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By Johnny Skillicorn-Aston - June 24, 2021

How can pharma engage with a changing NHS?

The recent NHS White Paper presents a blueprint for health and social care reform; a proposal for further integration of services built on the foundation of the Long Term Plan. It aims to reduce the burden of bureaucracy and thus ease the yoke of health inequalities; empower local leaders to act and build back better using the learning from the COVID-19 pandemic. These changes were already in train with health systems across the country building integrated care systems (ICS). In this exclusive article for Pharmafield, leading market access, clinical service and strategic consultancy, Conclusio has convened a panel of health care senior leaders to provide their view on the realities associated with a changing NHS and the opportunities for pharma to engage as a partner.

John Niland, recent NHS Provider chief executive and health consultant:

> "There is no doubt that the pandemic has raised the profile and stature of the Pharma industry. However, there are still many sceptics and regulations that limit the amount of engagement Community Providers and Primary Care Networks (PCNs) can have with Pharmaceutical companies. Historical attitudes persist, with some still questioning the pharma industry motives.
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> "A key issue of the pandemic is that the most vulnerable, the least wealthy, members of some communities and those with underlying health conditions have suffered disproportionately greater consequences when they have contracted the virus. The learning is clear; if you are fitter, healthier, enjoy better wellbeing and have opportunities to engage with your own overall wellness, you are more likely to have better overall outcomes."

Typically, the NHS has operated on inputs and outputs, input of sick people and output of treated people. It is an equation that provides solutions but often ones that miss the opportunity of adding value through myriad improvements in terms of longer, value-based outcomes. As the NHS pivots to address further change, it must focus on keeping people well for longer not just treating them more quickly when they become sick.

ICS' and PCNs will need to prioritise the overall health of their population through Population Health Management. That means having the right information about the health needs of their population and what are the underlying causes of ill health and drivers of health inequalities. It also means working with others to determine and demonstrate joint interest in, and endeavour toward, improving outcomes for the entire population.

Working together fully, integrating systems of care and those organisations and individuals who deliver that care, means engaging with all those committed to a common enterprise. The Pharma Industry has demonstrated its commitment to wellness during the pandemic, nowhere more clearly illustrated than through the development of vaccines. The industry can build on this by strengthening its commitment to the wellbeing of the population rather than a supplier interest in its ill health.

Further rate increase in the NHS step change requires support. The White Paper proposes reducing the 'red tape' that constrains transformation, reduces the opportunity for meaningful change and presents barriers to wide-reaching integration. The financial and contracting regimes in the NHS will see further change to facilitate further integration.

Andrew Geldard, NHS CEO and Finance Director:

> "The COVID-19 pandemic has hastened the end of the NHS internal market with NHS providers receiving direct payments and the payment by results (PBR) tariff effectively suspended. We now see
> stronger indications that the NHS will not return to the traditional purchaser/provider split, with funds moving around the system much more on an allocative basis.
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> "Requirements to 'competitively tender' will end, save in particular circumstances. ICS' will receive funds on a capitated basis and will allocate these to its local providers. The PBR tariff is likely to remain for only cross boundary flows and more specialised services. In addition, the commissioning role of CCGs is transferring into a merged ICS statutory entity.
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> "The emphasis of the commissioner (purchaser) provider (supplier) relationship will move radically away from 'trading' to a much more cooperative and system-based approach with the performance of all organisations tied together.
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> "Moving ICS partnerships onto a more statutory footing including top tier local authorities will also promote this system approach across health and social care building on the constructive work in addressing the pandemic. ICS Governance will ensure a pan-system performance metric, which in turn will demand that ICS stakeholders have a seat at the leadership table to underpin collective responsibility."

As ICS' draw up their governance, financial and contracting, performance measurement arrangements, their strategic partnerships and approaches, and their 'rules of engagement', the lure of sunnier uplands should not obscure the NHS eye from its endemic and persistent challenges.

Mike Proctor, recent NHS Trust chief executive, current NHS Trust non-executive director and chair of Conclusio:

> "For those of us who have worked within the NHS for decades, a changing environment is nothing new. The current proposals might be viewed by some as a 'political land-grab'; however, more than ever, we need strategies that direct us out of the challenges that dog the NHS. The COVID-19 pandemic is such an example and in a single year has undone the work of a decade to reduce waiting times for patients. For example, at the start of the pandemic about 1,000 patients were waiting more than a year for treatment. This has risen beyond 200,000 and is still going up.
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> "A less publicised problem is patients waiting for follow up appointments. Every organisation I know has tens of thousands of patients whose planned appointments are overdue but who have no date to be seen and little prospect of getting one. The potential patient harms as a result are largely unknown. Repeating the actions of the past, or seeking marginal gains, will not resolve this scale of challenge. It requires a paradigm-shift in thinking and actions.
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> "Reducing activity in hospitals and providing care for patients in community and home settings, promoting self-care and independence, will free secondary care to do what it does best, treating emergency, acute and complex needs. This will give Trusts the headroom to respond to the new care and financial regimes, while not continuing to jeopardise outcomes for patients.

> "Out of hospital care (including a hopefully reformed social care sector) will need to be stepped up to keep patients safe at home. Community pharmacy and the pharmaceutical Industry have a huge opportunity and a massive role to play in creating this shift in the point of care. Both the community pharmacy sector and the pharma industry have emerged from the pandemic with an enhanced reputation. Eyes have been opened to what they can offer as partners in the new systems. The moment has to be ceased, this is no time to sit back and wait to be invited to help. Be creative, proactive and positive about how you can contribute to the solutions the new NHS leaders will be seeking."

Home care models have increased their currency in the health care transaction and exchange system. Pre-dating both the White Paper and the pandemic, there are examples of new models of care that combine approaches between commissioners, secondary care, pharma and community pharmacy that demonstrate system leadership and patient centricity. In 2018 the Royal Marsden Hospital made it possible for cancer patients to receive some types of chemotherapy and supportive treatments at home. In the treatment of relapsing remitting multiple sclerosis, new home care therapies allow patients the same opportunity to avoid clinic time and rehabilitate aspects of life-opportunities previously lost to them as a result of their disease.

The benefits go beyond therapeutic efficacy; patient travel costs, disruption to daily routines, wait times associated with clinic appointments and attendance, freeing up clinical capacity for patients not suited to home care will all be factors to have benefited.

Community pharmacy can be a key player in this kind of care schematic. Supported home care models as part of an outreach approach in secondary care can be enhanced through the involvement of community pharmacy in supporting patient with their 'at home' therapy. In part, a shift into primary care.

The establishment of PCNs has increased the opportunity for community pharmacy. General Practice must now collaborate with a wider group of stakeholders at the 'place-based' level of health care. PCNs will be at the head of a reinvigorated primary care multidisciplinary team (MDT). As part of this, community pharmacies can collaborate to develop a provider-intentions and operate at place-based level on an equal footing with more established NHS providers. Conclusio has been supporting Local Pharmaceutical Committees to identify opportunities to work in this space and articulate their offer as a partner-provider. Place based budgets within the resource envelope of an ICS will evolve and all players within the place-based system will be encouraged to take an active part in service and resource planning.

ICS and place-based systems will be open to value added solutions and propositions coming from private and community enterprise. Conclusio has long-held the view that partnership is the emerging motif for the relationships the NHS has with what it once called suppliers.

The changes we are experiencing now in the NHS were seeded decades ago. The 1980s saw the first steps on the long road to ICS through shared planning; the 1990s brought shared protocols and the advent of the new century gave rise to whole system working. The most significant change and challenge now is how the NHS does business. It is the single factor that will draw together all the seismic and unprecedented changes into a framework of meaningful improvement for patients, health care partners, health care systems and health care practitioners.

James Roach Managing Director of Conclusio and experienced NHS Director, and recent leader of an Integrated Care Partnership:

> "It is a real leadership challenge, as many of the leaders in the various silos of the health and care sectors don't really know each other and the starting point can often be 'a lack of trust'.
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> "This generation of leaders, and the next' must look beyond the walls of any single institution and discover how to reshape whole health and care systems. We have a massive structural and revolutionary change piled on top of the post-COVID-19 wasteland of exhausted staff, massive increases in waiting times, increased non-COVID-19 excess deaths, increasing inequalities of health, estate shortcomings exposed, and some form of public sector financial reckoning on the horizon.
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> "Now is the time for a transformation programme unlike any ever seen before and pharma can play a key part in the restarting the NHS and changing the clinical landscape over the next 10 years.
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> "We have to learn new ways of working and develop new knowledge as the old ways and our past knowledge won't necessarily help us. The NHS White Paper provides a clear strategic route-map for the next 5 years and the ABPI Code for 2021 provides a unique platform to engage and become a partner with purpose. Now is the time to capitalise and add value."

Budgets for prescribed medicines will be held at PCN level with medicines management resource (staff) being devolved to/allocated to/developed in these groupings:

- Local CCG staff /PCN leadership will focus on care pathways and will explore best value approaches on a system-wide basis
- ICS and local systems will be open to value added solutions/propositions coming from private enterprise within this environment.
- Risk and reward share agreements may become a part of the future NHS where Pharma and other suppliers of innovative solutions have an opportunity to *trade* with the NHS

True partnership is a necessary yet illusive commodity. Trust, commonality, shared objectives, risks and rewards are important characteristics of partnership working. While the NHS might be more willing to say the 'C word' out load – *commercialisation* – and develop shared endeavours with the private sector, its history with pharma is a chequered one. Just as we are seeing much that is new in the design of healthcare, we need to refresh the principles for how pharma should partner and engage with the NHS. I suggest a five-point approach

1. Engage with confidence and insight, not speculatively
2. Go above brand and product
3. Live and breathe that partnership opportunity – as part of a cultural shift in an organisation
4. Be accountable – for your own part and that of all other stakeholders
5. Be aware – wide-angle focus on opportunities, outcomes and legacy