How VPAG Chapter 3 will Reshape the UK Pharma Landscape

Improving the visibility of patient support programmes and ensuring equitable adoption of new and innovative medicines

Information about the financials of the new voluntary scheme for branded medicines, pricing, access and growth (VPAG) has been widely shared, debated and disputed. Chapter 3 is less well socialised and considers a different angle. It provides an opportunity to improve the uptake of NICE technologies at a local level.

It's referred to as Chapter 3 as it is the third chapter of the scheme and the five priority areas within the Chapter 3 of the VPAG are:

1. Money moving into horizon scanning
2. The equitable adoption of newer and innovative medicines
3. Improve the visibility of patient support programmes
4. Initiatives looking at improving the life sciences industry in the UK
5. Improving sustainability of medicines in the NHS

System readiness

System readiness is an important part of the planning process. Industry, NHS England and NICE spend years arriving at a positive NICE and a scheme to make it affordable, but often little time is spent working with the systems to understand how and where this is going to fit in the pathway and whether the local system is ready for this new product or innovation. There can be issues around capacity and innovation adoption where the necessary systems are in place, but there is limited capacity to implement change which may include the need to run parallel systems to establish the new pathway and ensure it operates. There is an opportunity here for Patient Support Programmes to support the system to implement change.

System readiness needs to also be complemented with system architecture. The systems need to have the right integrated medicines optimisation committees with the right decision makers around the table to allow the assessment and adoption of NICE TAs.

Another factor is financial system readiness as there could be a greater cost in one department of a Trust that is offset by reduced emergency admissions, GP appointments or pressure on social care. As financial pressures increase, financial siloing also increases, so the mechanisms need to be in place for Integrated Care Boards (ICBs) to recognise the financial savings inferred by a NICE decision. ICBs and Integrated Care Systems (ICSs) are currently going through their own journeys to make better decisions for medicines in a timely manner that enables faster adoption.

Alzheimer's Research UK have been on the news this year, talking about the arrival of new breakthrough treatments that are best used in the early phases of Alzheimer's calling out the fact that the health and care system in the UK isn't ready as currently only 2% of dementia patients receive a PET scan or lumbar puncture which is required to be eligible for the new drugs. Work is needed within the system as a whole to ensure that when drugs arrive they can be utilised to enable patients to receive the best treatments and outcomes.[1]

There is an opportunity here about how industry might be able to support this and there needs to be collaboration and alignment across Life Sciences and the NHS to ensure the best patient care can be delivered in a timely way.

Adoption of NICE

IQVIA data[2], which was published two years ago in collaboration with the APBI, showed that it takes four years on average for local ICSs to take up NICE approved technologies to just 8% of the cohort that NICE declared were suitable. Four years after a two year NICE assessment, which is a six year delay to the uptake of innovation. Chapter 3 now has the potential to address this issue of slow and inequitable adoption of NICE.

Slow adoption can also impact the standard of care in the UK for clinical trials. Delays in adoption can mean that there isn't the right standard of care in place for clinical trials to take place, so this strong call out about rapid and equitable adoption of NICE TA's at local level in Chapter 3 should help to improve this too.

Although the healthcare system in England does have some good examples of getting clinical guidance and new innovations into the system rapidly such as the Early Access to Medicines (EAMs) Scheme, Innovative Licensing and Access pathway (ILAP) and the NHS accelerated access collaborative, new medicines are frequently adopted more slowly in England than in other countries. The data suggests that in some technologies and particularly medicines, the UK falls behind other countries. This is likely to be caused by a combination of pathways, lack of planning, concerns about budgets as well as other current pressures on the health and care system. The VPAG scheme is unable to solve all of these, but is designed to support improvement in the adoption of cost effective medicines across the system.

Chapter 3 includes a few statements on improving adoption of cost-effective medicines as part of a joint ambition and there's some practical steps that NHS England (NHSE) highlights as important:

1. To have an adequate database of formularies so everybody is aware of availability and status
2. To look at NHSE national clinical director role profiles with an expectation of having responsibility to adopt cost effective medicines and guidance
3. A move away from setting targets and bringing forward some initiatives that will help with the levelling up agenda that is needed with some medicines and improving the adoption of guidance throughout the NHS

In the weeks and months ahead there will be a clearer programme of work looking at how these will be delivered and taken forward.

The IQVIA work that was previously published showed that the higher the deprivation by ICS, the lower the uptake of NICE approved medicines. So equitable access within healthcare must be considered in planning and implementation.

The challenges in population health improvement

As ICSs and ICBs have formed, so has the narrative associated with their key aims of addressing health inequalities and population health management and this has become central to how decisions are made within ICSs and ICBs — by focusing on the population.

Using an insights platform that enables an ICS to build a digital understanding of the spread of the population is vital — be it from a socioeconomic perspective or a health condition perspective. It provides an understanding of the levels of long-term conditions in some parts of that system, coupled with other challenges faced by a population, and this helps to see where adoption can be improved. For example, in areas of high deprivation, access to medicines and access to services can sometimes be limited. Looking at NICE technology appraisals, adoption can provide insights to consider communications as well as the guidelines for access in affluent areas as well as in deprived areas.

There is also the need for systems to change the narrative around cost pressures being a barrier to the adoption of NICE TAs, as they will enable an improvement in healthcare and reduce healthcare utilisation. By changing a community's access to healthcare at an earlier stage and using medicines and intervention not just as a treatment, but as a preventative measure, will make sure that the healthcare utilised today is different of that tomorrow, with long-term cost savings.

To be financially ready, the system needs to understand the financial pressures and gains across the whole pathway as there could be an increased cost in one area that is offset by a gain in a different part of the system such as reduced emergency admissions, GP appointments or pressure on social care.

To have a sustainable NHS, there needs to be a change from looking at the short and medium term to looking at the long-term impact which is a big challenge with so many immediate pressures on the healthcare system. But system leaders need to present the long-term for a long-term sustainability plan. There is an opportunity for pharmacy professionals to change the scope and narrative of what medicines mean.

How industry can support making Chapter 3 a reality

Chapter 3 is a framework to deal with the affordability of medicines, by setting out the NHS and Government's spend on medicines for the next five years, creating some predictability.

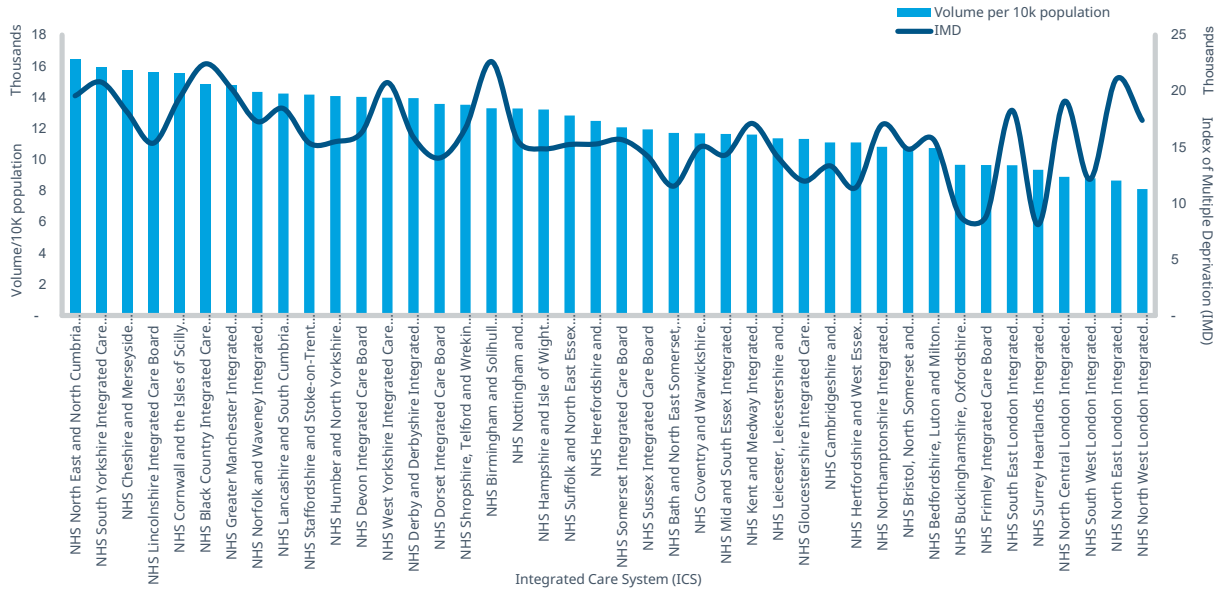
Globally, it is a very competitive marketplace for launching new medicines and industry will prioritise where they launch a medicine and where they carry out the clinical trials. Many organisations come to the UK to launch medicines which helps contribute towards affordability, but in return establishes some high level medicines policy elements that creates shared ambition. Although it is a challenge to understand how these filter down to every part of the system as it doesn't impact local budgets.

A measure of Chapter 3 will be if this deal remains successive over the coming years. If the right policies on adopting cost effective guidance are in place and clinical leaders are looking at medicines as a way to treat patients but also to save money and build in long-term investments in the right medicines.

If the balance is right, patients in the UK should be able to receive the best innovative treatments (that patients

Uptake of respiratory* medicines at Integrated Care System (ICS) level and how this correlates to deprivation[3]

Uptake of respiratory medicines by ICS (per 10,000 population) overlayed with Index of Multiple Deprivation (IMD)
Directionally, ICS's with a low deprivation index have a lower uptake of respiratory medicines



* Respiratory medicines are defined as any medicine categorised in the "R03 anti-asthma and COPD products" Anatomical Therapy Class (ATC)
Source: IQVIA Regional Prescription Analysis (RXA), volume, MAT Feb 2024

This analysis measures the volume/10k population uptake of anti-asthma and COPD medicines (defined by Anatomical Therapy Class R03) for the 12 months to February 2024

get elsewhere). In the past it's proven difficult to take forward some agreements and initiatives at scale across the whole system, but there is an opportunity to learn from that now. Chapter 3 of this scheme is more defined which should support implementation.

Chapter 3 can hopefully accelerate the adoption of NICE technologies at which IQVIA will continue to track through prescription data — which should provide a clear improvement in the time it takes to get uptake for NICE approved technologies.

What are local systems looking for from industry?

The ICS inception is a real opportunity to reimagine the relationship with the NHS and Life Sciences.

ICSs have the shared goal of addressing health inequalities. The narrative therefore is focused on working with any partner or stakeholder that aligns to the priorities of the system and this enables new and different working relationships with Life Sciences.

There is an opportunity to create a relationship that binds colleagues together to deliver higher quality services. Some ICSs are already working with industry through a service provider to deliver, for example, a clinical pharmacist to carry out diabetic reviews; an initiative sponsored by Life Sciences, but led through a service provider for a collaborative approach.

This is an opportunity which enables Life Sciences and the NHS to set their own benchmark in terms of what the relationship looks like. There are different ways that relationships can be fostered at the early stage and then developed, but the key priority is that industry and the NHS share a mutual ambition to improve population health, to address health inequalities and to make sure that the NHS money is spent well and there is a real value for money. This can absolutely be done together.

There are historically some challenging perceptions from some employees within the NHS about working with industry and this can create some barriers, although the pandemic was an opportunity to see the real difference Life Sciences made to developing vaccines and treatments.

Patient Support Programmes

The Patient Support Programmes (PSPs) are themselves a vehicle to empower and engage patients in their own healthcare, but they need to be set up in a way that is seamless and facilitated. PSPs would typically address the three key challenges that we face in healthcare; knowledge, skills and capacity. This is multifaceted and patients need to be engaged at the right part of their journey with the right tools to be able to effect change for themselves.

1. **Knowledge** and understanding of which patients need what type of intervention at what time. The key is how to identify those patients to start with and how are they empowered to prompt that part of care for themselves.
2. **Skills** refers to the capability within the NHS — who has the skill set — to treat the patient and to provide optimal care.
3. **Capacity** is a big challenge currently. There is a large backlog in care and the shadow of the pandemic is still hanging over the NHS. For a patient to access timely treatment, the health system needs more capacity for treatment.

The true value in a PSP is how often it is utilised and what benefit it brings. The people who benefit from PSPs receive earlier diagnosis, more rapid access to treatment, seamless escalation through treatment pathways and improved safety and efficacy of treatment.

The funding of PSPs can vary. Some may be funded by the NHS directly — many initiatives are — and others

are funded by Life Sciences and MedTech industries that bring value in their area of the pathway where they have specific expertise.

How would you define a PSP?

The government definition of a PSP[4] does not actually define what many current PSPs are which is challenging.

Deloitte offer a more accurate definition which is more applicable to the current models of PSPs[5]. There is a question around what definition VPAG will use for PSPs - will it involve supporting access to medicines through patient activation and/or enhance medicine usage and engaging patients to support adherence for increased effectiveness? It should include data collection to demonstrate impact.

There is a patchwork of evidence about PSPs, who is responsible for them, where the governance sits, what the outcomes are, whether they are running according to certain protocols and the clear evidence of their effect. So, there's an opportunity to collect and properly assess all of the programmes across the whole of the medicines industry.

NHS England do not directly manage all of these programmes themselves, often they are managed across other parts of the NHS, so there is an opportunity to take stock of this, to share best practise (across NHS and Life Sciences - not just through an NHS lens but what is most impactful for patients), cut out duplication and to ensure that the investment (there may be a lot of time and money invested) is achieving better outcomes and that those outcomes can be spread more widely.

The NHS frequently funds PSPs directly which means these clearly add value to patients and industry can provide additional expertise working collaboratively to ensure patients have better and equal access to medicines. PSPs are a beneficial initiative and there will be more to learn in terms of the opportunities once the data starts to be built up.

Who is implementing Patient Support Programmes?

IQVIA have a national team of clinicians including pharmacists, nurses and other allied healthcare professionals, delivering patient support programmes, looking at guideline adoption, accelerated access to treatment or supporting patients on treatment, either virtually or in a patient's home - helping facilitate training on injection techniques, delivery of treatment and monitoring of treatments for efficacy and safety.

Some of the IQVIA programmes involve supporting guideline adoption into long term conditions. A well-publicised area is in atrial fibrillation and helping to adopt CG 180 guidelines into general practice

in the Northwest of England where overlaying the guidelines onto clinical practice and helping to drive adoption resulted in a 22% reduction in stroke incidents within a 12-month period of which learnings were shared nationally through NICE shared learning zones and the anticoagulation association.

Case Study — Reducing the backlog of care for phlebotomy services:

Following the COVID-19 pandemic, NHS Trusts were struggling to carry out blood monitoring required to ensure safe treatment of patients. Lack of capacity was resulting in delays in initiation/delivery of critical oncology treatments for a client with an innovative cancer treatment. Patients were frustrated due to lack of access, and anxious to visit established healthcare environments at the height of the pandemic. IQVIA proposed the provision of a home phlebotomy service to take blood in a safe and comfortable environment.

The service was implemented within the current nurse/ Phlebotomy teams and available to deploy

immediately, allowing patients to start/continue treatment while the NHS was still under significant pressures.

This programme reduced the requirement for hospital visits for patients, resulting in reduction in the risk of infection, reduced disease burden on the NHS, reduced patient costs for travel to phlebotomy centres, and ultimately a reduction in delays in treatment pathways. These significant benefits to patients, the NHS, and cost saving improved efficiencies, reduced capacity constraints, and resulted in significant numbers of new patients enrolled monthly — the 6-month service was extended by a further 18 months.

The impact of Patient Support Programmes

IQVIA have a strong philosophy of learn nationally, share locally and as a global human data science organisation, can implement both at a local and national level.

By looking at all of the successes throughout the inception, delivery and outcomes, there is an opportunity to blend different factors to build strong solutions that enable patients to get better access to treatments in a timely manner. Allowing this to be shared through Chapter 3 will be impactful.

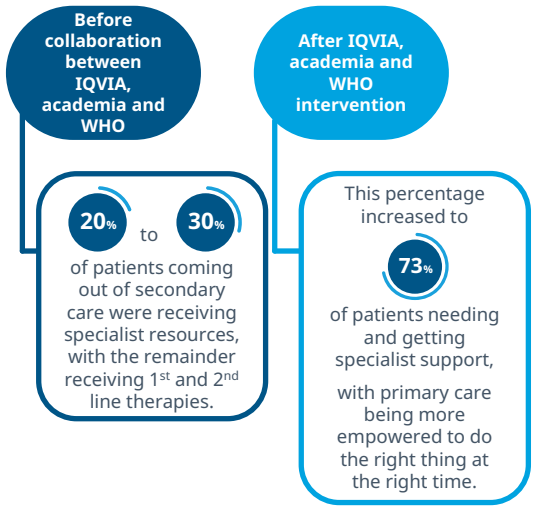
Over the past 12 months, IQVIA have been delivering a respiratory patient support programme that has been looking to identify patients using inhaled devices to make sure that they can use them efficiently and effectively and that they're using them in a sustainable manner. This supports a cost effective and sustainable NHS. The initiative reached 11,000 patients last year and prevented waste of around 50,000 devices which has a significant carbon impact.

Other initiatives have involved IQVIA working and collaborating with other agencies, for example bringing together academia and the World Health Organisation (WHO) to shape a bone programme looking at the pathway to involve patients in the right part of the pathway at the right time. This was a primary care delivered initiative, but solving a problem that was apparent in secondary care as patients should have been managed within primary care but weren't empowered to do this in the primary care pathway.

This programme included patients with low bone density, including hip and vertebral fractures or repeated low top trauma fractures, such as osteoporotic osteogenic patients. These patients were appearing in secondary care, but being prescribed therapies which could have been prescribed in primary care, and therefore the patients who were in need of access to specialist support were unable to receive it as so many patients had been referred for treatments they could have received in primary care.

The profile of the patient who should be presenting at secondary care was redefined. Before this intervention, 70 - 80% of patients coming out of secondary care were receiving first and second line therapies and only 20 - 30% of patients receiving more specialist resources. Post intervention that changed to 73% who were needing and getting specialist support, and therefore needed intervention and importantly primary care were empowered to do the right thing at the right time in the patient pathway.

Collaborative bone programme to ensure patients are involved in the right part of the pathway at the right time



Patient Support Programmes add huge value and can be a critical part of population health prevention, productivity and improving health equity.

Conclusion

VPAG Chapter 3 provides an opportunity to improve the uptake of NICE technologies at a local level with a focus on improving the visibility of Patient Support Programmes and increasing equitable adoption of new and innovative medicines.

System readiness, system architecture and financial readiness are key to improving the adoption of a positive NICE as without these being in place there can be increased delays, increased financial pressure on the system and inequitable access to healthcare.

Work previously published by IQVIA[6] shows that the higher the deprivation by ICS, the lower the uptake of NICE approved medicines. So equitable access within healthcare needs to be considered throughout planning and implementation.

PSPs can assist with the uptake of NICE approved medicines by providing support where there are gaps and challenges that need addressing to enable adoption. PSPs add huge value to the healthcare system and can be a critical part of population health prevention, productivity and improving health equity.

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