Looking Ahead 2021

Reset, partnerships, recovery

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Introduction

If 2020 proved anything it is that prediction is a fool's game.

Within the UK healthcare system it is possible to identify some emerging trends and to establish some of the future policy that will come to fruition in 2021 and change the NHS landscape.

The first thing this white paper must do, however, is confront the current reality.

At the moment the health service faces a crisis of unimaginable proportions. In hospitals, the day-to-day care of coronavirus patients, the adequate functioning of hospital services, infection control, safety and ensuring sufficient staffing will be top priority, for weeks to come. Likewise primary care will have a relentless Covid-19 focus - not least via the rollout of the national vaccination programme.

Behind these concerning scenes however, lies a different story – and perhaps a more positive one.

Throughout 2020, rapid developments in healthcare were taking place in real time - ones that had been years in the making but took on a new urgency as the pandemic set in.

Integration, collaboration, digital transformation, out-of-hospital care and homecare – all elements of 2019's NHS long-term plan, still the primary driver of NHS policy – are now accepted, valued and widely-used concepts, and this white paper will look at how some of them will be transforming systems in 2021.

Underlying these changes is a policy agenda to change the organisational arrangements of the NHS.

Careful not to make the same sweeping (and non-evidence-based) changes of the Lansley era in the 2010s, NHS England under chief executive Simon Stevens has been patiently laying the groundwork for a shift over the past five years, basing it around population-based healthcare, integrated and joined up working between organisations, joint accountability for patients in systems, shared local budgeting, and a move away from paying providers for levels of activity.

2021 will be the year where we see this new model NHS really take shape, prior to new laws that will enshrine these changes by April 2022.

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It's notable that the principal organisation representing the NHS management tier – the NHS Confederation – has been **wholehearted in its support** for the general principles of integration.

"Covid-19 has demonstrated the critical importance of integration and partnership working. The pandemic created a common purpose that in many areas broke down barriers and enabled services to be transformed for the benefit of patients, local communities and staff. Over this period, partnership working has been strengthened, with organisations across health and care coming together to address shared challenges. This is now the 'new normal' and key to putting the health and care system on a stronger footing".

Finally, we will look at the changing status of Industry as it attempts to understand, interact with, and influence the NHS.

In an extremely challenging period for field-based representatives, we will explore some of the commentary around the future of the role, plus address recent developments in relationships built over the course of the pandemic between industry and healthcare; in addition to an analysis of what the aforementioned developments in the healthcare system will mean for Industry throughout this white paper.

The state of the current crisis

A look at Health Service Journal during January offers some concerning headlines.

Ten trusts have at least half their beds occupied by Covid-19 patients, more than 1,000 patients in one region are awaiting urgent cancer surgery, more than a third of ICU capacity in one region – the East of England – **is taken up by Covid-19 patients**.

Furthermore, a new, more infectious strain of the disease has hit some parts of the country harder than others, and at different rates.

In London, the south east and the east regions bed occupancy is often overwhelming individual trusts and even systems, but growth is moderate and slowing. Over the seven days to 11 January, the three systems have all seen a 16 per cent increase in Covid-19 bed numbers down from 33 – 43 per cent rises seen over the previous week. Both the south east and east regions have around two half times more covid-19 patients than at the peak of the first wave; London has one and half times the number.

At the other end of the spectrum, the south west and north west regions are seeing very dramatic and accelerating increases - Bed occupancy in the south west is up 38 per cent, compared to 27 per cent rise in the previous period, and stands at 184 per cent of its, relatively low, first wave peak.

In the north west, the number of Covid-19 inpatients rose 33 per cent (compared to 20 per cent in the previous week) and is at 122 per cent of the April maximum.

Industry impact

In case it needed saying, Covid-19 continues to dominate the activity of the NHS and this will be the case for some time to come. This means that the oxygen is not there for many customers to engage with suppliers in the normal way. Many projects, partnerships and associations will have to be postponed, face-to-face meetings are extremely unlikely and even remote meetings and contact may just not be able to happen for the time being.

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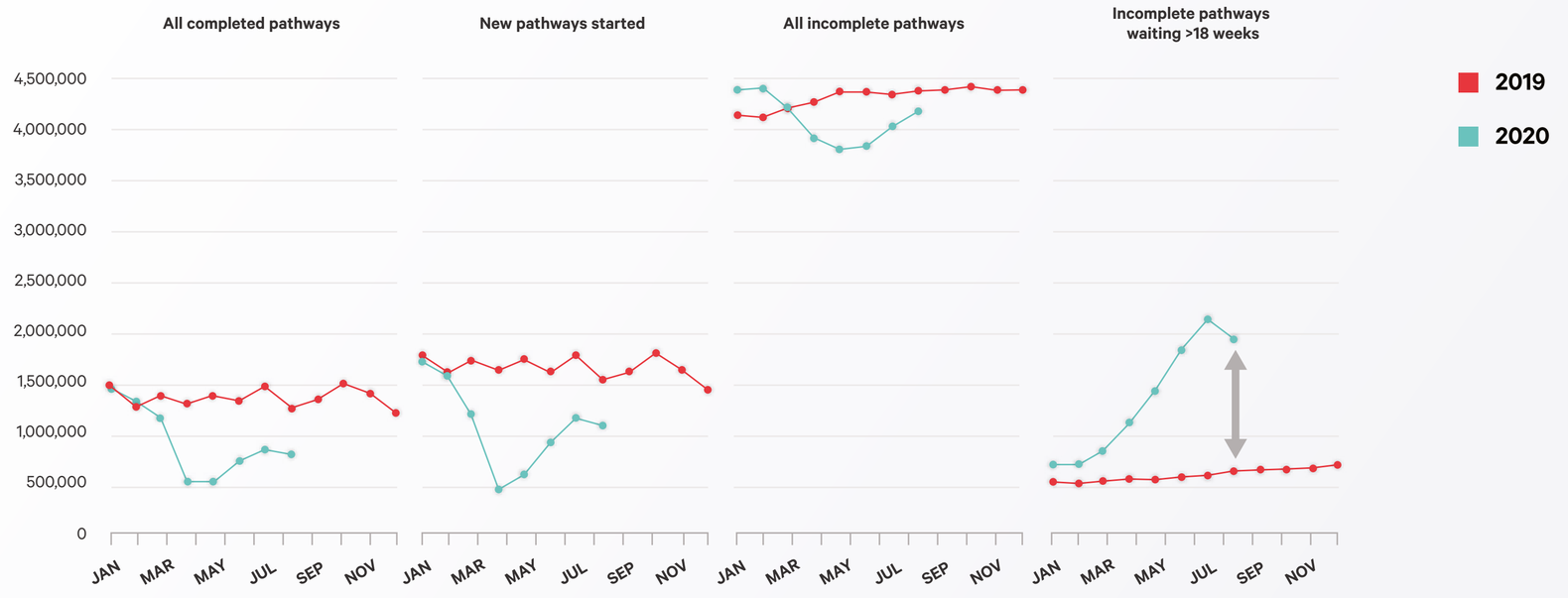
Just as concerning, and in the long-term, perhaps more so, is the ‘gap in care’ developing.

A telling graph from the Health Foundation reveals a gap of some 800,000 patients based on ‘completed pathways’ from 2019 compared with 2020 up til July. New pathways initiated were also well down, to the tune of some 500,000 patients.

In addition to the great clinical concern, it is also difficult for pharma to reach new and ‘switch’ patients if they are not coming into the system and being diagnosed in the first place.

These ‘future patients’ are likely to then present with later stages of disease progression, could be more difficult to treat, and will represent a big demand on the NHS for years to come.



The number of completed, incomplete and new pathways by month in England in 2019

The Health Foundation 2020 | Source: NHS England, Consultant-led Referral to Treatment Waiting Times

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NHS Planning for 2021/22

However, the 'regular' business of the NHS has to go on. Operational guidance for the NHS in 2021 was **quietly released** a couple of days before Christmas 2020. As well as the immediate pressures of Covid-19 and winter, the main priorities of the service going forward can be clearly seen. These are longer term plans, so you can observe what the NHS would like systems to focus on once the immediate Covid-19-related challenges are addressed.

1. **Recover non-Covid-19 services**, in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, improve productivity on high-volume clinical pathways with the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics. The Government has provided an additional £1bn of funding for elective recovery in 2021/22.

2. **Develop system-based recovery plans** that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation.

3. **Address the health inequalities** that Covid-19 has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress.

4. Accelerate the planned **expansion in mental health services** with the additional funding provided in the spending review.

5. Prioritise **investment in primary and community care**, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity.

6. Build on the development of **effective partnership working at place and system level**.

7. **Support the use of data and digital technologies**, including the introduction of a minimum shared care record in all systems by September 2021 to which we will target some national funding, and improved use of remote monitoring for long term conditions.

- Investment in primary and community care
- Effective partnership working at place and system level
- Expansion in mental health services
- Recover non-covid services
- Address health inequalities
- Develop system-based recovery plans
- Support the use of data and digital technologies

Industry impact

Look out for opportunities to align your agenda with the NHS this year in areas such as health inequalities. Industry can point to data that establishes unmet need in certain patient populations. Such insights could be crucial to system leaders as they build new pathways based on population needs and all the more relevant since Covid-19 has almost certainly established a heavy burden of undiagnosed conditions.

Wilmington Healthcare Insight

Wilmington Healthcare provides data stories and visualisation to share with NHS customers using our **Quantis** platform which can be aligned to deprivation indices.

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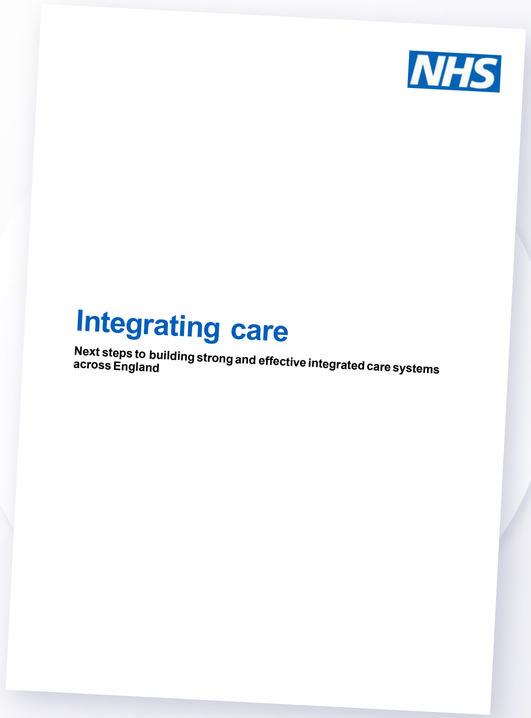
Integrating care

The NHS's **Integrating care** document, published in late November, is probably the most helpful single policy piece to emerge this season.

It brings into one place the services plans for reform going into 2021 and beyond, setting out how integrated care systems will be the basic unit of the local NHS, how the finance will work for population-based healthcare, what will be expected of all the partners within systems – at all levels, who will be responsible for what, in addition to setting out some aims for systems such as reducing inequalities, supporting new clinical pathways and involving clinicians in wide-ranging changes.



- ICSs in place by law in April 2022
- Activity payment switched to block/ blended contracts
- Single pot of finance per system
- CCGs personnel and functions absorbed into ICS
- Clinically-led changes to pathways
- Providers to form collaboratives
- Patient data sharing across all systems
- Specialised commissioning budget and responsibilities devolved to ICS

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ICSs in place by law by April 2022...

The main headline – and the wellspring from which the rest of the reforms take shape – is the establishment of ICSs in law.

There will be around 42 ICSs by April 2022. Some are already up and running; some are operating in 'shadow form'. Expect more to come fully online over the course of this year.

Integrated care systems were originally STPs – sustainability and transformation partnerships – and were established as loose, non-statutory 'virtual organisations' where fellow stakeholders in the same locale could begin to collaborate, rather than compete.

Interestingly, another thing the NHS publication states is **competition between organisations**, governed by section 75 of the 2013 Health and Social Care Act – will also be abolished. It is something like an end of an era for market forces in the NHS.

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A Government white paper – leaked...

Just as we were going to press, our colleague Andy Cowper at HSJ published **a draft of the White Paper** which sets out the legislative framework for the future of the NHS, with the working title of *Integration and Innovation: working together to improve health and social care for all.*

The paper solidifies much of what readers of Wilmington Healthcare white papers will be familiar with; as HSJ's Dave West says, they "are what NHS England has been asking for in formal proposals over the last 18 months, and reflect the direction the NHS has been moving slowly but inexorably towards for several years."

The proposals will roll back key parts of the 2012 Health and Social Care Act, also include key measures which had been proposed by NHSE, such as turning integrated care systems into statutory bodies, allowing new limits on capital spending for foundation trusts, and to allow NHS commissioners to award contracts without a tender process.

An eye-catching measure is to award more power to ministers to intervene in 'reconfigurations' – that is, what work each part of the system does. This seems to include intervening, directing and overseeing the work of NHS England itself.

If implemented in this form, the white paper will largely undo the legacy of the 2012 Health and Social Care Act, placing integration (and integrated care systems) centrally, and returning accountability to government instead of what was previously essentially, a 'hands-off' approach.

Industry impact

One area mentioned by the White Paper which will be of interest to industry concerns **medicine registries**.

It is proposed that the MHRA develops and maintains publicly funded and operated medicine registries and to work with the NHS to populate and maintain them where there is a clear patient safety or other important clinical interest.

This would be publicly funded and would provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.

Medicine registries can consolidate prescribing data for specific medicines with data from clinical care and other databases and can be further developed to capture more detailed and bespoke data on the cohorts of patients receiving these medicines.

Another area concerns the **tariff** – according to the draft, providers will no longer have to apply to NHS Improvement for local modifications to tariff prices. This could spell a raft of local variation on healthcare pricing bundles and how valuable products could be within them.

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CCG personnel and functions to be absorbed into ICSs...

The document also confirms NHS England is backing legislation to abolish clinical commissioning groups (CCGs) by April 2022.

The way this will work is essentially for the **core statutory functions of the CCG into the ICSs**, which as we now know will themselves be established in law by April 2022.

Previously, NHSE has steered away from a full reorganisation, but its paper says the response to the coronavirus pandemic, and the development of ICS so far, had "increased the appetite for statutory 'clarity'". All CCGs will therefore merge to the size of their ICS before April 2022.

There are around 130 CCGs, and 42 ICSs and sustainability and transformation partnerships, due to become ICSs. **NHSE is seeking to give an assurance of job security during the reorganisation** transition period for CCG staff below the top level.

Industry impact

For your territory and account planning, for your assumptions of who your customers and payers are, and for other issues such as who controls rebates, and how area prescribing committees will operate and on whose behalf, this is obviously a huge development.

This will also affect CRM system data. Look out for mergers between CCGs this year as they attempt before April 2022 to become ICS-sized structures.

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Wilmington Healthcare is there to support your data needs - all these structural and personnel changes are incorporated into our UK healthcare customer data as they happen. If you need to update your databases, whether via a CRM or otherwise, please do **get in touch**.

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Look out for more CCG mergers...

And for an example of the scale and pace of some of these, examine the situation in the North West.

Here NHS England **has rejected plans to merge four clinical commissioning groups in north Merseyside** – insisting the merger must also include the five other CCGs in the wider health system.

National guidance issued in January 2020 said there should "typically" be only one CCG for each of the 42 ICSs in England, which implied there could be flexibility for very large systems such as Cheshire and Merseyside.

This encouraged four Merseyside CCGs — covering Liverpool, Knowsley, South Sefton and Southport and Formby — to press ahead with a merger plan, with a view to this transaction taking place by April 2021. Meanwhile, four CCGs in Cheshire completed their long-planned merger in April 2020.

However, the four Merseyside CCGs were told in September by NHS England there must be a single commissioning body for the entire Cheshire and Merseyside system, as a bid for their four-way merger was rejected. It would cover a population of around 2.7 million.

Industry impact

Many area prescribing committees (APCs) – who by and large govern the listing and implementation of formularies in England – will be affected by the move away from CCGs. In some cases, the territory covered by the present APC will not change, but in others, where for example two or three CCGs all with separate APCs merge to fit the size of an ICS, or are absorbed by the system, the number of APCs could decline. This is definitely a space to watch.

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Our new **InFormulary XD** service will help you keep on top of all the latest formulary developments, covering the work of new bodies and new APC establishment as 'systems' kick in.

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Providers to form collaboratives...

Meanwhile, all NHS provider trusts **will be expected to be part of a provider collaborative**.

Trusts that operate across either a large area or are within a small ICS will likely want to be part of a collaborative that spans “multiple systems”. NHSE/I will set out guidance on how to do this in “early 2021”.

This will cover elements of horizontal integration – where hospitals of a similar size and role work with each other – but also vertical integration, with NHS trusts working with specialist, care, ambulance, primary care networks and social care services.

Will hospitals actually merge?

While some horizontal integration, joint governance between certain trusts, and hospital group purchasing has been going on for some time, it’s likely this will be accelerated by the provider collaborative agenda.

Some hospitals have been told to form ‘hospital groups’ by NHS England – an initiative originally touted in 2015’s Five year forward view and modelled by the original acute care collaborative ‘vanguards’ in places such as Northumbria and Greater Manchester.

Now, **Wolverhampton, Walsall, Dudley and Birmingham** will form just such a group. Such a move is not without controversy and the trusts are at different stages in their ‘need’ for such a move.

Industry impact

Again, this is going to have an impact on the stakeholder map if you work in hospitals. NHS plans, KPIs, staffing, and to an extent finance will be based upon the collaborative rather than the individual hospital trusts. This could well have an impact on procurement too, with the future operating model for procurement recommending aggregate purchasing in many cases.

The provider collaborative space is definitely one to watch. Many healthcare commentators have been focusing on the **centrality of ‘place’** in the Long-term plan; in the sense that this is where the locus of local decision-making should be, rather than at the higher ICS level, that should be seen as more aligned to strategic commissioning. If ‘place’ is going to be central to NHS development, then provider collaboratives will be central to ‘place’.

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The ‘single pot’...

One of the most important policies to emerge from the Integrated care document is the specifics on the ‘single pot’ of finance that will cover all providers within a system.

The document says there will be a:

> “single pot... which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems”.

This pot will be held at integrated care system (ICS) level.

Industry impact

It means that the financial assumptions worked on by some parts of industry for many years – that it exists in a transactional relationship with individual hospital trusts – is not really the truth anymore, and hospital budgets will exist in a wider health economic ecosystem where money is distributed according to population health need.

This could spell the end of the hospital as ‘revenue-generator.’

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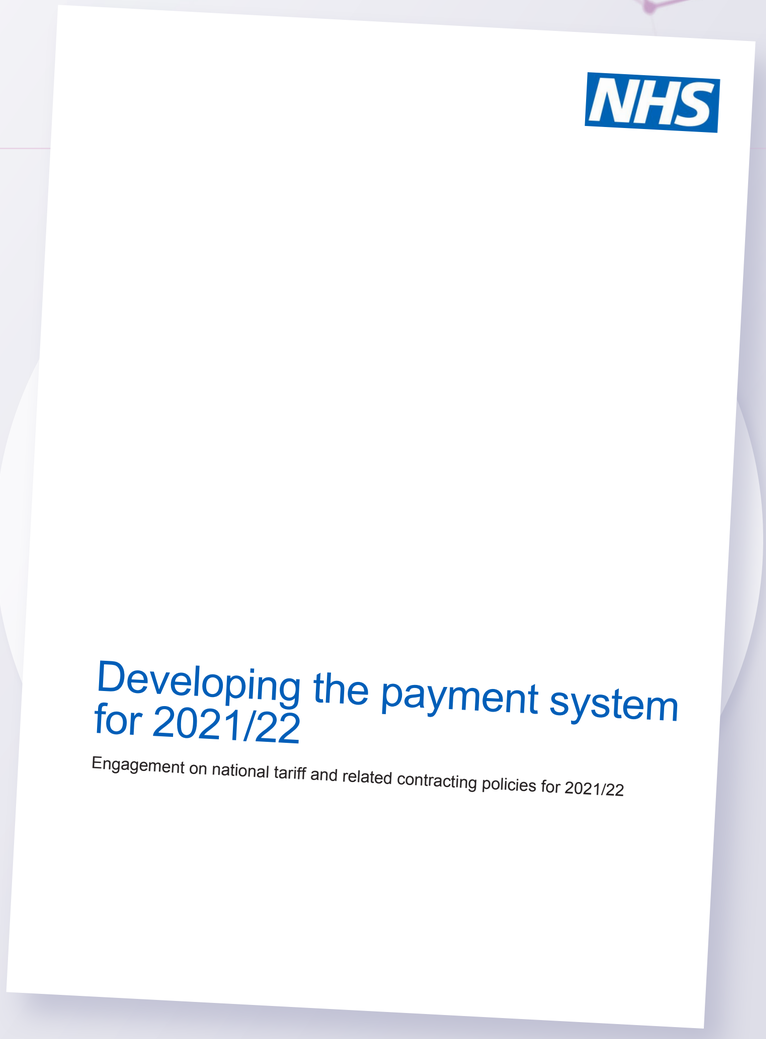
Changes in the payment system...

In addition to the single pot initiative, a supportive paper gives us some more details on how finance will work this year.

The revenue funding distributed at system level will be based on the previous CCG allocations, plus the 'Financial Recovery Fund' each system would have been allocated in 2021/22.

There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

Again it's worth noting that these changes have not gone down universally well – with one **leading trust chief branding NHSE's new financial regime as 'very risky'**.



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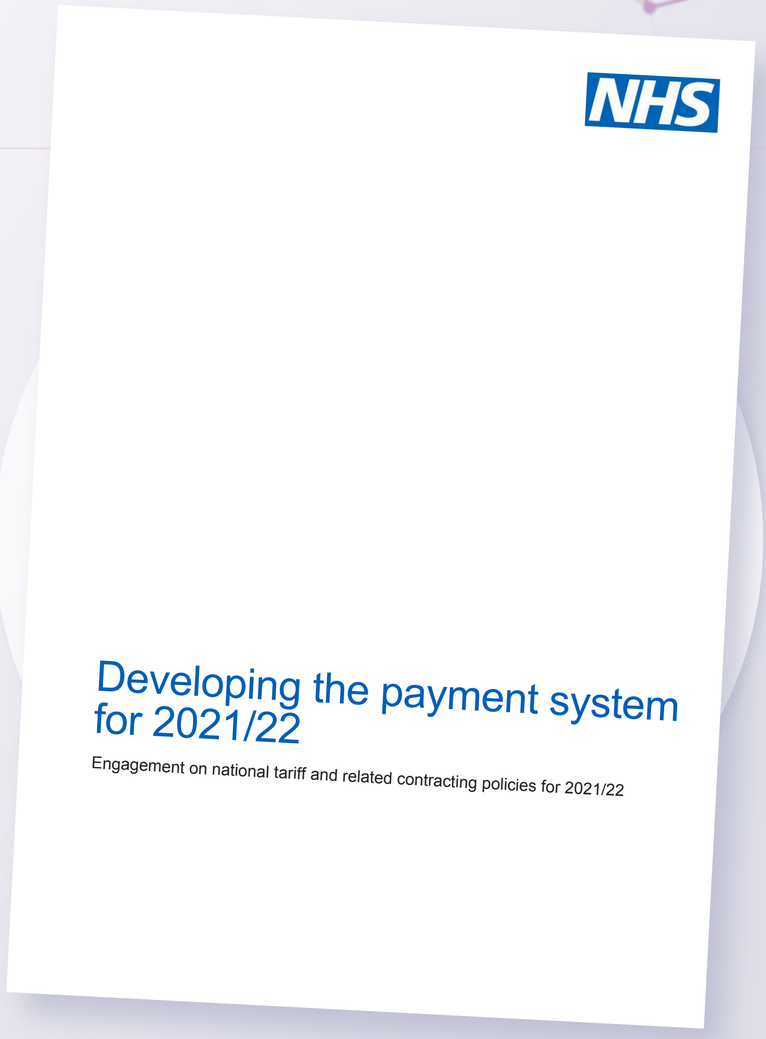
Developing the payment system...

The 2021/22 financial system will aim to:

- Build on the shift away from activity-related payments
- Support increased system working and the development of ICSs
- Support the positive innovations introduced in response to Covid-19, such as increased use of virtual outpatient appointments
- Move to the LTP objective of moving to population-based funding
- Support systems to reduce the backlog in elective activity
- Encourage equality and address health inequalities



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Blended payments – what are they and why does it matter?

NHS England has proposed a 'blended' payment model for the vast majority of secondary healthcare services.

This would replace the individual service-level payments introduced in previous tariffs.

The blended payment model for 2021/22 would include a fixed payment, based on the costs of delivering a level of activity that conforms to the ICS system plan, and a variable element for some elective activity.

Alongside the blended payment arrangements, providers and commissioners would need to sign up to a System Collaboration and Financial Management Agreement (SCFMA), under the terms of the NHS Standard Contract.

This SCFMA shares financial risk across the system CQUIN and best practice tariffs would continue to incentivise care quality.

Industry impact

The fixed payment element starts all trusts off this year on a sure financial footing, eases the pressure on hospitals to do 'as much activity as possible', and supports working with others in order to provide joined up services - as well as allowing services to be moved off site and taken on by other areas or providers within a collaborative. It means patients that have to receive treatment in another area will be covered by the fixed budget of the system where they live.

Where will drugs fit into the payment system? Many high-cost drugs will still be 'excluded from tariff' and bought by trusts – or in the future – systems – on cost and volume. Conversations with NHS England have thrown up some thinking that some drugs – such as generic chemotherapy or antifungals – will come under system block contract. Such 'block drugs' may be therefore sold in a local negotiation – with the money coming from population-based budgets for ICSs.

NHS England has suggested a move to local blended contract inclusion for biologics on normal secondary care contracts. This would suggest the cost no longer 'passes through' to the CCG but is covered by the provider. This might induce a greater perception by providers of the cost of such medicines. It's possible that such 'block drugs' will be handled through local negotiation.

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Specialised commissioning devolved to ICSs...

This is a big story. Specialised services have since 2013 been commissioned by NHS England itself, via its regional specialised commissioning hubs.

It is now proposed and confirmed by NHSE, that while NHSE will hold the budget for a few nationally commissioned services and rare diseases, the majority of the specialised budget will be held at ICS level and will be real, not indicative. This will cover such areas as chemotherapy, mental health and cystic fibrosis. NHSE does however say that for some services ICSs will need to work together:

"Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national. For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions".

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If you work with a product that is 'specialised commissioned' and you have some concerns about how these changes will affect your company, feel free to make an appointment with our **Consultancy team** who can devise further training and advice on this crucial area.

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What is happening in primary care?

Primary care has absorbed a lot of shocks over the past year.

As well as being in the NHS frontline over the pandemic, they have had to cope with the rapid adoption of a click-first service and telephone triage, as well as adopting remote technologies to maintain existing and new long-term conditions patients.

Out-of-hospital care has also been at a premium with many patients unable to enter hospital settings. In many cases it has been primary and community nursing services that have had to step in.

This has also been the first full year of PCNs or primary care networks – groupings of practices with shared budgets and plans, as envisioned by the long-term plan.

Now PCNs are tasked with the rollout of the Covid-19 vaccine which will undoubtedly take up a lot of organisational oxygen.

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If you would like to approach **PCNs** and engage with them, Wilmington Healthcare has extensive and country wide customer data on **primary care networks**.

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Things to look out for in 2021:

Service reconfiguration

Increasingly decision makers on the inside, are realising that some of the changes forced upon the system this year are here to stay.

But as other services, hampered or curtailed during 2020, are brought back online, expect some grand rationalisations within systems and places.

Strategies adopted in different regions will include choices: whether to continue unchanged, replace, transfer, triage, rationalise, centralise, cancel or suspend, or reduce.

These kind of reconfigurations will also be affected by the activity of the emerging ICSs, ICPs and PCNs – with much discussion expected about which providers will be responsible for which services, and who will hold contracts for what.

Industry impact

This will vary widely from place to place – so one job Industry has next year is to map out the shape and size of services in territories – what will be done by whom and for which patient group – expect a lot of change in this area.

Digital transformation

The website **Primarycarepathways** offers several insights into just how much digital transformation has mattered – particularly in primary care – and how much it is now embedded in NHS ways of working.

Claiming "an overwhelmingly positive responses to the rapid deployment of tools that have been waiting for adoption for a long time" it gives the examples of:

- Virtual clinics and appointments
- Digitalisation of home working, remote desktop software, flexible working
- e-rostering
- e-consult type platforms so patients can provide information, self-help, self-refer
- virtual care home ward rounds by video

Industry impact

It's really the tip of the iceberg in 2021 – expect to hear a lot more about AI in system reconfiguration and patient prioritisation, and of the impact of shared care records across systems. These will allow a far richer picture of outcomes for spend on particular pathways and if accessed, could provide the basis of more authentic budgetary impact models for products.

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GIRFT

GIRFT – the Getting it Right First Time programme to reduce variation in services – has been active throughout 2020 and we can expect its influence to carry on into 2021.

GIRFT teams have been engaging with hospitals to do deep dive work on best practice, gathering data that adds some evidence to exactly what blend of technique, product, staffing, patient engagement, pathway and resource management will best unlock the NHS' capacity to be 'high-flow', and free up staff time to get those millions of patients treated.

GIRFT is perhaps **surprisingly optimistic**:

"We are in a strong position to help specialties refocus in the post-Covid-19 world, where changes that did not seem possible pre-Covid-19 now seem more achievable."

Cataract surgery is a good example of what this will entail – and a good bellwether of how other specialties could cope, given that pre-Covid-19 it was the most common operation. GIRFT has recently published a piece of **guidance** that takes in all of the above challenges, as well as the clinical, organisational and technological progress that has rapidly been made during the pandemic.

GIRFT: pathway redesign and patient flows

Crucial to understand is that GIRFT is encouraging NHS specialties to look at their pathways as something of a blank slate, ripe for service redesign. In the case of cataract surgery, this covers the consenting process; a transparent, consistent set of prioritisation criteria to direct care to those most in need; and a method of returning to a normal or near normal number of cases per list rapidly by using appropriate mitigation, for example, 'Covid-19 free or light' pathways and patient selection processes.

GIRFT looks at data to understand theatre flow, patient journey times and number of cases per list to understand where bottlenecks are occurring and what can be done to make improvements. It establishes the necessity of consistently grading patients for risk and complexity, and to interpret and benchmark this data.

One stop pre-assessment clinics can be used to minimise the number of times patients need to attend the hospital. And a joined-up service is also crucial, with pre-operative appointments linked to dates for surgery and post-operative review, along with a short timeframe, supported by telephone or video consultations.

GIRFT thinks that if measures like this are introduced wholesale, then the cataract backlog can be effectively managed.

Industry impact

One thing to be aware of is GIRFT, historically associated with acute care, is now advising on 'whole system pathways' that also cover primary and community care – for example, in the Ophthalmology review the primary care handling of wet age-related macular degeneration is included. It's well worth familiarising yourself with GIRFT reports in your clinical area. Similar measures are covered in GIRFT's joint work on **stroke with the Oxford AHSN**, and with the GIRFT diabetes recommendations.

One space to watch here is the impact of GIRFT on provider collaboratives. For example, the diabetes GIRFT report has some primary care objectives - even though GIRFT was originally designed to hold trusts to account. This will mean in order to satisfy the objectives, provider collaboratives and partnerships involving primary care will have to have shared objectives.

Out-of-hospital care

Nowhere has the importance of keeping vulnerable patients out of hospital been a more fraught issue than in the field of cancer.

The NHS has developed **several ways of delivering cancer care out of hospital**, many of which will be retained by systems in the new era.

Four cancer buses, based in North Middlesex University Hospital in London and Airedale NHS Trust in Yorkshire, have allowed around 60 sessions a day to go ahead. The buses have space for clinical teams to give chemo to four patients at a time, either directly outside of the hospital or in a convenient location for patients.

Hospitals have also significantly increased the use of chemo at home, with local pharmacy teams and community nurses providing the service to reduce cancer patients' risk of exposure to the virus.

At the Clatterbridge Cancer Centre in Merseyside, the number of people receiving care at home from specialist chemo nurses has increased by 15% during the outbreak, with 285 patients in the area having oral chemotherapy delivered to their door by local volunteers.

The NHS has set out steps to treat more patients safely, including carrying out multiple same day tests to minimise patient visits and expand cancer hubs so that surgeries can be restored to pre pandemic levels.

This action joins a series of measures, including the rollout of 'covid protected' cancer hubs for treatment and online consultations so people do not have to go to hospitals for regular checks.

What is the future of the sales rep?

Industry insiders **Paul Simms** and Jessica Federer ran a webinar on pharma predictions for 2021 in January

One prediction concerned the future of the sales rep; the speakers felt that the age of 'sales' was coming to end, given that the activity of sales reps is often not directly connected to revenue and many companies have managed to retain profitability without having a fieldforce on the road. Effective digital engagement through a variety of channels was also carrying a lot of market presence in the Covid-19 era.

They predicted there would still be a role for field reps, but it was likely to take on less of a 'sales' dimension – instead education, training, liaison, information sourcing functions and point-of-contact queries would be the valuable function. There would also likely be an expansion of medical science liaison roles.

How five big impacts of the pandemic will carry over into 2021

1. **Face-to-face visits with healthcare professionals have declined** – which has meant a dearth of new diagnoses, new treatment initiations, new evaluations of current patients, and switching of treatments. It's therefore been a difficult year for launch products, which need new patient and 'switch' patients to take off.

2. **There is now a backlog of non Covid-19 patients in the system,** patients who have either not seen treatment, or whose treatment has been delayed or sub-optimal. We have yet to assess the health impact of these delayed or absent treatments for patients, which could play out as more severe or advanced disease presentation, higher co-morbidities and even earlier deaths – all this can play a part in establishing the true value of medicines going forward.

3. **Patient journeys are occurring in different settings**, and we can expect this to become a feature of the healthcare landscape in the future.

4. **Products which allowed patients to self-administer have had an advantage** - self-administration could become consistently attractive, such as with oral and subcut treatments.

5. **Self-administration may become a bigger factor in HTA in 2021**, such as a clinical effectiveness criterion for NICE appraisal.

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NICE's new pathway...

NICE collaboration on streamlined licensing and patient access process for **new medicines opened on January 1st 2021** – providing a potential new opportunity for pharma.

Companies can now submit medicines for the new Innovative Licensing and Access Pathway (ILAP) following close collaboration between the NICE, drug regulators, the NHS and equivalent organisations in Scotland.

Describing the pathway as 'frictionless', NICE says it will be working with the MHRA to provide advice for companies on clinical trial design to ensure optimal data is generated for both regulatory approval and health technology appraisal.

The NICE Scientific Advice and Office for Market Access services will also contribute to supporting products in the ILAP.

Industry impact

The ILAP enables multiple entry points depending on the stage of development of the product, the data available, the ambition of the applicant to engage with UK stakeholders, and the applicant's "appetite for new innovative ways of working".

Therefore, the pathway will allow entry very early, based on non-clinical data, where all the regulatory tools described below might be options, as well as catering for products with mid-development dossiers. However, to maximise the benefits, applicants are encouraged to apply early in the development of their products.

Could pharma end up in a stronger position after Covid-19?

APM Europe reports on the work of a credit agency, Scope Ratings, looking to see how the pandemic will affect the outlook for the pharma industry.

As a result of the crisis, there will be a “renewed trust” in pharmaceutical products. The crisis has also affected demand for over-the-counter products and health-related nutrition. Companies, including Germany’s Merck KGaA, via its life sciences division Sigma Aldrich, have “already benefited from this”, it said.

The agency added: “While the pharmaceutical industry, in particular, has grappled with a negative public image in the recent past, the present crisis provides a welcome catalyst to change popular perceptions profoundly.”

Governments around the world, which last year poured large sums of money into the vaccine sector, have also increased spending on healthcare in general, the report said.

> “If the industry can use this opportunity to position itself as a partner of governments and [become a] rescuer of society, we believe this might unlock further significant growth potential - and possibly less price regulation in future.”

Wilmington Healthcare

Contributors to this paper

Our expert team is highly experienced in working with the NHS and the wider healthcare community. This wide-ranging experience allows us to have empathy with our clients' challenges and the evolving needs of the NHS.

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With unparalleled NHS expertise and outstanding industry knowledge, Wilmington Healthcare offers data, data visualisation, insight and analysis on a variety of UK healthcare fields. We deliver sustainable outcomes for NHS suppliers and ultimately patients.

We hope you found this white paper useful. Much of the insight contained in this document is drawn from Wilmington Healthcare's portfolio of data and intelligence solutions, curated by our team of experts and consultants.

For more information or to request a demo of a solution please contact us in any of the following ways:

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