Engaging with Impact and Innovation

Industries response to the NHS Long Term Plan

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Inspiring Innovation

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Section 1 – Reality Check

How do front line staff currently see things?

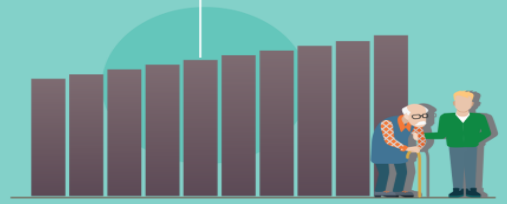
NHS staff tend to see a system that has been under acute pressure for some time

There is concern that the challenges facing the NHS will mean that the pressures will continue to mount…

Typical System Challenges

Health and care services use different information systems, don't always work together and are often unable to access each other's records. Patients are asked to repeat the same information and tests and procedures can be carried out unnecessarily, taking up patients' time and wasting money.

Too many Hertfordshire and west Essex patients are admitted to, or remain in, hospital who could have been looked after better in other ways.



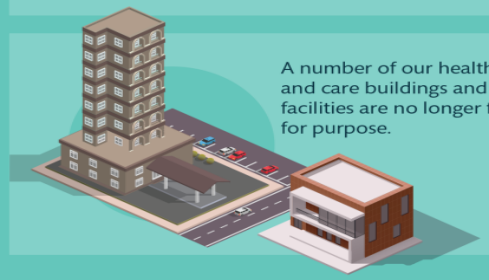
We expect the number of over-75s to increase by 37% in the next 10 years. More older people and people with long-term conditions means higher care costs.

↑ **37%**

The health of our population is generally better than the national average, but there are some more deprived areas where health is poor. Obesity, smoking, alcohol consumption and not enough exercise are all causing health problems.

Some of our residents are dying from illnesses like circulatory diseases, cancer and respiratory diseases at a younger age than we would expect.

Hospitals in our STP area often struggle to meet the requirements to treat, admit or transfer 95% of patients attending A&E within four hours of arrival.



A number of our health and care buildings and facilities are no longer fit for purpose.

70% ↑

High living costs mean that attracting and retaining health and care workers with the right skills can be difficult. The average monthly rent in St Albans is £1,150, compared with nearby Bedford which is £675*. That's 70% higher.

* (source Esri UK)

34% of GPs are thinking of retiring in the next five years (according to a national British Medical Association survey).

-£550m

We currently spend about £3.1 billion per year on health and social care in Hertfordshire and west Essex. Our funding gap is forecast to reach more than £550m million per year by 2020/21 if we don't improve the health of our population and deliver services differently.

Section 2 – Key structural changes

Strategic Direction

National direction – the NHS Long Term Plan

- As outlined in the NHS Long Term Plan, the whole of England will be covered by 40 Integrated Care Systems (ICS) over the next 2 years.
- ICS are seen as central to the delivery of the Long Term Plan.
- The number of CCGs will reduce and there will be a single CCG/Executive Commissioning Leadership for each ICS area.
- ICS are likely to cover populations of 1 million plus and will lead the commissioning and delivery of healthcare systems. Specialised commissioning responsibility and budgets will devolve to Integrated Care Systems.
- Integrated Care Systems will be wholly reflective of the whole health and care pathway.

Each ICS will have:

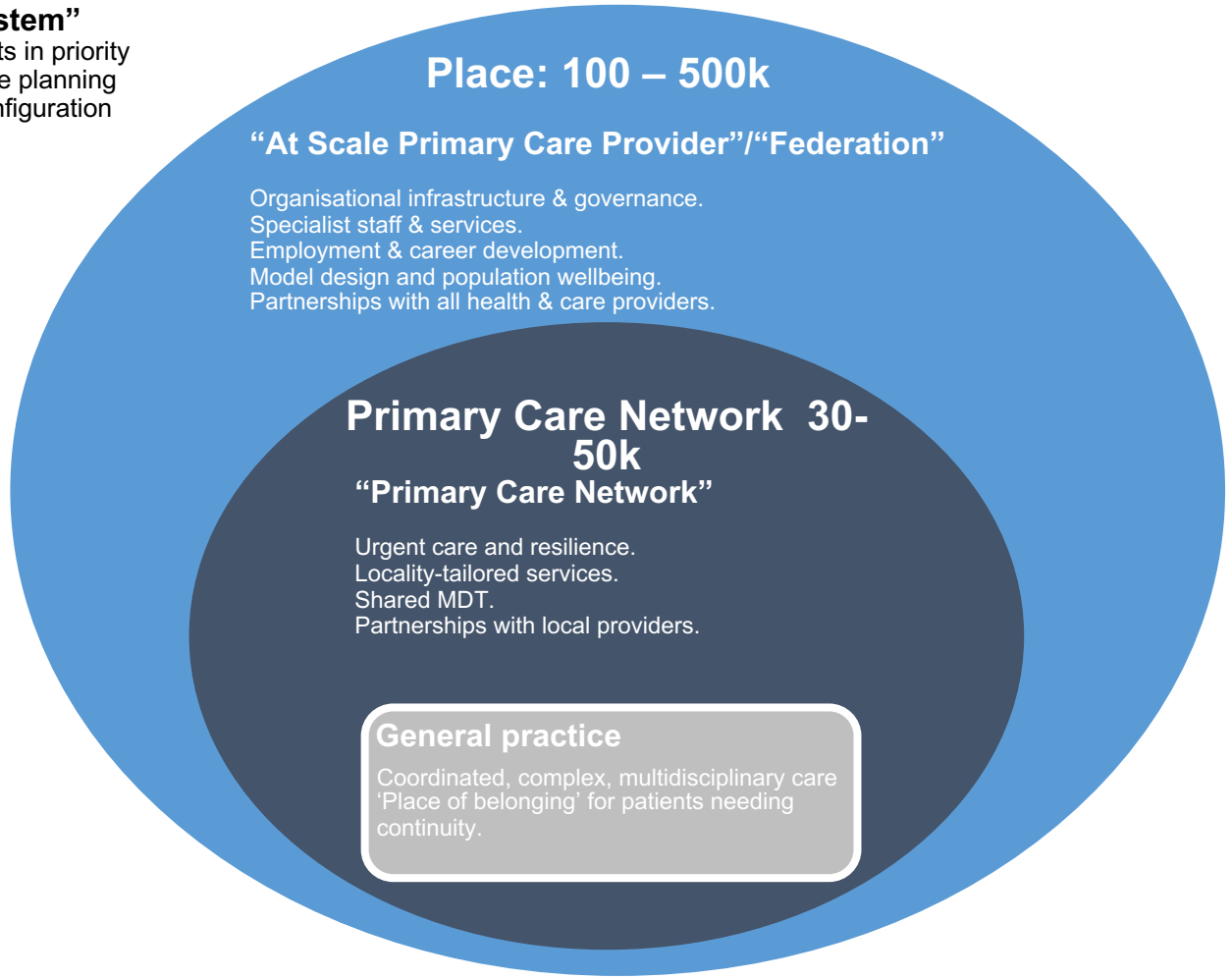
- A partnership board which includes Commissioners, Provider Trusts and Primary Care along with representations from social care/Local Authorities.
- A non executive Chair and one single executive team with authority to act across the geography.
- Assigned clinical leadership including responsibility for specialist services.
- Greater emphasis on system wide quality.
- Number of Primary Care Networks (PCNs) with responsibility for development of integrated primary care and community health services and focus on therapy optimisation.
- The opportunity to develop longer term contracts to enforce this collaboration.

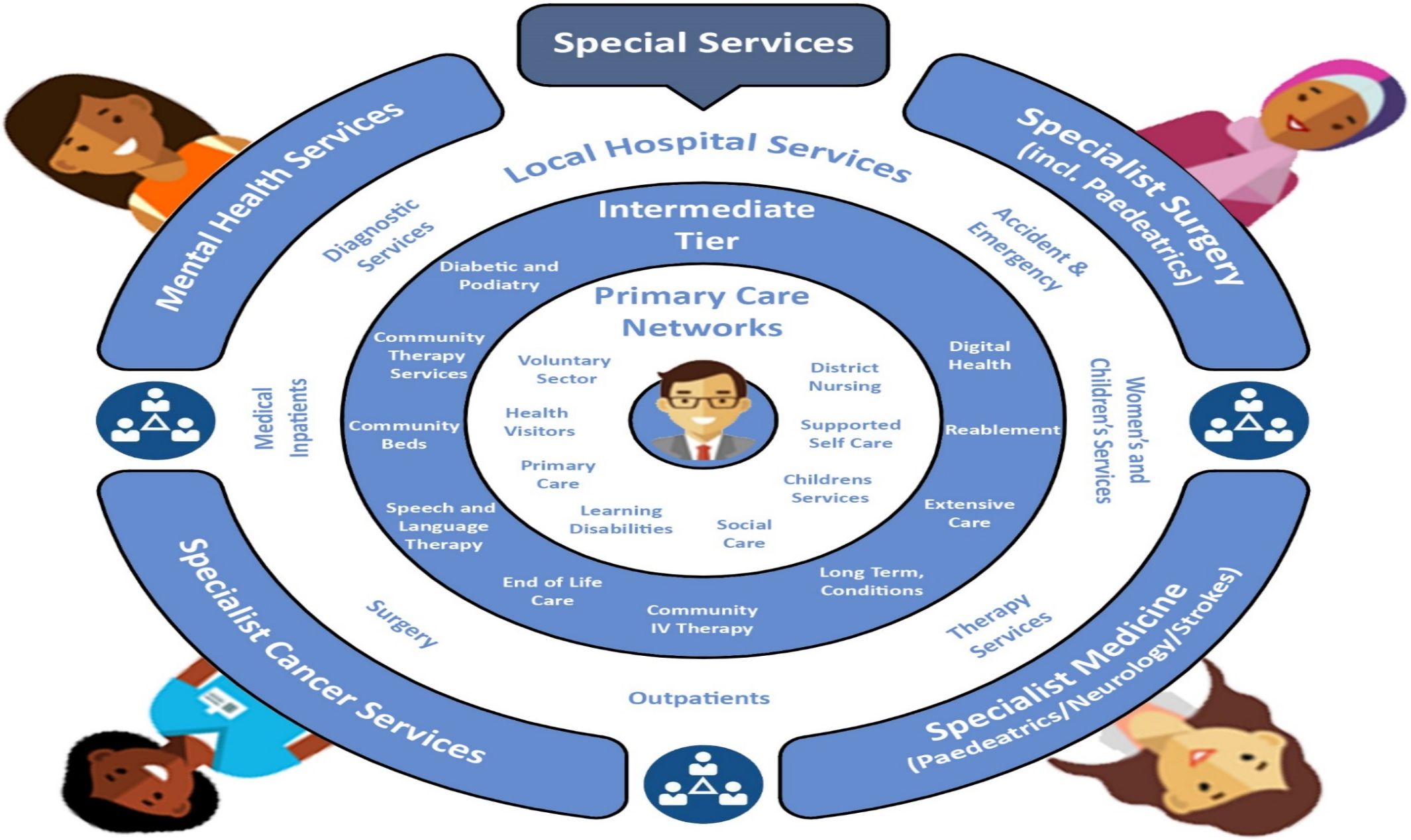
The NHS Long Term Plan- Emerging Structure

System: 1m+

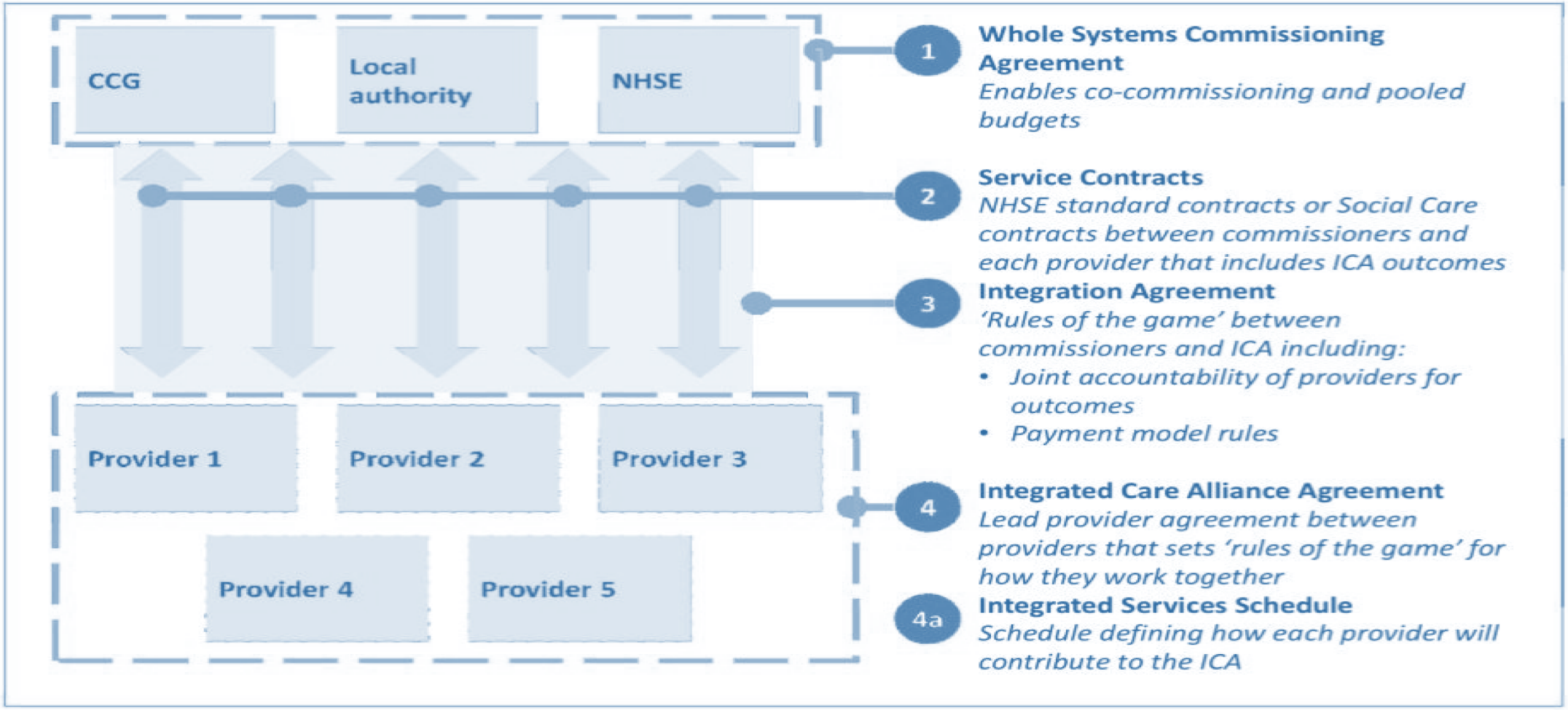
“Integrated care system”

Major partnerships & shifts in priority
Workforce & infrastructure planning
Large scale service reconfiguration




Special Services
Mental Health Services
Specialist Surgery (incl. Paedeatrics)
Specialist Cancer Services
Specialist Medicine (Paedeatrics/Neurology/Strokes)
Local Hospital Services
Intermediate Tier
Primary Care Networks
Diagnostic Services
Accident & Emergency
Diabetic and Podiatry
Community Therapy Services
Digital Health
Medical Inpatients
Community Beds
Voluntary Sector
District Nursing
Health Visitors
Supported Self Care
Reablement
Primary Care
Childrens Services
Women's and Children's Services
Speech and Language Therapy
Learning Disabilities
Social Care
Extensive Care
End of Life Care
Long Term, Conditions
Community IV Therapy
Surgery
Therapy Services
Outpatients

What are the contractual rules of the game- new business opportunities !



Typical objectives of an Integrated Care System and what they mean in reality…

Right care, right place, right time

Enable more patients to get the right care and support, in the right place, at the right time – focusing this year on improvements in operational processes and use of data

Better integration of care

Expand and connect developments that enable better integration of care – focusing this year on establishing strong partnerships and involvement, new care models and systems to support collaboration

Reduce unwarranted variation

Reduce unwarranted variations in care pathways – focusing this year on projects supported by the Flow Coaching Academy Imperial and guided by external benchmarking quality and efficiencies

Improving financial health

Develop strategic solutions to key challenges – focusing this year on staff recruitment and retention, reducing underlying financial deficit and estates redevelopment

Research and innovation

Strengthen connections between service development and research – focusing this year on data and digital initiatives and expanding staff involvement

Organisational culture

Achieve a measurable improvement in organisational culture – focusing this year on improvements in leadership, fairness, and collaboration

Local leadership of specialised commissioning

Future of specialised commissioning in NHS England

- The introduction of ICS's is redefining the provision of specialised commissioning, a number of models around future service provision are currently being tested with funding devolved.
- Elements of NHS England's Specialised commissioning portfolio have began to be divested to CCG/ICS areas.
- A new specialised services strategic framework has been announced.
- The Clinical Priorities Advisory Groups has developed a number of clinical workstreams to support this work.
- Specialised Commissioning at NHS England level currently accounts for 15% of the NHS budget at circa £17 billion per annum. It is this scale and the need to deliver services in a more sustainable cost effective way that makes the work of the Accelerated Access Collaborative (AAC) so critical.
- Localisation of the budget impact test.
- Spending on specialised services is due to rise by around 5.6% per year.
- As Simons Stevens said *"Preparations are under way to make sure the NHS can adopt the next generation of treatments"*. Across Specialised Commissioning there now appears to be a real appetite for medicines innovation and optimisation that will contribute to the transformation and savings that the NHS wants to achieve as part of the Long Term Plan.

Key questions to consider

The challenges and opportunities associated with the NHS 10-year plan?

How does the focus on ICS, ICP and PCN change the way you engage and interact with the market?

To what extent will the payer landscape change?

How best to engage, educate and empower the payer?

How does shift to population health models change the way the product is positioned?

AHSNS and their relevance?

How best to engage with influence? The influence matrix

What is the best joint working approach for the industry?

How do you think current market engagement is perceived and how would you improve?

Is the transition from supplier to partner possible?

How will ICS and ICPs evaluate investment decisions?

What is the key to deciding on value for the NHS?

How can NHS and Industry finance work together to support the move to new care models (less transactions and more complete models of care)?

What could be the role of industry finance teams in changing the relationship between NHS and pharma companies?

Section 3 – Historic challenges, but future opportunities

Typical challenges

Inability accessing senior level customers or having valuable conversations beyond the clinical messaging of our products

Misconceptions around process, governance and the “conversations” we are permitted to have

Do NHS customers really understand the brand or know all they should about the product?

The market access model has not moved with the times

“One size fits all“ marketing approach doesn’t always align to what the customer needs or wants and isn’t necessarily embedded within the operational and financial realities of the NHS

The partnership and joint working approach message has become cluttered and confused

Key Principles to Underpin Market Access

Time needs to be taken to truly understand the key players within the locality and their proximity with different manufacturers

Must drive the agenda constantly to ensure good intentions are translated into key actions, timing and expectations met

Top down approach at Regional Strategic Level more impactful than picking off CCGs one at a time as a higher level of influence is needed to bring about wholesale change

CCGs and System Leaders need to be convinced about the wider opportunities associated with the products and the clinical outcomes it delivers

Clinical support is necessary to ensure uptake of initiatives and communication of product positioning

Demonstrate a commitment for the long term

We are working from a challenging “historic“ baseline and are in the process of developing a framework for growth and enhanced partnership working with the wider health system for the next 5 years

A more comprehensive offer is required

Given the challenges in the landscape and the changing tone at NHS England and the DHSC, the industry has a new opportunity to position itself as the catalyst for change

Industry can add value to challenging systems in many different ways:

Specialist expertise in the disease, the patient and the potential of the project

Training, education and communications

Maximising the outcomes from new therapies and technologies

Articulating true cost and impact through Real World Evidence

Pump priming innovation and new service development

Applying industry rigour and commercial acumen to inefficient high cost service models

Section 4 – Developing a framework for market access in a changing NHS

Adding Value

Key approaches across health systems	A suggested approach
Lead with evidence of impact and harness the power of data and analytics	• Opportunity analysis cut at regional, CCG, Neighbourhood and practice • Such a market access approach will ensure you stand out from the traditional approach as it will embedded with the realities of what the local NHS need and understand • Alignment of real world evidence
Make it relevant	• Demonstrate how the underlying quality gap will be bridged • Targeting patient segments where you can secure a strong position for growth • Simplify messaging • Build on the fertile ground of research and development and clinical credibility
Reinforcing the Health Care Professional and Patient Dialogue	• Through understanding of the opportunities at practice level and enabling prevention and management of disease • Developing a local group of clinical ambassadors
Moving from a single value proposition to a more comprehensive approach for different payers and different clinical models	• Through an understanding of “what works“ • Apply an established joint working and clinical development model
Engaging with impact	• Multi-channel engagement with appropriate differention by customer value • Focused engagement with Senior Leaders, national and regional payers, influential clinicians and key prescribers • Simplify the benefits of the product to customers at all levels

Set Clear Objectives that the NHS can buy into

Objective 1: Understand the level of variation analysis to identify service optimisation opportunities and increase access

Objective 2: Demonstrate to local health systems the level of variation through pathway modelling and clearly articulate how delivery of the optimal care pathway will reduce cost and generate a wider societal, clinical and financial return on investment

Objective 3: Build a local credible case for change that local health system leaders understand and a link to a service delivery model they will adopt

Objective 4: Create a RWE/Population health framework to collect patient and carer generated service experience along with operational and financial data

Objective 5: To increase the profile of the impact of the product and the benefits associated with making a market leading product available

Objective 6: To transition from supplier to a recognised partner in local health systems

Working through the influence matrix

Influencers

- NHS Commissioners
- Those leading NICE and TA approvals (recognizing that this will cut across a number of organisations and areas of influence)
- Providers (CEO, Director of Finance and Clinical Director level) working on the basis that they will have more autonomy to act in the future and with a change in payment models will be keen to look at whole pathway solutions to derive value and reduce cost
- Clinical networks (i.e. cancer cardiac etc.)
- AHSN
- Individual clinical leads.
- Patient groups

Supporters

A number of influencers will naturally be supporters but in this regard there will be emphasis on:

- Clinical networks
- Collective discussions at ICP and ICS level.
- Clinicians with influence and “finger on the pulse“
- Front line clinicians that market access team engage wit
- AMROCS

Tone

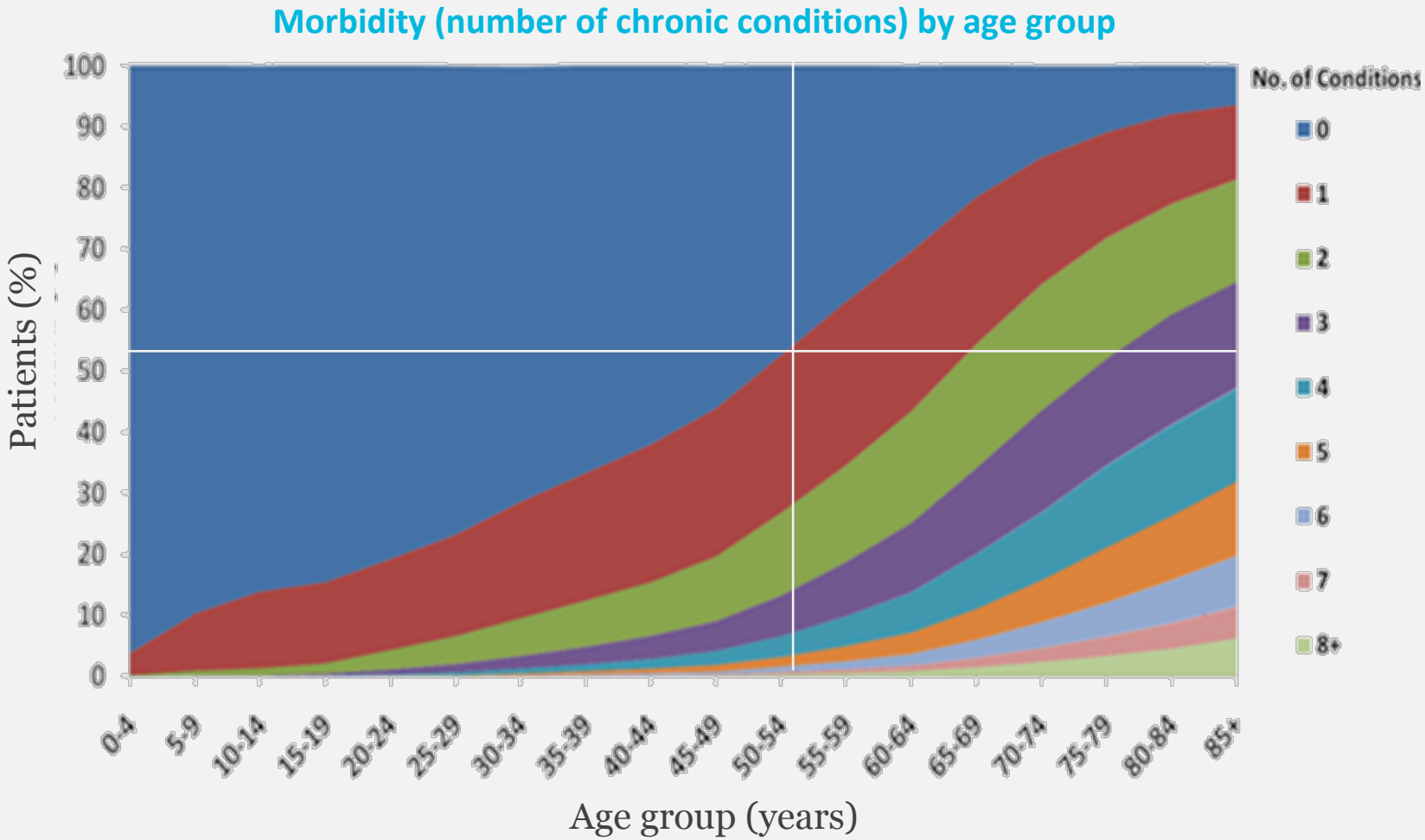
- Seniority of engagement is critical and need to consider
- MSL square up
- Senior to senior
- Also consider where best to allocate resource, view that 44 STP/ICS offer better scale than 200 CCG and will be more cost effective
- Exploratory rather than “hard sell“
- Resource and prioritise the first pitch (as it is likely it will be the only shot)
- Positive
- Transparent

Constraints

- Information Governance/data sharing agreement
- Existing governance arrangements
- Financial constraints
- Perception of pharma
- Culture
- Mindset
- Organisation and structures
- Compliance which often trumps competence

Section 5 – Time to Shift Left !

Complexity is increasing

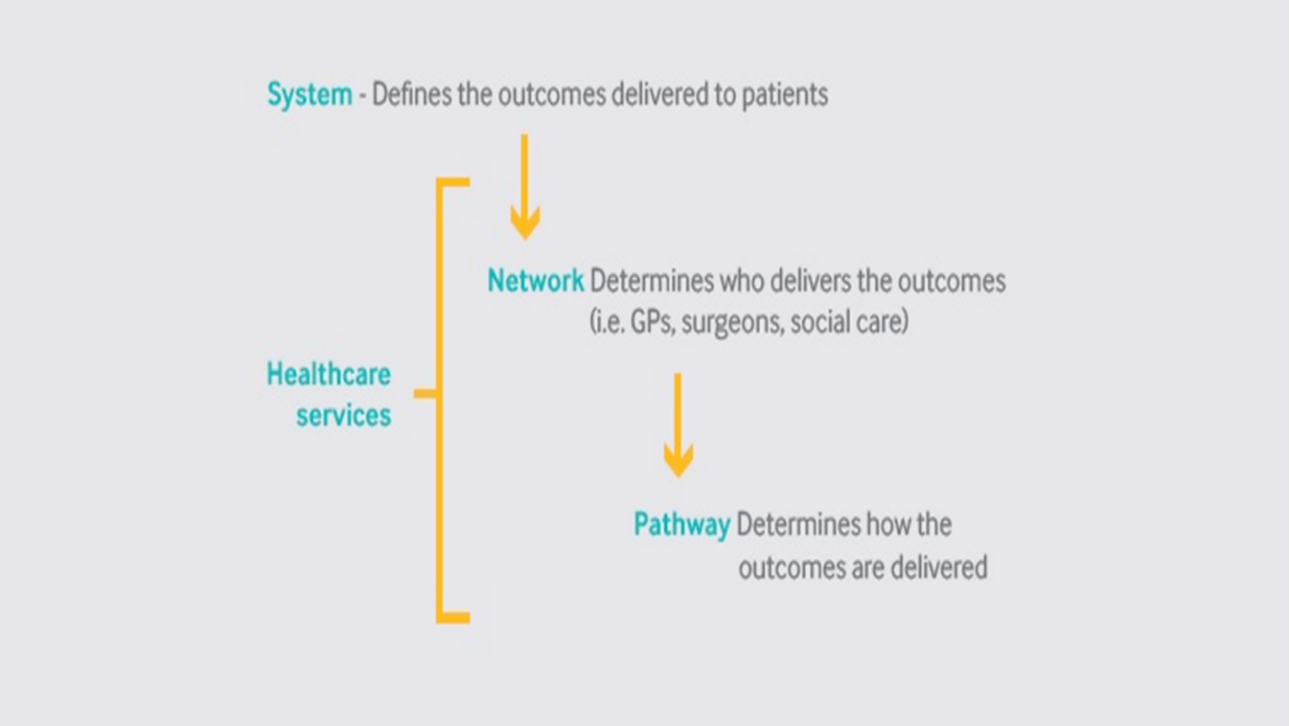


Based on: The Lancet doi: 10.1016/S0140-6736(12)60240-2

Problems of 20th Century Healthcare

Not focusing on the outcomes that matter !

- Patient harm
- Unwarranted variation in outcomes
- Inequity
- Failure to prevent the preventable
- Waste of finite resources (financial and human)
- Increasing need and demand
- Stagnant/decreasing resources



The Big Strategic Ambition for a new NHS

Industry need to enable the Shift Left !

Improve Patient Outcomes

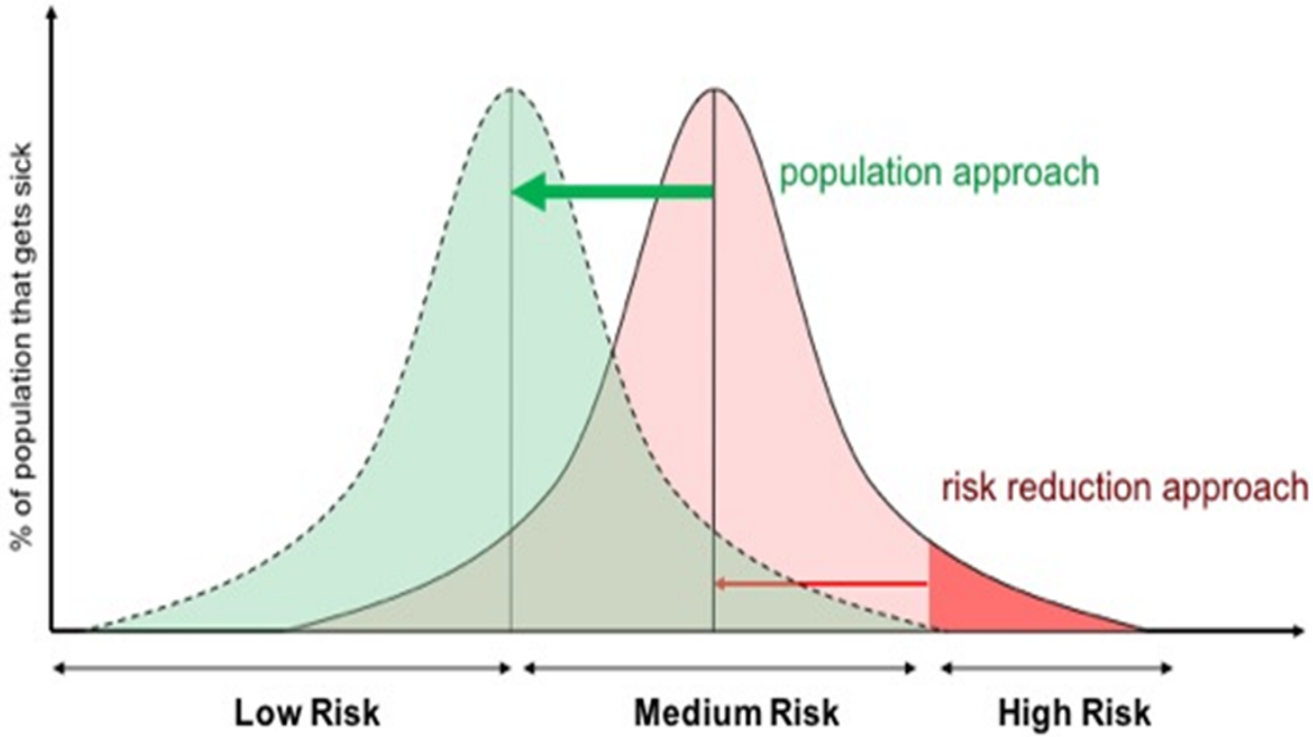
objective clinical outcomes & subjective individual needs

Improve Population Outcomes

addressing unmet need and equality/equity

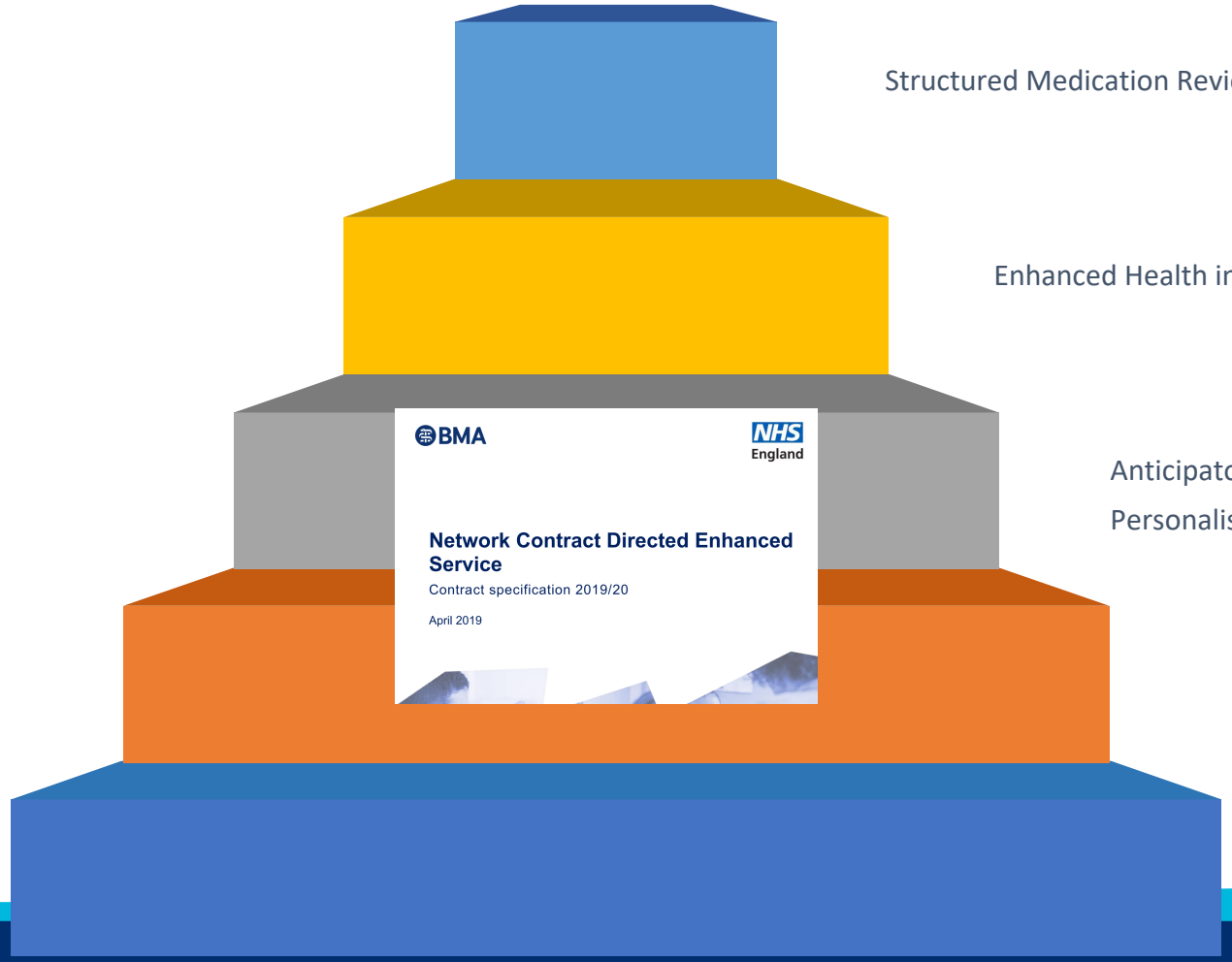
Optimise Resource Utilisation

money, time (healthcare and citizen), space, carbon



Rose, G. 1985. *Sick Individuals and Sick Populations*

The Role of Primary Care Networks



Structured Medication Review and Optimisation from 2020/21

Enhanced Health in Care Homes from 2020/21

Anticipatory Care requirements from 2020/21

Personalised care from 2020/21

Tackling neighbourhood inequalities from 2021/22

Supporting early cancer diagnosis from 2020/21

CVD prevention and diagnosis from 2021/22

Clinical Pharmacists

Meds Optimisation is the new currency

What they do now?

- Improve prescribing, medicines reconciliation, complex polypharmacy, de-prescribing, medication errors and drug expenditure
- Long Term Conditions e.g. Diabetes, Hypertension, COPD/Asthma
- Minor illness clinics
- Better anti-coagulation management
- Assisting with Telephone triage – meds / minor ailments / infections / hayfever / GIT
- Medication reviews including care homes
- Prescription queries and hospital letters
- Link between community, hospital and CCG Pharmacists

What could they do in the future?

- The pharmacist focuses on a particular cohort that is a specific need of the PCN e.g. severe mental health. They will then takes on all these patients for the network.
- Create you own medication review centre for all practices taking this work AWAY from practices and being co-ordinated by one (then 3 then 5 in successive years) pharmacists. Likely need some admin time/pharmacy tech support as year 1-2 will be too much work for one person and needs a highly trained pharmacist for prescribing rights and shared IT systems.
- Hub model for medication reviews where patients go to the hub and not their practice. Will create unified med reviews across practices and will work better with local prescribing team aims.

Targeting the Opportunity

- More Clinical Pharmacists in primary care working to see patients
- Face to face, reducing polypharmacy - which should help to improve outcomes – and reducing admissions from adverse events
- Achieving the right balance is critical to unlocking wider opportunities within primary care management that sit around better long term patient outcomes and sustainability and affordability

High prescribing, low admissions

Summary: Good patient outcomes, but at high prescribing cost

Action: Improve prescribing efficiency

High prescribing, high admissions

Summary: Inefficient prescribing and possible patient harms

Action: Validate practice register, high prescribing not reducing admissions – prioritising patient reviews required

Low prescribing, low admissions

Summary: Best practice care

Action: Maintain, share best practice with peers

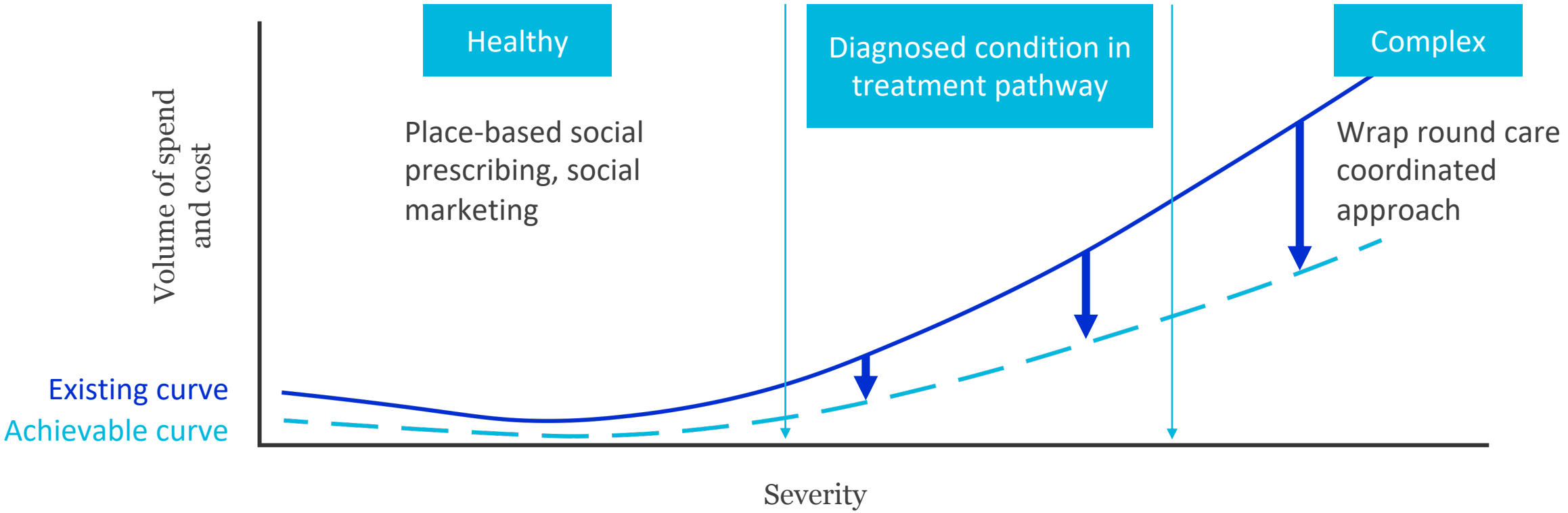
Low prescribing, high admissions

Summary: Possible under-treatment and possible patient harms

Action: Validate practice register, low prescribing with higher admissions than expected – targeted patient reviews required

Demonstrating impact across a care pathway

The aim is reducing the spend curve… and the whole supply chain can play a part



Making Every Contact count in primary care-

Rising Risk
4-5%

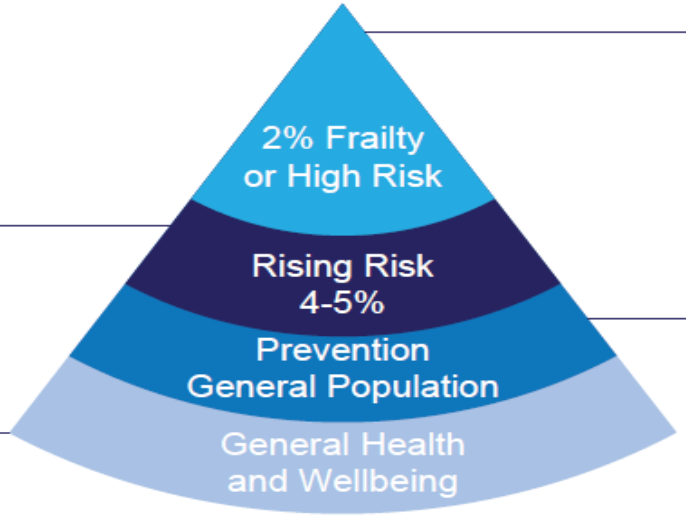
Polypharmacy review
Falls prevention service
Smoking cessation
Supported self management
Exercise groups
Flu vaccine
Home safety check
Community agents
Power of Attorney

General Health and Wellbeing

Medical certifications
Vaccination
Health checks
Pharmacy
Access to care navigators
Family planning
Weight management

Neighbourhood Model

30-50,000 patient population



2% Frailty
or High Risk

Older peoples health checks
Home safety checks
Crisis care plan
End of life conversation
Anticipatory prescribing
Referral for carers assessment
Geriatric assessment
Proactive case management

Prevention
General Population

Healthy eating
Smoking cessation
Cancer
Cardiac screening
Health and wellbeing events
Will writing
Physical exercise

Section 6 – Messaging with Impact

Typical Barriers and reasons not to engage

- Not sustainable
- Predictable and familiar
- Those that shout loudest get heard
- Process orientated -v- system understanding
- Too prescriptive
- Not flexible and will leave people behind
- Lack of common sense - too rigid
- Bureaucratic forms, correct forum
- Lacks sustainability – target achieved without hearts and minds
- Hierarchical/restrictive/crisis-driven
- Not empowering
- Does not engage shop floor

Engagement – Commitment – Mobilisation

- Need to shift left in our thinking
- Connecting with the deep seated values that brought clinicians into healthcare in the first place
- Traditional tactics need to be re-examined – " this is how things are always done" is no longer acceptable when it is clear that current system (inclusive of the supply chain) is not delivering good patient care
- The mindset must be to do something different to improve clinical patent outcomes
- The Common Endeavour is Sustainability

What resonates ….

- ✓ Mass
- ✓ Passion
- ✓ Commitment
- ✓ Pace and momentum
- ✓ Spread
- ✓ Longevity
- ✓ As a minimum need
- ✓ Executive sign up
- ✓ Organised
- ✓ Clear expectations and goals
- ✓ Clarity in terms of " whats in it for me"
- ✓ Planning and order for sanity check !
- ✓ Building blocks
- ✓ Measures and demonstrates improvement
- ✓ Clear boundaries and clear aims
- ✓ Governance realistic

A Framework for Partnership Working

Clinical

1. Enabling self-activation
2. Therapies optimization
3. Case finding and cohorting
4. Real world evidence
5. Enabling evidence and research across whole systems
6. Developing core and extended clinical skills
7. Localism

Transform

Corporate

1. Comms .media and engagement
2. Horizon scanning
3. HR and workforce
4. Service efficiency (reviews of systems and processes in the NHS)
5. Financial efficiency and supply chain
6. Leadership exchange

Enable

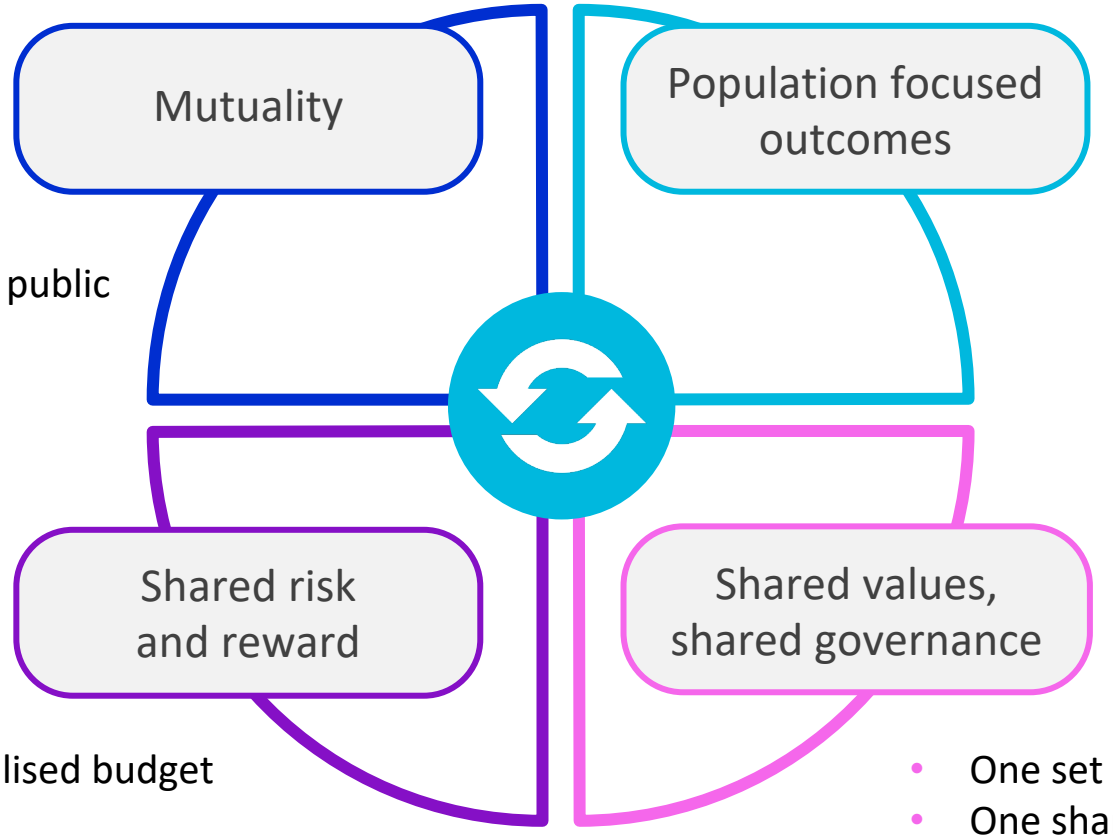
Commercial

1. Outcomes-based contracting
2. Pump priming of technology and new innovations
3. Delivery partnerships
4. Cost frameworks
5. Developing gain share models in areas such as biosimilars
6. Risk and gain share in partnership

Transact

Mutuality is key

- One system
- No organisational boundaries
- Clear, collective leadership
- Engagement with patients and the public



- Prevention and self management
- Integration
- Flexible workforce
- Operational commissioning

- Whole population capitalised budget
- Shared financial plan
- Shared system wide risks
- Shared upside and downside risks

- One set of values
- One shared culture
- Shared clinical and corporate governance

NHS needs a strong partnership approach from industry… now more than ever

System Value

- Leadership & mentoring
- New ways of working
- Network development
- Supporting workforce development & capacity
- Research & innovation
- Real world evidence

Pathway Value

- Patient identification & early diagnosis
- Reduced LoS & earlier discharge
- Care in the right place at the right time
- Improved patient outcomes
- Reducing unwarranted variation
- Better integration of care

Clinical Value

- Improving patient outcomes & reducing complications of disease
- Evidence based
- Case studies
- Education & support

Transitioning from Supplier to Partner

Conclusio Ltd

Inspiring Innovation