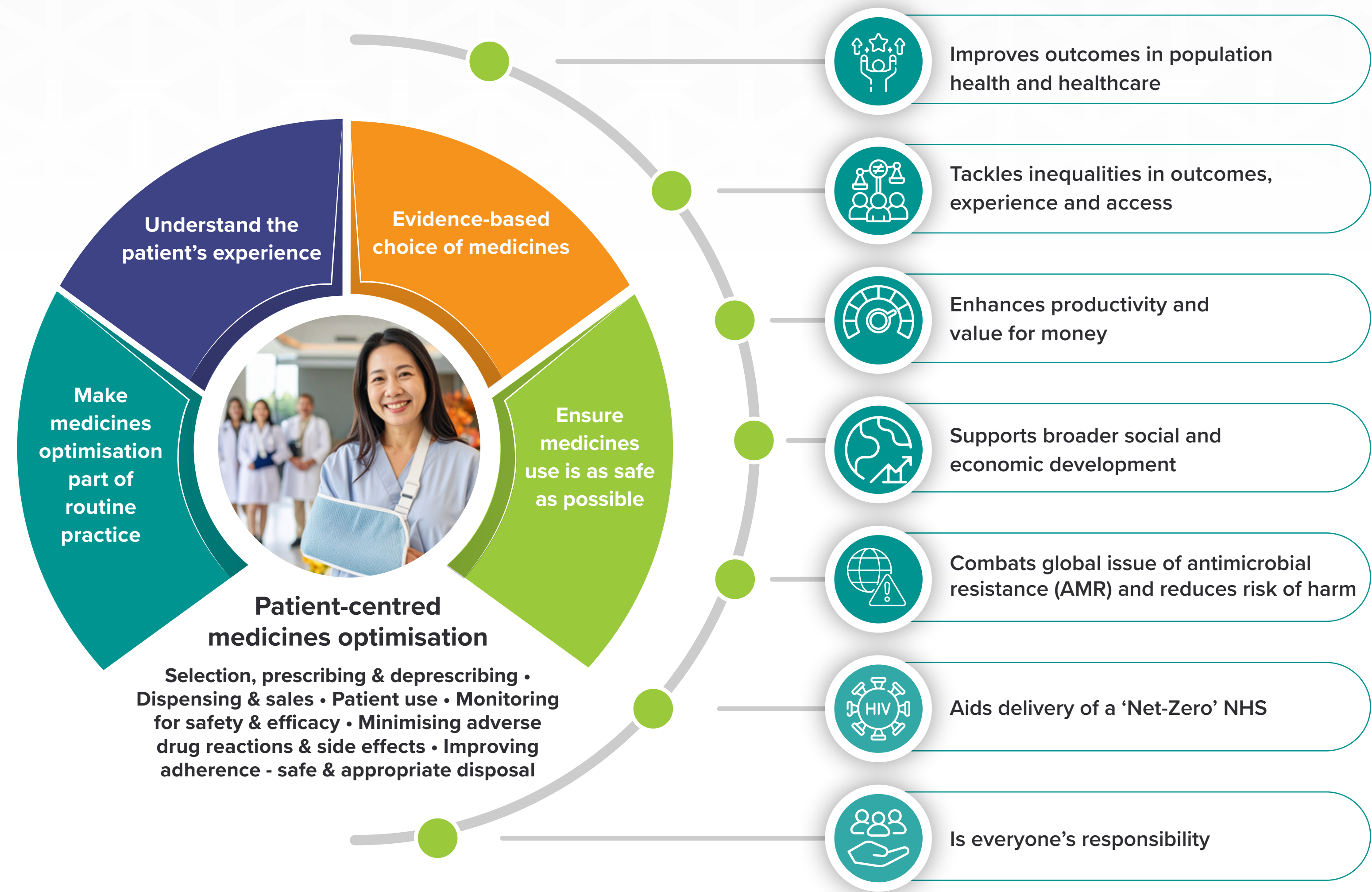
Goals of medicines optimisation



Additional considerations and levers from 2025, with publication of the new NHS 10 year health plan for England¹

-  Prevention not just treatment
-  Keep patients out of hospital by reducing complications and hospital admissions
-  Increase use of digital solutions
-  Develop a single national formulary

Vision of patient-centred medicines optimisation³



Additional considerations from 2025, with publication of the new NHS 10 year health plan for England¹



Neighbourhoods teams aim to support patient care and optimisation of treatments closer to home

Patient-centric care for long-term conditions



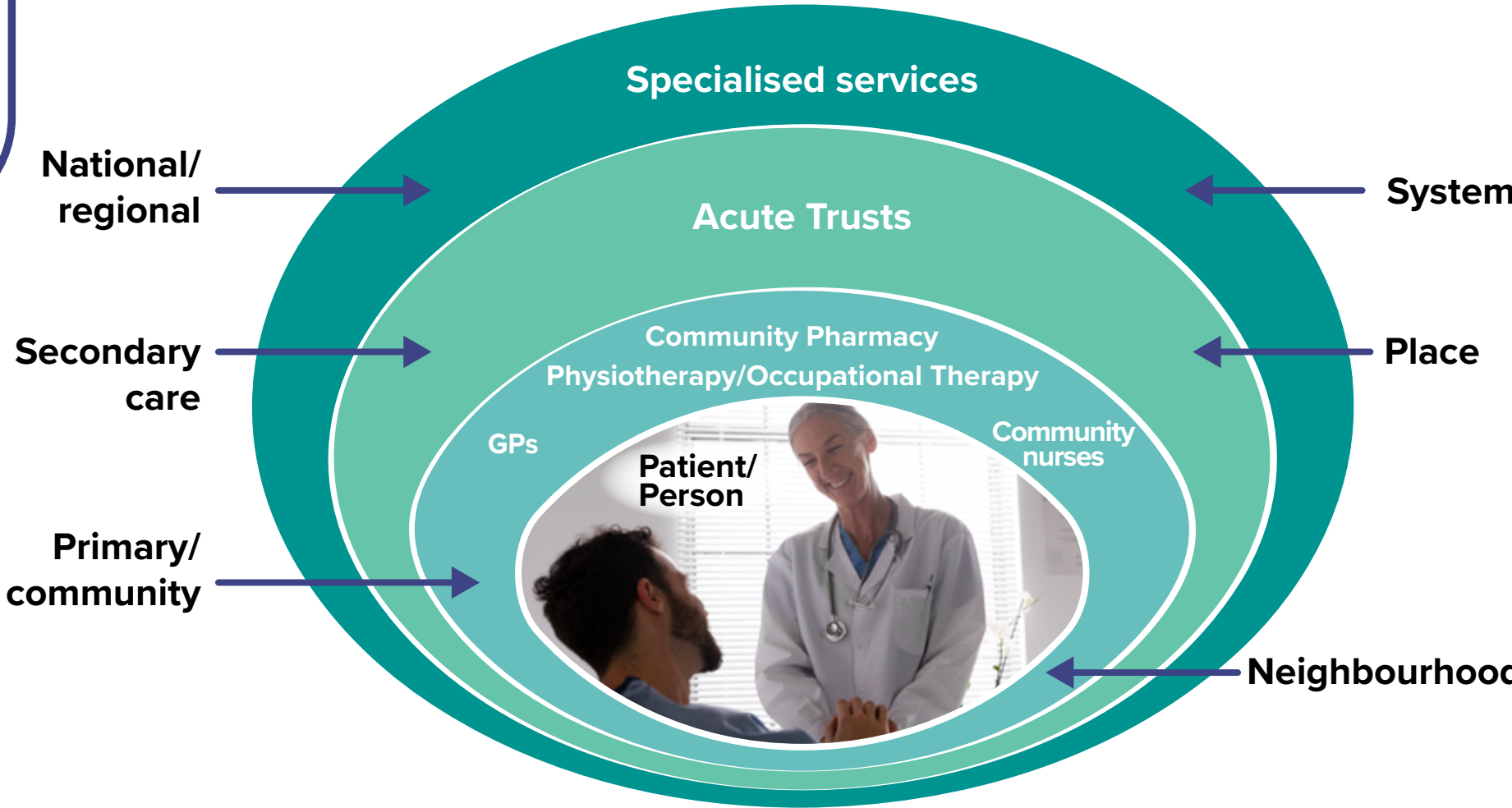
When a person becomes ill, they are pulled into the NHS, the system dictates what the patient needs, and once that has been achieved, they are discharged out of the system. This can be effective for patients with episodic and isolated problems, but it is not the best approach for patients with long-term conditions.

The question is how to put the patient living with a long-term condition at the centre of their own life and their own care?



The answer may be to introduce the concept of centricity of care for patients with comorbidities and those who need complex management, with decision-making on behalf of the person with that person, looking holistically at their health status and for the duration of their condition.

With the 2025 NHS 10 year health plan,¹ the new neighbourhood teams will help to support this and will also work towards the goal of prevention.



Purpose of this paper

In June 2025, HSJ Advisory ran a single roundtable event, supported and funded by Aspire Pharma, bringing together key pharmacy stakeholders (Contributors) to debate and discuss the value of medicines in the patient pathway.

The aims of the roundtable were to:

- discuss the importance of patient access to medicines
- describe barriers to providing equitable access to the right medicines to the right patient at the right time
- generate ideas to make change
- identify the key metrics of success to monitor the change
- generate understanding of the expected impact by the change in the current system
- identify the call to action through key messages for thought leadership.

Under Chatham House Rule, delegates were asked to give their views on the state of medicines optimisation today, barriers for patients, and whether medicines optimisation is centred around patients. They then discussed how medicines optimisation could be changed to increase patient centricity. Finally, they discussed the role of industry and the next steps for all stakeholders.

This white paper summarises the key themes of the discussions, with a view to helping address some of the issues raised by delegates and pointing the way towards ensuring medicines optimisation within the NHS is more patient centric.



Patient-centric access to medicines:
How do we ensure services are delivered with patients in mind?

“
Quotes included throughout this paper are adapted from the discussions at the round table meeting, have been edited for sense, and may reference individual examples provided by attendees.

Barriers to ensuring patients have equitable access to the right medicines at the right time



“Does the NHS culture actually foster medicine optimisation and collaboration?”

Multiple barriers prevent patient-centric access to medicines

Click each heading
to find out more:



**System
communication barriers**



Commissioning



Digital



**Resistance to
industry collaboration**



Administrative



Financial



**Education and
training gaps**



Patient access





System communication barriers

Different NHS systems do not communicate effectively with each other, creating barriers to information sharing. This results in information gaps, decision-making without a holistic view of the patient, and delays in patient care.

Healthcare **organisations** across **different healthcare settings** use **multiple systems** that often **do not communicate effectively with each other**. **Lack of full system interoperability** leads to **barriers to accessing records**, so **HCPs** often **cannot access complete patient information**. This can result in **repeated information gathering**, **decisions** made **without a holistic view** of **patients' overall health**, **significant delays in patient care**, and **potential gaps in treatment**.

Although **some systems** have **potential for widespread use** across trusts, integrated care boards (ICBs) and community settings, **implementation remains inconsistent**.

Impact on patient care

- Delays in treatment and medication access
- Disjointed care
- Increased administrative burden on HCPs
- Reduced efficiency in healthcare delivery
- Barriers to implementing patient-centric approaches to care

”

The NHS has great systems, but they don't talk to each other. That, in itself, creates a barrier.

”

In pharmacy, having two systems to handle different parts of the pharmacy workflow creates unnecessary complexity.

”

Why aren't companies contracted to work together for something that affects how HCPs work?

”

We need better digital infrastructure and interoperability between different healthcare systems to reduce delays and inefficiencies in patient care.



Administrative barriers

Departments and organisations operate independently, which results in administrative barriers that impact the healthcare system's ability to collaborate, implement innovative solutions and ultimately deliver efficient patient-centred care.

Different NHS departments and organisations operate independently rather than as an integrated network. This can create significant administrative hurdles and boundaries that impede collaboration and information sharing and is a major obstacle to healthcare providers providing coordinated care.

Administrative processes and form-based bureaucracy can give an illusion of efficiency, but traditional administrative channels and rigid collaboration frameworks may actually be creating inefficiencies. For example, conventional procurement and partnership processes are often slow and bureaucratic, while a focus on metrics and administrative processes can shift attention from patient-centric care, affecting the quality of healthcare delivery.

Funding and support allocation across different healthcare initiatives often favours some programmes over others based on administrative priorities not patient needs.

Impact on patient care

- Reduced access to care
- Delayed treatment
- Fragmented care experience
- Medication management issues
- Exclusion of vulnerable groups

”

If I face challenges accessing healthcare as an HCP, how bad can it be for a non-HCP to navigate the health system?

”

Inefficiencies in the system mean that I can spend an hour a day sorting 'out of stocks' when I could be sorting patients.

”

The NHS has cultural resistance to change and innovation that prevents adoption of new approaches.

”

Communication was happening between primary and secondary care... in ways that anyone who has ever worked in information governance would probably have to put their hands over their ears and shut their eyes.



Financial barriers

Budget constraints and short-term fiscal cycles make it difficult to implement long-term care plans and cost-effective solutions.

The NHS operates on **short-term financial planning and fiscal cycles**, which makes it **difficult to implement long-term, cost-effective healthcare solutions**. For example, **preventative measures for kidney disease** would **save money in the long-term** but require **up-front investment**. **Secondary care** faces significant **financial challenges and capital shortages** that **limit implementation of innovative treatments and new technologies**.

How funding is distributed within the NHS is also an issue. **Block contracts** can **influence treatment decisions**, with **financial incentives in contracting** potentially **affecting clinical decisions** about treatment methods. **The money returned** from pharmaceutical companies **through schemes like the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG)** is handled by the Department of Health and Social Care, and the impacts this has on funding flows to ICBs is not transparently communicated, with ICB finance colleagues being largely unaware of the VPAG scheme.

Impact on patient care

- Inequalities in access
- Digital exclusion
- Delayed implementation of innovations
- Reduced patient engagement

”
There is frustration in being accountable for large public finances with little connection between spending on technical products and patient outcomes.

”
Our block contract means that we should be giving an infusion because we get more money, rather than a subcut, which would mean that your patient gets out quicker.

”
ICBs continue trying to get in the way of new innovations, because they haven't got any money.

”
Prescribing budget is a cash cow.

”
It doesn't make sense to try and cut back on the ICB medicines budgets, as there are minimal areas of low hanging fruits left in these prescribing budgets... why instead are they not asking acute trusts why they are overspending?



Commissioning barriers

The nature of commissioning within the NHS creates significant challenges to efficient and effective healthcare delivery, which makes it difficult to create integrated care pathways, resulting in fragmented patient experiences.

Despite desire for collaboration, the competitive nature of commissioning within the NHS creates barriers to working together effectively and can delay adoption of innovative medicines and technologies.

Individual NHS bodies develop different pathways and services, which can result in significant duplication of work.



Impact on patient care

- Inequalities in access
- Delays to adoption of innovation
- Fragmented patient experience
- Reduced quality of care

”

It's not pharmacy first, it's pharmacy second.

”

Pathfinder is Pharmacy First on steroids.

”

We need chief executives who say “Go and innovate... I've got your back”.

”

Community pharmacy contract is not fit for purpose – it needs to be a population health contract.

”

Shared care is needed, but certain practices might not agree and that is where the patient can get left behind or stranded.

”

CAR-T therapy costs £250,000 per patient in Plymouth, which spends 12–13% on drugs. This cost has to be counterbalanced by reducing bed days, so there needs to be focus on a population health approach.



Digital barriers

Poor digital infrastructure due to excessive information governance requirements and bureaucracy on sharing patient data prevents timely exchange of information, which results in poor communication and delays in timely patient care. The main port of call for patients accessing digitally is the NHS app.

Inadequate digital infrastructure and varying data standards between different organisations within the NHS make integration difficult. The resultant **lack of integrated records** leads to **poor communication between primary and secondary care. HCPs** spend valuable **time navigating disconnected systems** rather than providing care. **Patients experience disjointed care** as their **information does not flow smoothly between fragmented services** and often **need to repeat their information** at different points in the system.

While business as usual in primary care, electronic prescribing systems (EPS) are not widely available in secondary care, creating **delays and inefficiencies.**

General practice lacks infrastructure to deliver **real-time performance data** for **quality improvement initiatives.**

Impact on patient care

- Delayed care
- Inefficient processes
- Inequitable access
- Fragmented care journeys
- Duplication of efforts
- Inefficient use of resources



The NHS has been really poor at digital enablement compared to industry innovations.



Nobody should be allowed to introduce a single thing digitally into the NHS unless it can interface with other systems.

Patient access barriers

Many different issues create barriers for patients to navigate the system effectively, including complexity of treatment pathways, onerous digital systems, administrative burdens and financial, accessibility and disability barriers.

Complex healthcare pathways and systems and excessive forms create unnecessary stress for patients and exclude or discourage some from accessing appropriate care in a timely manner. This disproportionately affects vulnerable patients, such as those with hearing difficulties, language barriers, learning difficulties and poor digital literacy/access, who find it difficult to access or navigate complicated systems.

HCPs do not always explain treatments in patients' preferred language styles, which can discourage engagement, leading to lack of patient involvement in their own care.

Patients on low incomes face financial burdens that may exclude them from some care pathways. Examples include subscriptions to authentication apps to log into healthcare apps, the cost of phone calls, internet access and travel to

appointments. Even patients who receive free prescriptions are required to purchase over-the-counter (OTC) medications, which can be a financial burden. Patients with disabilities may find it difficult to travel to appointments.

Patients with chronic pain have to buy painkillers such as paracetamol and ibuprofen every time they need pain relief due to limits on the number that can be bought at one time. Prescribers should be able to make a risk assessment and provide a certificate to confirm that specific patients should be able to purchase more.



Impact on patient care

- Delayed treatment
- Health inequalities
- Reduced medication adherence
- Inefficient resource use
- Patient frustration

”

Some patients can't sit on the phone, can't hear, can't press the button.

”

When patients struggle to access healthcare, medication compliance suffers.

”

Multi-factor authentication for patient apps costing £2.99 per month creates a health inequality barrier for lower-income patients.



Education and training gaps

Education and training gaps significantly impact the NHS's ability to provide optimal patient care and foster medicine optimisation and collaboration.

HCPs often **do not have training** for prescribing **newer or specialised medications**. Training on use of **digital systems and technologies** that could improve patient care **is also lacking**, with **varying levels of digital competence** across the workforce. HCPs, particularly **newer HCPs**, are often **not trained** in **appropriate risk management**, which can **result in overreliance on investigations** due to **lack of confidence**.

Reluctance to accept **education via industry** based on **scepticism** around **perceived bias** means that HCPs may **miss valuable education** and **upskilling opportunities**.

Such **knowledge gaps** may mean that **patients experience delayed access to optimal treatments** or **do not receive** the most **appropriate or newest treatments**.

Impact on patient care

- Suboptimal treatment decisions
- Inconsistent care quality
- Inefficient resource use, with unnecessary referrals and overuse of investigations
- Poor communication
- Reduced patient involvement
- Poor patient experience

”

[As a pharmacist], I see my patients more often than general practice...I know them inside out...however, I was not able to make any meaningful decisions for that patient's health.

”

When healthcare professionals cannot receive education from industry because of the perception that it's biased...how do you expect GPs, pharmacists or any prescribers to upskill in the latest medicines?

”

Additional Roles Reimbursement Scheme pharmacists have limited career development, as the ceiling is only Band 7.





Resistance to industry collaboration



Mistrust toward industry collaboration, stemming from past negative experiences, results in reluctance to form partnerships that could potentially improve patient care.

Cultural reluctance within the NHS **to collaborate with industry partners remains**, despite potential benefits. This **tension** in how the **NHS** and **industry partners work together** can come from the perception that **industry partners focus** too much on **brand promotion**. Consequently, the **NHS** has **overly complex administrative procedures** for **external collaboration**, which can make it **difficult to engage directly** with industry partners **to solve specific healthcare challenges**. This **reluctance to collaborate** with industry means the **NHS may miss opportunities for innovative solutions** that could **improve patient outcomes**.

Impact on patient care

- Reduced access
- Inefficient care pathways
- Exclusion of vulnerable groups
- Missed opportunities for innovation

”

We've still got this issue... it's all cultural. It stems from historical concerns and past incidents that have tarnished the whole system.

”

Why is it fine to spend with [management] consultancies, but not with pharma? There are scientists in pharma and ex-NHS people.

”

There was blue sky thinking with industry – approaches from industry to run a pilot then the ICB said they couldn't do that.

”

The ABPI code is often seen as a barrier, but it is more an 'excuse'... there is still a lot of suspicion around the Pharma industry.

”

How do we challenge the perception that chief pharmacists who need help and reach out to industry are a sign of failure?

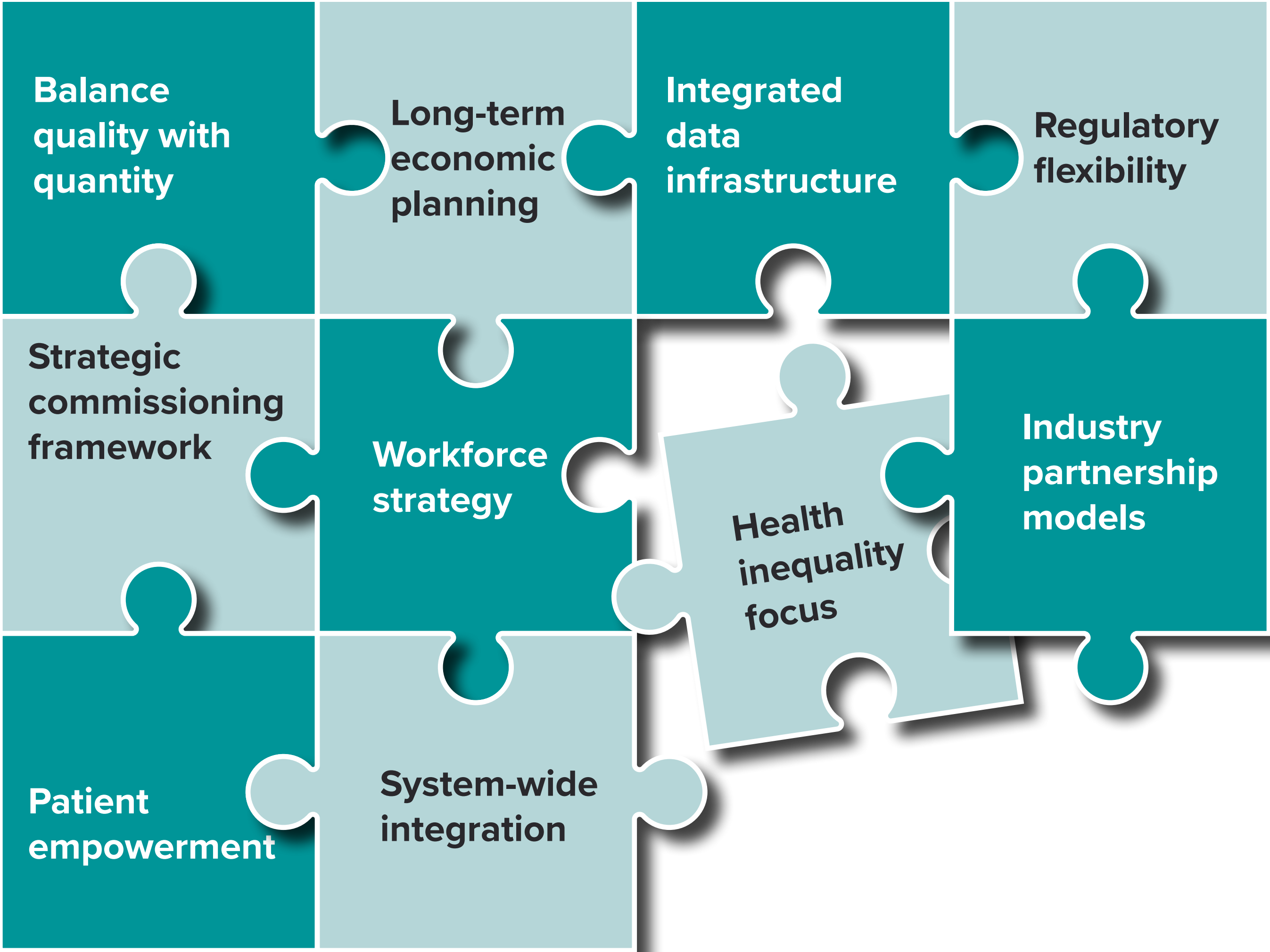
”

People want to be open to partnership – but the ABPI code is so strict.

”

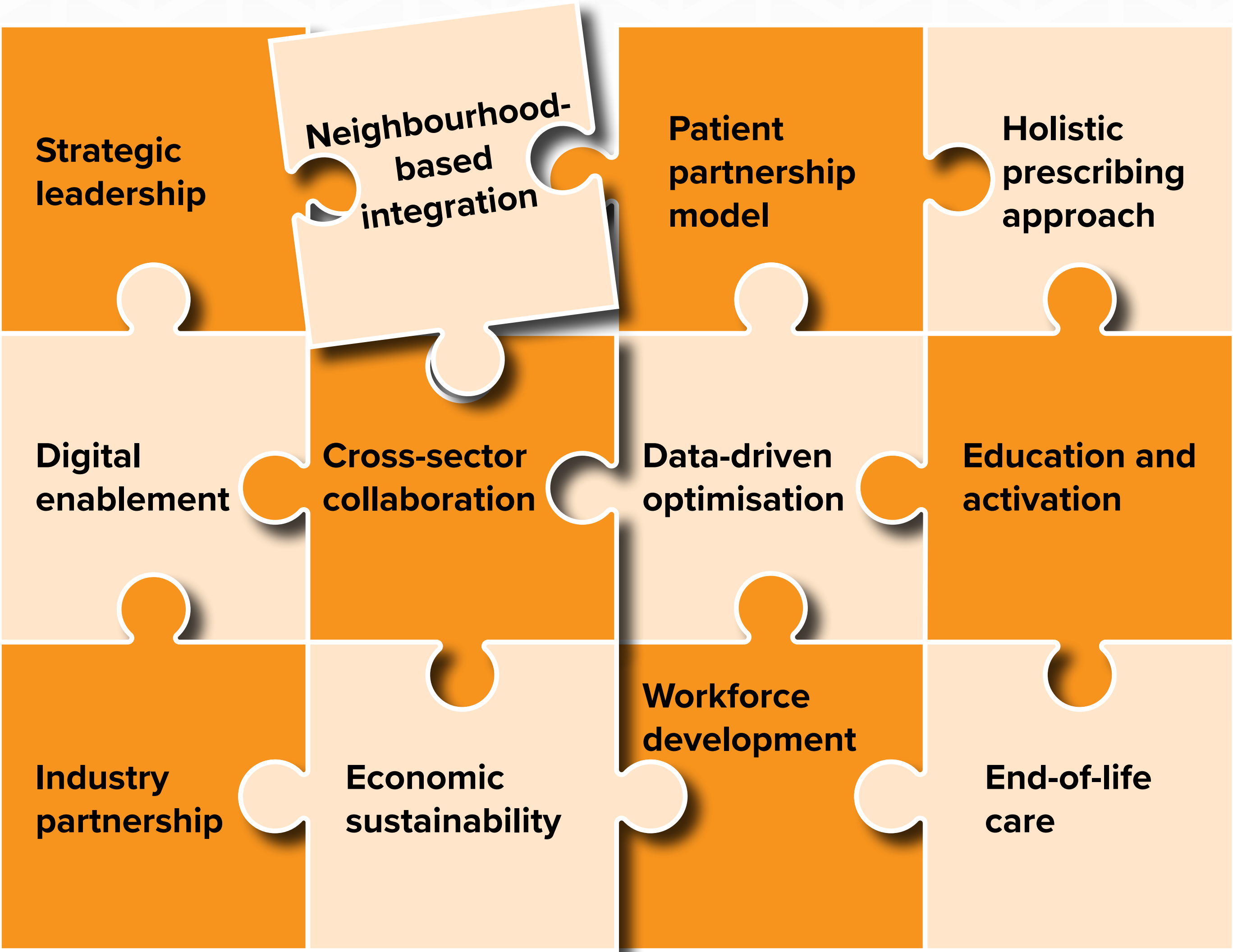
The NHS always says collaborate... but it is not in a place to do so...

NHS aspirations for improving patient equitable access



Click on each jigsaw piece for more information. 

Medicines optimisation team aspirations for ensuring equitable access



Click on each jigsaw piece for more information. 

How medicines optimisation could change to improve patient-centred care



Putting the patient at the centre of care delivery is essential. We expect patients to do all these things, jump through all these hoops. That's difficult for the patient...They're not a patient, they're a person.

Addressing barriers requires system-wide changes and a more patient-centric approach to healthcare delivery

Click each heading to find out more:



Patient-centric approaches



Collaborative care models



Technology and AI solutions



System improvements



Industry collaboration



Education and training



These solutions emphasise a shift toward patient-centred approaches, collaborative partnerships, and streamlined processes to overcome barriers currently impacting healthcare delivery.



Patient-centric approaches

Partnership approach

Take a **partnership approach**, involving **patients** in **decision-making** about their care, **explaining risks and benefits** of medications in the **patient's language and style**, and providing **information in accessible formats**.

Community engagement

Involve patients in **co-design of services**, such as **local authorities working with patients** with **learning disabilities and autism**.

Introduce **group consultations** in **specific communities** to address **cultural stigma** and **improve access to healthcare** – for example, in **Asian communities**.

Innovative service redesign

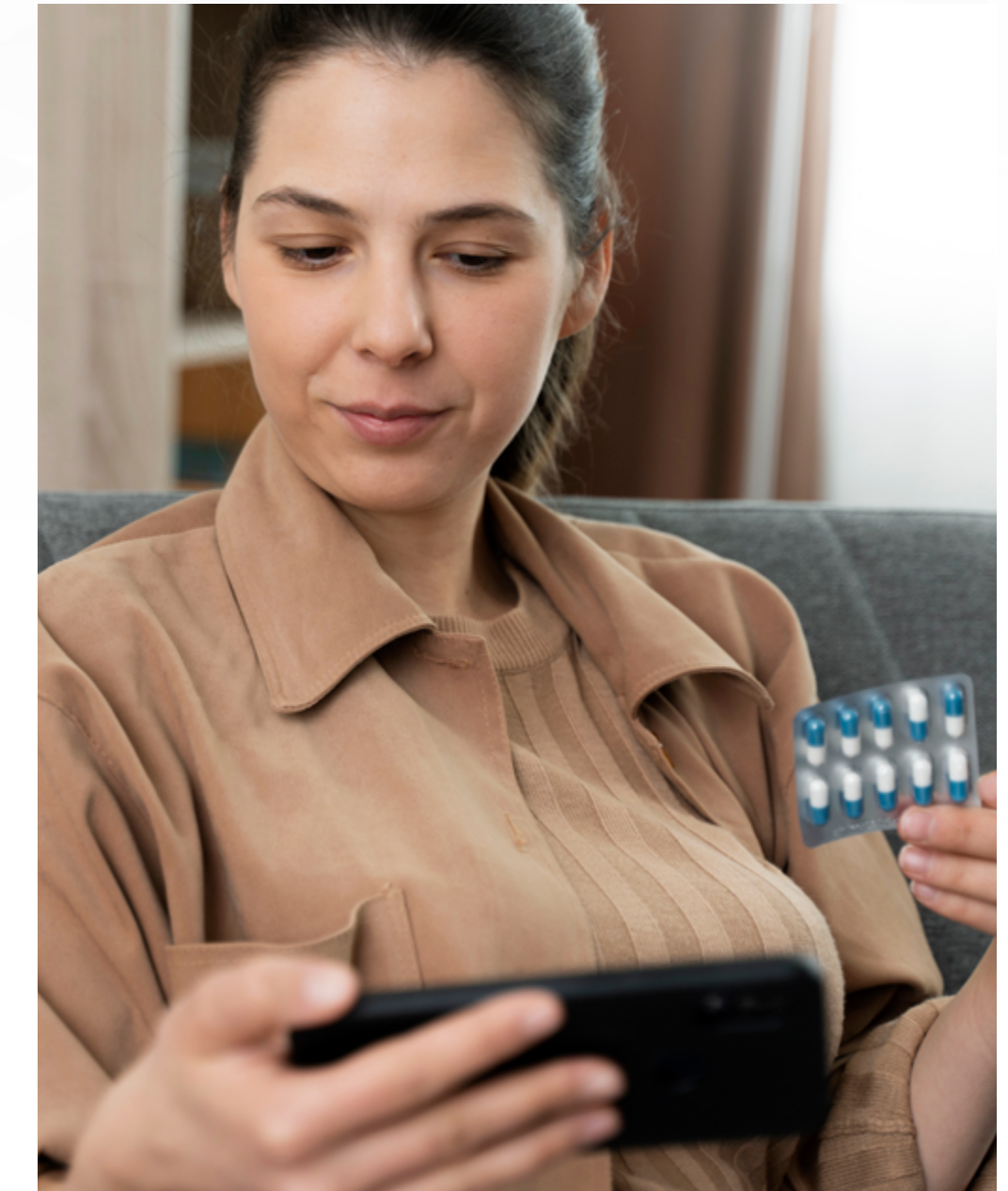
Redesign systems around **patient needs** and **eliminate unnecessary barriers** by **reducing the use of forms and other processes** that increase the **administrative burden** and **financial costs for patients**.

Stratify patients to ensure those at **highest risk** receive care first.

Host group consultations in **community settings** such as gyms to **demystify healthcare** and leverage **peer-to-peer education**.

Digital solutions

Develop digital tools and apps to provide **additional support** and **broaden the approach to patient care**. **Reduce digital barriers** by ensuring **digital solutions are accessible** to all patients **regardless of socioeconomic status**.



”

We need to take a partnership approach with patients, explaining the risks and benefits of medications in the patient's own language and style.

”

The system should be built around the patient, not healthcare professional agendas.

”

When one practice prioritised those at highest risk, uptake rates were three times higher than comparable practices because they ensured the person who needs it most got in first.

”

Educate, inform, activate.

”

Community pharmacists, being highly accessible HCPs, have the most communication with patients.



System improvements

Policy and governance

Transition from an **in-year approach** to **healthcare funding** with **longer-term planning horizons**.

Introduce **mandated interoperability**, requiring **all digital solutions** to **interface with other NHS systems** to **prevent fragmentation**.

Use **strategic commissioning** to define good **digital infrastructure requirements**. **Build trust** across organisations by **fostering relationships** that enable **more effective data sharing**. Create **uniform approaches** to **patient consent** for **data sharing** and **national data standards** while allowing **local implementation approaches**. **Reward organisations** that effectively **share data** to **improve patient care**.

Identify processes that can be **standardised across the NHS** rather than **duplicated at local levels**.

”

Let’s just stop and work out what can be just done once.

”

What’s the barrier? Where’s the block? How can each one of us work to get it correct and sorted out?

Strategic commissioning

Ensure **commissioning processes** centre on **patient needs** rather than organisational structures. Focus on **population health outcomes** rather than individual services and administrative metrics to **address fragmentation** and **unnecessary administrative barriers**.

Explore **reduction of variability** using **strategic commissioning** on an **integrated neighbourhood team** footprint.





Collaborative care models

Collaborative commissioning

Move from competitive to **collaborative commissioning** models, including primary and secondary care and HCPs within integrated teams, to **improve efficiency and patient outcomes**.

Consider **integrated neighbourhood teams** to create local healthcare teams that work together to develop **Tier 2 interventions** that **bridge the gap** between **primary and secondary care**, **community pharmacy and dentistry** to **reduce variability** in care.

Develop integrated care between **mental health and primary care teams** to **distribute risk**, share decision making with patients and **improve patient outcomes**.



Enhancing services

Enable **community pharmacy** to take a more prominent role as an **equal partner in primary care** to improve **access to medicines closer to homes**. Encourage **community pharmacies** to become **pathfinder pharmacies** that **provide enhanced services** traditionally offered by GPs, such as **cardiovascular disease management**, and **walk-in services**, where patients do not have to wait for GP appointments.

Broaden use of **independent prescribing** to funnel patients into **appropriate pathways** and **reduce GP-centric care**.



Technology and artificial intelligence (AI) solutions



Improved digital infrastructure and system integration

Develop **systems built around patient needs** rather than HCP agendas. Ensure **all digital systems** in the NHS **interface with each other** and **share data** to provide a **complete view** of a **patient's health journey** and improve **data-driven decision making**.

Patient-centricity

Develop **digital applications** and **patient-centric apps** that **streamline administrative processes** and **improve patient experience** and **access experience**. Use technology to **enable different patient groups** to **manage their own care** based on their **specific needs and preferences**. **Replace forms** with **more accessible communication** methods.

Use **digital redirects** and **social prescribers** to provide **additional support for patients**.

Use **AI** to help with **risk stratification** of patients.

Industry collaboration

Work with technology companies to implement **innovative solutions**.



I think there is a big problem of risk at the moment...and the solution to this may well be AI... AI might be able to give a proper risk stratification to perhaps a younger doctor to help them learn to live with what risk actually looks like.



Education and training

Peer-to-peer and shared learning

Use **group consultations** to help **HCPs learn from each other**. Develop **mentorship programmes** in which **experienced clinicians mentor newer staff** in specialised areas.

Cross-sector training with **joint sessions** between **primary and secondary care** can **improve understanding of patient pathways**. **Shared learning** – for example, involving HCPs such as **dietitians, physiotherapists, health coaches, social prescribers and care coordinators** – can promote **comprehensive care**.

Digital solutions

AI-assisted learning can educate **younger doctors** on **managing risk**. **Virtual training platforms** can provide **accessible digital training** resources that fit around **clinical schedules**.

Patient-centred education

Train HCPs to better **educate and involve patients** in their care, including **enhanced training in communication skills** to help HCPs **explain treatments in patients' preferred languages and styles**. **Train clinicians** on the importance of a **long-term care perspective** and **encourage** HCPs to maintain **regular contact** with patients to **reassess conditions** and **reinforce treatment benefits**.

Specialised training programmes

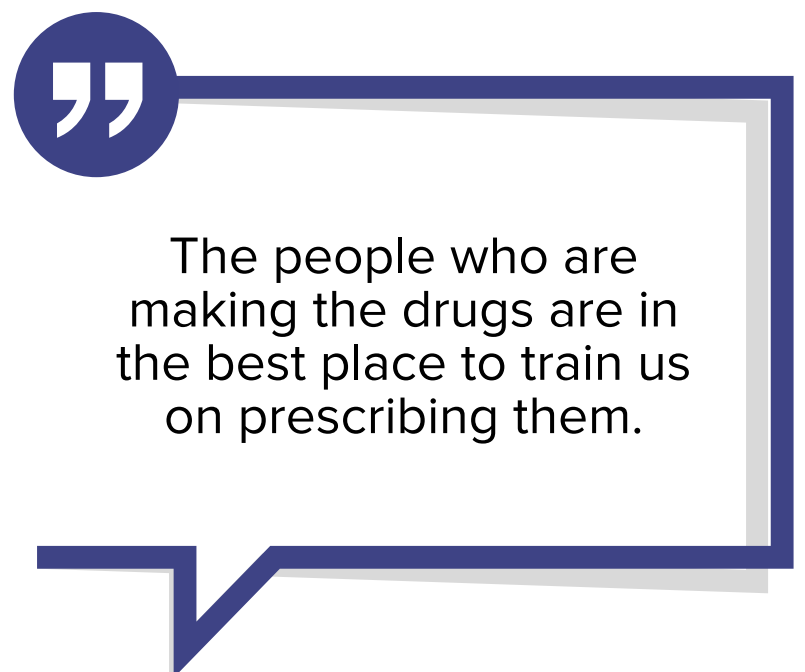
Expand **training for non-medical prescribers** to **reduce GP workload**. Introduce **risk assessment training** with **dedicated programmes** to **improve confidence in clinical decision-making** and **reduce over-investigation**.

Alternative education delivery

Develop **cost-effective, specialised training materials** as **alternatives to expensive courses**. **Deliver training in community settings** to **improve accessibility**.

Collaborative education models

Develop **relationships with industry** for **educational purposes** to **leverage pharmaceutical expertise** while **maintaining appropriate governance and transparency**.



The people who are making the drugs are in the best place to train us on prescribing them.



Industry collaboration

Collaborate with industry partners at **trust and ICB level** to provide **innovative solutions** that the NHS may not have internally.

Work with technology providers to develop more **integrated digital solutions** that **support patient care**.

Leverage industry expertise for **complex data analysis** when **internal capabilities are insufficient**.

Introduce **smoother financial arrangements** with industry partners to help with **initial implementation costs of long-term solutions**.

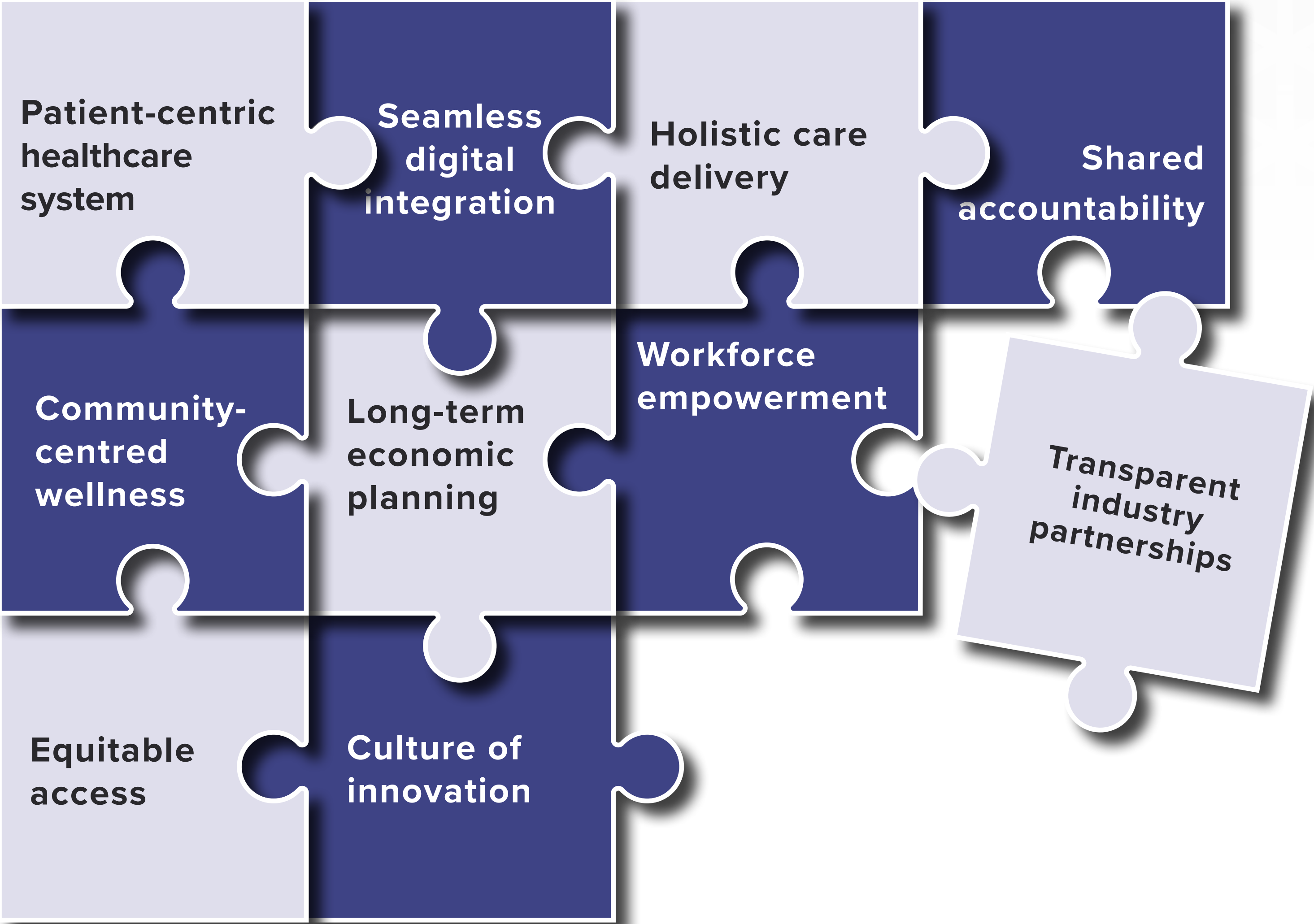


“The NHS needs to develop a more mature relationship with industry based on governance and transparency. This will involve a fundamental cultural shift toward pragmatic problem-solving asking “how do we?” rather than “should we?”

“I just put a notice out to industry...I’ve got a problem with diabetes, cardiovascular disease... and I opened the door to anybody who’s got an idea.

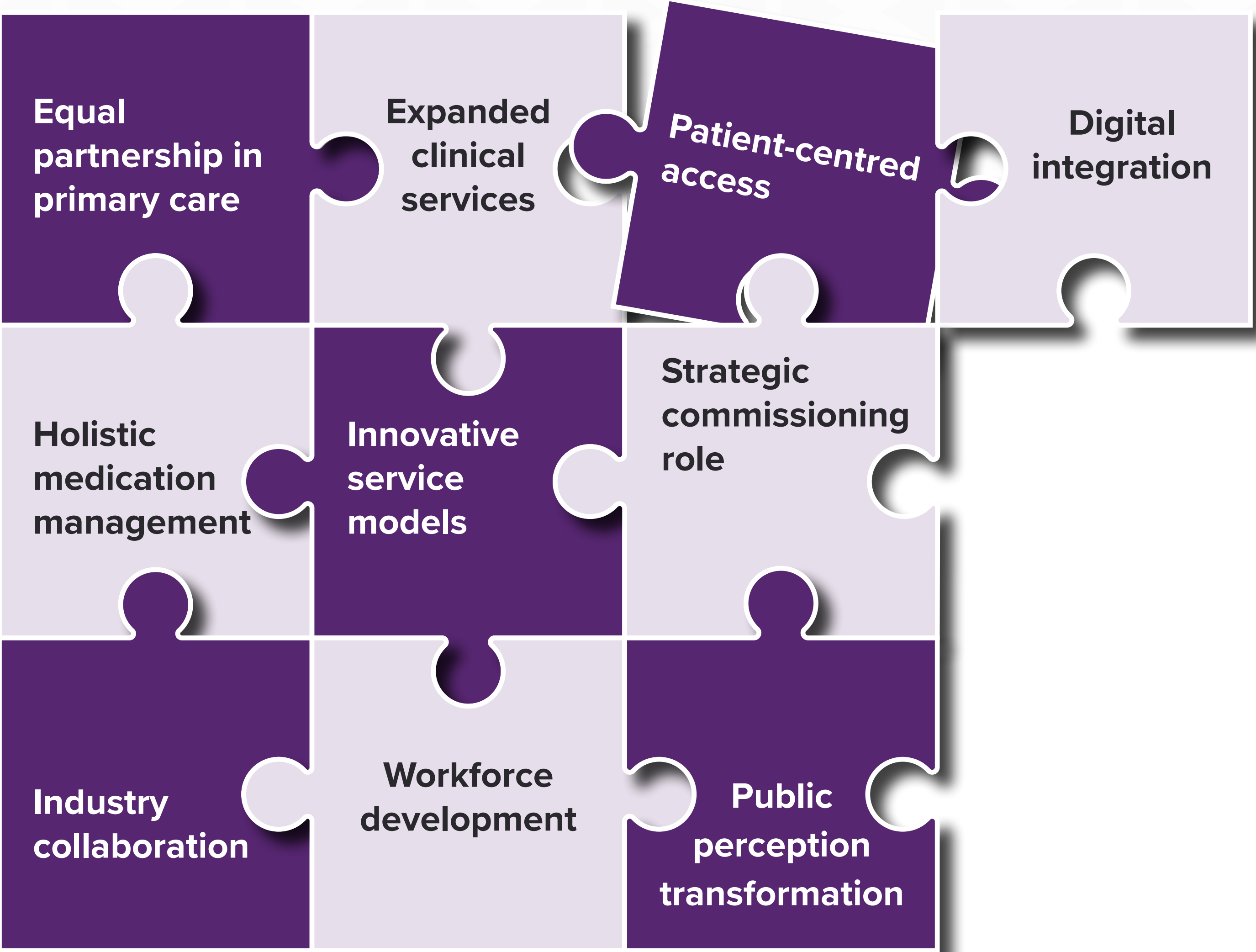
“Industry partners with us to actually help get something around. They provide a solution that we didn’t know existed in the NHS... We’ll try that. If it fails, we’ll try something else.

NHS aspirations for how industry can support



Click on each jigsaw piece for more information. 

System aspirations for delivery of patient-centric medicines optimisation



Click on each jigsaw piece for more information. 

Call to action



NHS call to action

PATIENT ACCESS

Ensure prescribing autonomy of pharmacist for OTC items, on prescription where needed.

INTEGRATED CARE PATHWAYS

Develop holistic, integrated care pathways that address multiple conditions simultaneously rather than treating each condition in isolation. Expand use of group consultations and community-based interventions as cost-effective alternatives to traditional care delivery models.

INNOVATIVE SOLUTIONS

Implement pilot programmes for innovative solutions that prioritise patient needs over short-term performance metrics. Create collaborative forums for HCPs to identify and scale successful local innovations across the broader NHS system.

DATA SHARING

Enhance data-sharing capabilities and analysis tools across the healthcare system to improve decision-making and resource allocation. Conduct a comprehensive review of current performance metrics to ensure alignment with high-quality, patient-centred care objectives.

INCENTIVE STRUCTURES

Reform contracting and incentive structures to align healthcare providers around shared patient outcomes instead of siloed targets.

DIGITAL INFRASTRUCTURE

Prioritise digital infrastructure improvements and interoperability standards across the NHS to create a seamless patient experience.

EDUCATION AND TRAINING

Establish mandatory cross-training or job shadowing programmes to promote better integration and understanding between different healthcare providers.

Industry call to action

DIGITAL SOLUTIONS

Ensure any digital solutions are interoperable and seamlessly integrate with existing NHS infrastructure to enhance connectivity between healthcare providers and improve patient experience.

OUTCOME-BASED CONTRACTS

Partner with NHS on outcome-based contracting models that align industry incentives with patient-centred healthcare goals rather than volume-based metrics.

INNOVATIVE DELIVERY

Invest in pilot programmes that demonstrate innovative healthcare delivery solutions with clear pathways to scale successful initiatives across the NHS.

Establish industry-NHS innovation forums to identify local healthcare successes and create pathways to scale these solutions nationally.

INNOVATIVE DISTRIBUTION

Support for bringing global experience of innovative pharmaceutical distribution models that support expanded pharmacist roles in providing over-the-counter medications directly to patients.

INTEGRATED CARE TOOLS

Support for bringing global experience of integrated care technologies that facilitate holistic treatment approaches for patients with multiple conditions.

Exploring and sharing examples in development of group consultation technologies and community-based intervention tools that can deliver cost-effective care outside traditional settings.

EDUCATION AND TRAINING

Collaborate with other partners offering cross-training opportunities and educational resources to help different healthcare professionals better understand each other's roles and capabilities.

DATA ANALYTICS PLATFORMS

Support in building advanced data analytics platforms that enable secure sharing and meaningful analysis of healthcare information across different NHS organisations.

Collaborate on developing performance metrics and evaluation frameworks that accurately measure patient-centred outcomes and quality of care.

Abbreviations

ABPI	Association of the British Pharmaceutical Industry
AI	artificial intelligence
AMR	antimicrobial resistance
CAR T	chimeric antigen receptor T-cell
EPS	electronic prescribing system
GP	general practitioner
HCP	healthcare professional
ICB	Integrated Care Board
IT	information technology
OTC	over the counter
PSA	prostate-specific antigen
RMOC	regional medicines optimisation committee
VPAG	Voluntary Scheme for Branded Medicines Pricing, Access and Growth

References

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2. NHS England. *Medicines optimisation*. Available at: <https://www.england.nhs.uk/medicines-2/medicines-optimisation/> (accessed September 2025).
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Medicines optimisation is a tool -
however sometimes we need to
remind ourselves of its purpose.
If it doesn't service our patients
well - does it need refining?

