A guide to joint working between NHS and industry
At Novo Nordisk, we are committed to fighting diabetes and advancing diabetes care for the benefit of the growing numbers of people living with diabetes. We must continue to make progress in the fight against the diabetes pandemic.

However, change will not be achieved by working alone.

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We share the desire to focus on improving outcomes for people with diabetes, providing a higher quality of care and better management of their condition. Only by working together and ensuring that people with diabetes are given a voice, we can look to change the future of diabetes.

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Time to bury old stereotypes

At the height of the political expenses scandal in 2009, a national survey found that only one UK profession was trusted less than MPs – and that was journalists. In an era of stereotypes, one can only assume they missed ‘pharmaceutical executives’ off the questionnaire.

Trust, in any profession, is a vital component. The pharmaceutical industry knows this only too well – it’s been battling the issue for many years. If the papers are to be believed (oh, the irony!) there are few industries trusted less than pharma.

The media has, unfairly, been giving the drug sector a bad press for eons – despite its considerable contribution to society as a whole. As the industry’s main mechanism for getting messages to market, medical sales professionals are often accused of being at the root of the problem. “Trust me, I’m a drug rep,” doesn’t sound terribly convincing.

In 2009, Pharmaceutical Field (PF) ran an interview with former ABPI President Chris Brinsmead, now the Government’s Life Sciences Business Advisor, who said that the future role of the field force would be to facilitate NHS/industry partnerships – but for that to succeed, the industry would need to address the issue of trust among its customer-base. He said that the sector must look at its ‘behaviours’ and be open and transparent in its engagement with the NHS.

It was within this context that the idea for Partnership in Practice (PiP) was conceived. In the spirit of transparency, PiP has been developed for, and delivered to, readers on both sides of the apparent ‘divide’. The publication comprises perspectives on the evolution of joint working from both NHS and industry thought-leaders. It attempts to define partnership working and what is driving it. It examines the regulatory environment, setting the parameters for what can be done. And, crucially, it showcases real examples of joint working in today’s marketplace – true partnership in practice.

These case studies demonstrate the significant benefits of collaborative working and how mature and trusting relationships can deliver meaningful outcomes for patients. But examples are sadly all too few.

To progress, it’s clear that levels of trust between industry and NHS still need to improve. A recent online poll of medical representatives showed that a lack of trust in the industry was the biggest perceived barrier to facilitating NHS/industry partnerships. Cynics will dismiss this as a convenient smokescreen to explain a lack of real progress in developing the partnership agenda. It’s a pretty safe excuse to hide behind. But pharmaceutical sales professionals should be better than that. And so should the NHS.

The issue of a lack of trust between pharma and doctors is a red herring. Historically there has been a strong collective relationship between clinicians and industry. There has been contact, dialogue and genuine collaboration.

Arguably the barrier has been at NHS management level where, it would seem, a deeper scepticism of industry still exists.

The NHS landscape is, of course, changing. Assuming the Government’s stuttering reform programme survives parliament, PCTs will soon disappear and new healthcare decision-makers will emerge. But the opportunities – and the need – for progress are now. And they are shared opportunities.

The quest for efficiencies is driving a greater need for partnership and, as such, the willingness to work together will no doubt grow. In turn, the drug industry must continue to demonstrate its value in the delivery of healthcare and build transparent business-to-business relationships with its customers. For the good of patient care. Hiding behind old and clichéd stereotypes will get us nowhere.

This is, of course, just my view. But as you know, you can trust me, I’m a journalist.

Chris Ross
Editor
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PERSPECTIVES

Don’t waste the opportunity
Mike Farrar outlines a strong evidence-base for joint working.

A problem shared
Mark Wilkinson looks at how effecting meaningful change cannot be a solo pursuit.

Building from base camp
Dr Richard Barker describes how the pharmaceutical industry is changing to meet the needs of its evolving customer-base.

“It’s about the patients, stupid”
The driver for joint working between NHS and industry is simple: it’s all about patient care. Anthony McKeever reports.

Time to wake up
Omar Ali says the current paradigm for joint working is not fit for purpose.

Pharmacy: a protocol for partnership
Partnerships between industry and hospital pharmacy are a rare commodity. Mark Harries outlines why it’s time things changed.

Building business-to-business relationships
Anna Gibbins looks at the maturing relationship between industry and the NHS.

Getting real – opportunities for joint working
Jean-Francois Delas presents the story so far with joint working.

CASE STUDIES

Improving care in COPD
A joint working project between Weanside PBC and GSK.

Getting sorted in diabetes
A joint working project between NHS Diabetes, Leeds Metropolitan University and Novo Nordisk Ltd.

Commissioning for outcomes – the Balanced Scorecard
A joint working project between Wakefield PCT and MSD.

REGULATION

Playing by the rules
Steven Gray looks at current ABPI regulations for joint working.
There are some compelling reasons why now, more than ever, the NHS and the life sciences sector in the UK should start to explore working in partnership. Primarily, there is a huge opportunity for the UK to get real competitive advantage in the world market if both sectors are able to forge a better collaboration than that which we currently have. Some of the drivers for partnership are borne of significant negatives; the waste of ineffective prescribing, which leads to poorer outcomes and greater use of resources for patients; the waste in terms of pain or additional suffering that people endure as a consequence; the wasted resources spent by the life sciences sector in developing innovative technologies that simply don’t get applied; and the waste of development costs that are so (unnecessarily) high that companies have to try to recoup them through their pricing – which only exacerbates the problem.

If we can turn that around, the prize is enormous. We’ll have a health system that is efficient, gets superb outcomes and delivers a great patient experience. We’ll have a life sciences sector that has more resources to plough back into its development phases. And we’ll have an industry that can compete on a global stage to attract more investment, creating more jobs and more opportunities for the UK.

An additional driver is, of course, the economy – and in the case of the NHS, the QIPP imperatives. The need to improve quality and productivity while finding substantial cost-efficiencies in the system is undoubtedly fuelling greater interest in industry/NHS partnership. Necessity is, after all, the mother of invention. People are focusing on joint working now because they have realised the consequences of not focusing on it in the past. Does it matter if people are exploring this now because economic constraints have forced their hand? No. Joint working is at long last being given some sensible consideration, and that can only be a good thing.

But whilst the economic situation can be regarded as another catalyst for further exploration of joint working, it would be inaccurate to suggest that the concept itself is about reducing waste and minimising costs on both sides. The positives of collaborative working are such that they deliver sustainable long-term benefit.

What is joint working?

In simple terms, joint working is a clear
business-to-business relationship where
the benefits to both parties are identified
in terms of the opportunity. It starts with
agreement on a common core purpose and
is underpinned by joint architecture that
can deliver the mechanisms for that core
purpose to be achieved. And critically, those
mechanisms are supported by incentives
that are aligned so that both sectors can
immediately benefit as a consequence of
doing the right thing by each other. So the
three key elements of joint working are:
- Common purpose
- Compatible architecture
- Aligned incentives

The common purpose must be patient care.

Building relationships
The relationship between industry and the
NHS has, for many years, been perceived to
be an adversarial one, best characterised, at
least anecdotally, by the image of the ‘pushy
drug rep’. But attitudes on both sides have
begun to change. There is now a much
broader understanding that prescribing
plays a massive part in care pathways and
that without effective prescribing as part of
an overall care package, some of the
other interventions being made can be
undermined. As people have begun to
understand care pathways, an increasing
number of examples demonstrating the
value of a good relationship have emerged.

The Exemplar example
One such example is the North West
Exemplar on the time, speed and reliability
of setting up clinical trials. For some
time, the UK industry has been losing
worldwide share of clinical trials. The NHS
has become safety cautious, our research
governance has become bureaucratic and
the importance of speed and reliability has
been underestimated. As a consequence,
we’re not competitive in those areas and
people have begun to invest resources in
clinical trials in other countries. In the North
West, we decided to do something about
it. We got all of the research-intensive
organisations around the table with the
NIHR Clinical Research Networks in the
North West, and agreed to offer drug
companies the opportunity to see what we
could do to become amongst the best in
Europe.

To date we have taken 20 clinical
trials into the Exemplar programme:
pharmaceutical companies have put their
trials into the North West. All of those
trials have been global ones, and we
have recruited the first global patient into
seven of them, outperforming the world.
Our speed in delivering the permission
to get those trials up and running has
improved from an average of over 100
days to around 50 days. Effectively, this
is comparable to the best in Europe.
These trials are now being done faster,
more reliably and recruiting as well as
anywhere in Europe. We now plan to roll
out the lessons learned from this initiative
nationally. The pharmaceutical industry
gave us the chance to prove what we
could do with their trials and, in return,
we’ve shown that through the NHS, we
can not only compete with our European
counterparts, but we can beat them. It’s a
huge win-win.

It is becoming increasingly clear that
joint working is important – but it is not a
magic wand. Success is about hard work,
and appealing to hearts and minds. The
‘minds’ aspect is very straightforward.
Evidence is emerging that failure to address
the issues we face is costing money, is
wasting opportunity and, in some cases,
is creating an economic problem as
companies withdraw their support for the
UK. On the ‘hearts’ side, we must continue
to demonstrate the benefits of what can
be achieved by working together so that
we provide almost a moral obligation that
everyone should be exploring it.

Making this work is a collective
responsibility. In a changing NHS it is
no easy task. At the NHS Life Sciences
Innovation Delivery Board our challenge
now is to pitch this into the new
architecture – we are looking at how we
can use GP consortia and the National
Commissioning Board to get effective
arrangements for partnerships in place. As
new leaders emerge, how do we ensure
that the National Commissioning Board,
for example, recognises the opportunity we
have got with life sciences? At GP consortia
level, how do we frame it so that when they
inherit the commissioning responsibility that
they are using evidence-based practice to
push prescribing improvements – and finding
a way to engage with industry around
strategic partnerships?

In the short term, there is the risk that
the new reforms destabilise some of the
areas where we have already made progress
with the partnership philosophy. But the
benefit is that in the ‘new world’, there’s
an opportunity to build in what we know
works well and to make it the norm rather
than the exception. The Commissioning
Board wants to judge people by outcomes,
which means they will need evidence-based
interventions. NICE Quality Standards are
going to inform the way consortia do
their work, which creates an opportunity
for partnership as individual GPs look for
improvements in their prescribing practices.
There are real gains to be made in primary
care. So too in R&D, where there are great
incentives – in terms of productivity, quality
and patient care – in forging joint ventures
with the industry.

The future
Critics will say that we’ve been talking
about the opportunity for more than 10
years, and we’re doing so now. And they’d
be right. We are not yet at the stage
where we’ve reached the tipping point and
that this is the norm. But we continue to
demonstrate that this can be done. There
are increasing examples of productive joint
working, and not always in the field of
prescribing. There have been innovative
risk-sharing agreements. The debate
about cancer drugs has had an impact
on the public perception of the need to
demonstrate quality of life years and the
subsequent introduction of the Cancer
Drugs Fund. There are numerous examples
that illustrate how good prescribing as part
of a care pathway has led to reductions
in hospital admissions. And we’ve had a
continuous uptake in some new products
that have entered the market – statins
being a good example of that.

But there are still barriers on both sides.
There needn’t be. This is really good, easy
win-win stuff. When the NHS is facing
the prospect of trying to reduce services
and people look at the opportunity cost
of not working as closely as they can with
the pharmaceutical industry, joint working
should be the first port of call. It’s easy
wins, early wins, better for the patient,
better for the taxpayer and better for the
NHS budget – it’s a no-brainer. I would
strongly urge NHS professionals to consider
this quickly and constructively. If not, it
may get to the stage in the near future
when you’ll start to be asked questions
around why you are inappropriately
prescribing – which then becomes a clinical
governance issue about why you’re not
following evidence-based practice.

The evidence that joint working works
is already there.

Mike Farrar CBE is Chief Executive of
NHS North West and Chairman of the
NHS Life Sciences Innovation Delivery
Board, a DH position.
The UK health service is currently operating in a cold climate. It is no secret that financial constraints mean that, collectively, the NHS needs to do more with less. But, against a backdrop of significant organisational reforms, the task ahead is not an easy one. Going it alone will no longer be sufficient.

The battle to facilitate greater joint working between the NHS and industry sits within this challenging environment. Some observers may claim that it is the cold climate that is driving the need for partnership working between industry and the NHS, but this is only to a certain extent true. The partnership agenda predates the dramatic downturn in the UK’s economy. There has, for some time, been a recognition that the NHS cannot solve all of the challenges it faces and meet patients’ needs all on its own. It needs to innovate and collaborate.

But recognition is one thing, action is quite another. The NHS is beginning to show a willingness to open itself up to work in partnership with others. The challenge now is to ensure that the progress made in isolated pockets of the health service is spread across the whole of the NHS. It’s time for a joined-up approach to joint working.

The NHS Life Sciences Innovation Delivery Board was set up in January 2010 with three key objectives; to help increase the use of cost-effective medicines and medical technologies, to enhance the UK’s global reputation as an important location for clinical trials and product development, and to improve the strategic relationship between the life sciences sector and the NHS. Joint working can become a vital mechanism in helping us reach all three of these aims.

Improving relationships between industry and NHS is arguably the key to success. One of the biggest barriers to joint working in the past has been the perceived mistrust between the health service and industry – in particular pharma. This needs to be overcome. But it is, of course, dangerous to talk about the NHS as if it is one homogenous entity. In truth, the pharma industry has over many years built some strong NHS relationships with, for example, clinicians. There has been contact, dialogue, opportunities for collaboration and, where appropriate, sponsorship-based relationships. But...
contact between the industry and NHS organisations, in particular NHS management in PCTs and SHAs, has, in the main, been limited and is yet to reach maturity. In addition, although sponsorship remains permissible there is a growing recognition that the relationship needs to become more explicitly two way. The industry has needed to reach new customers such as medicines management, directors of commissioning, and GP commissioning leads. It has been these customers who the industry has needed to convince and they have different needs than simply seeking sponsorship.

**Reforms: a driver?**
The *Health and Social Care Bill* changes things further. There is a clear desire to empower clinicians, chiefly GPs, in making commissioning decisions. This promises to be good news for joint working. Pharma and GPs know each other well and have worked together productively for many years. Generally, GPs are innovative and open to new ways of doing things – so the introduction of GP-led commissioning could be a catalyst to push highly local and differentiated joint working to the next level. At the same time, other elements of the Bill, such as NICE setting Quality Standards and Commissioning Accountabilities, appear to suggest a more standardised, evidence-driven NHS and so will offer different opportunities.

So it’s clear that the environment around us is changing – but the challenge moving forward is not to be passive about it. We must embrace change, rather than allow it to become something that simply happens unto us. My own personal focus is on achieving change in the NHS to improve the quality of care and the benefits we deliver to patients. Partnership, and building the relationships between all parties, is a vital component in this endeavour.

So why is joint working important? The answer is simple: it can play a significant part in helping to improve patient outcomes. And as we move towards an NHS that is increasingly outcomes-focused, any mechanism that can help support that aim must be explored. There is already clear evidence emerging that partnership between NHS and industry can make a positive contribution. The benefits are manifold but, in the main, they can be broken down into three categories:

1. Benefits around medicines – making sure the right patients receive the right medicine at the right time
2. Benefits around services that are connected to medicines
3. Benefits around skills exchange – the opportunity for both NHS and pharma to learn from each other.

**Innovation**
To progress, we need to be innovative. In what we do and in how we think. Research shows that to be truly innovative, you need to be able to collaborate – to work across team boundaries, organisational boundaries or, in this case, public and private sector boundaries. The simple truth is that we cannot work alone – and we’ll be able to do much more if we have a conversation. That’s a key argument for joint working.

Being innovative does not require the development of revolutionary new concepts. The challenge for the NHS is not to find new inventions, but to spread out what we already do in pockets and ensure it is applied more consistently across the health service. There are many examples of good practice, but too often they are isolated. The task is not to come up with 50 new ideas, but to take the best of the things that we are already doing and to apply them further and faster across the whole service.

Ensuring partnership not only happens but, more importantly, works needs to be a collective responsibility. The definition of innovation is ‘change for the better’ – and so if we assume that everybody wants to continually improve services, it’s clearly in everyone’s interest to innovate to make things work. Historically, some organisations have been resistant to change and have placed obstacles in the pathway of partnership. This has only made the challenge harder. Most PCTs have policies that govern working with the industry – those policies don’t say you can’t do it, they talk about how you should do it. In some ways, this can imply that joint working is risky or dangerous – but the greater risk comes from not considering it at all. NHS leaders are now starting to give permission to this topic. The main premise of *Liberating the NHS* is that there is a whole set of clinicians that want to do the best they can to change things for their patients – it is the job of managers and others to set them free and not get in their way.

**A contact sport**
So how do you move this forward? Progress needs to start with dialogue. Partnership is a contact sport. It’s all about building relationships. The best joint working schemes have been where people have developed a mutual trust and, as a consequence, started to identify areas of common interest. Collaborative goals are important. NHS and pharma need to find those out. But individual NHS professionals must not wait for the opportunity to come to them. Traditionally, pharma has always made the first move and there are few examples the other way around. We need to move away from the concept where pharma proposes and NHS opposes – it needs to become a more equal arrangement.

In the present environment, an increasing number of NHS organisations are becoming more open to the concept of joint working and, as a consequence, more receptive to approaches from pharma companies. But change will not happen overnight. Partnership working is a cultural shift that depends upon changing attitudes that have accumulated over 20 years or more. The current resource climate, however, is a source of momentum that we must all grasp – we need to be open to try new things.

At an individual level, the message to the NHS is clear: joint working provides a real opportunity to effect meaningful and positive change within your local health economy. At the very least, it should be considered. Ask yourself what are the biggest challenges you face in improving NHS quality and productivity. What are the things that are keeping you awake? Once you have identified them, try speaking to people within the pharma industry to explore whether they can help you meet your objectives. At the end of those discussions you’ll need to decide whether there is something of value that you can do together to address those challenges in partnership.

Collectively, the NHS must find its own voice in the argument for joint working. Failure to explore it risks missing out on the opportunity to improve health outcomes for your patients. These are challenging times. But, as the saying goes, a problem shared…

Mark Wilkinson is Director for Life Sciences Innovation.
The role of the pharmaceutical industry in relation to the National Health Service is moving quite rapidly from mere supplier of innovative products, to a genuine partner in delivering better health. Not only is the industry gearing itself to think in that way but also, increasingly, the more enlightened parts of the NHS are thinking in that way too.

To date, the ABPI, as well as individual pharma companies, has run a number of projects that have been focused not on improving the sales of products, but on improving health outcomes for patients. In many areas, finding and treating patients that have not been adequately treated does, of course, boost sales of products – but joint working as a whole is a mutual interest for the industry and the NHS. Moreover, it is a refreshing change from what one senior NHS manager described as ‘trench warfare’ – the familiar situation where the industry promotes its products and PCTs try to counteract it. This is a very unhealthy relationship to have with any customer, and it’s one that has long needed to change.

The journey towards widespread joint working between the NHS and the pharma industry is long and ongoing. But, in a volatile UK marketplace where the ability to deliver healthcare is being outstripped by growing demand for it, the pursuit of partnership is a worthwhile one. Dr Richard Barker describes how the industry is changing to meet the needs of its evolving customer-base.

Building from base camp
The current economic climate has meant that making that change is ever more important. There is a growing gap between the healthcare we’d like to provide and consume, and that which we can afford. We face a future where we are going to have increasing difficulty in paying for all the healthcare that we want. So how should the industry be seen in that environment? It can either be seen as added cost, or it can be seen as a partner working jointly on disease burden. In almost all diseases, the pharmaceutical is a minor cost – but it also a high and, in some cases, discretionary cost. If the industry is seen as a source of cost it will suffer badly as a consequence in the current environment. And so will patients. But if it is seen as a partner in tackling the burden of disease and therefore the appropriate pharmaceutical is recognised as a key part of an effective care pathway, then there ought to be some mutual benefit. The challenge is to get the right medicine at the right time for the right patient. In this regard, joint working could be a win-win for the NHS, the industry and the patient.

But this is a mindset shift, and we are not there yet on either side. We are merely at base camp. Of course, you have to get to base camp – it's often hard work getting there and you might need to rest a little when you do - but there is much further to go. The ABPI has been part of around a dozen very exciting and largely productive joint working projects. Likewise, there have been other companies who have developed their own innovative partnership projects. We are beginning to count the benefits. One project, for example, saved £170,000 in a single PCT alone. But in terms of the penetration of the NHS with projects of this nature, we’ve still got a long way to go.

So how do we change the mindset? Attitudes change one person at a time and, in my experience, they only change when there is a personal encounter. Sending people emails won’t change their attitudes. The joint working toolkit is a valuable resource, but it won’t change attitudes. What changes attitudes is when people in the industry who have a broad view of its mission meet people in the NHS that have a problem they need help in solving. Progress is going to be based on that approach. And it’s going to be a hard slog.

There has never been any expectation that partnership working would be mandated. Sir David Nicholson and his colleagues at the top of the NHS are not forcing people to do joint working. But they are encouraging of it. And as the health service evolves through the latest reforms, we anticipate this support will continue. The reforms themselves perhaps dictate an even greater need for partnership.

Attitudes on both sides have been barriers to progress. Transparency and shared goals are key. Mutual understanding, respect and a joint focus on the patient must underpin joint working.

The Health and Social Care Bill brings with it new challenges for the joint working movement. The industry needs to make the transition into the new NHS environment. All of the players are shifting. We’ve got to base camp on the older NHS, but now we need to form a similar base camp on the emerging NHS. How do the clinical commissioning consortia see joint working in the new world? We must engage with them to find out.

The industry is changing. It knows it needs to prove the value of its products, not just their uniqueness. That value has to be in terms of improving the pathway of care and the outcomes for patients. If the new clinical consortia are going to be measured by outcomes and the industry’s products are going to be valued according to their outcomes, there’s an obvious marriage. We should be sitting down together and talking about how we can improve the overall outcomes by creating value pathways, not just value products. That should be a natural conversation – and it should be a win-win.

Of course attitudes on both sides have, in the past, been barriers to progress and getting the ‘marriage’ to work. So how do we overcome that? Transparency and shared goals are key. Mutual understanding, respect and a joint focus on the patient must underpin joint working – and that's something we've worked hard to address. One of the ABPI principles in applying the Code and in engineering and designing our joint working programmes is to ensure that the patient is always at the centre. If it's the right thing for the patient then that should be an identity of an objective for the NHS and the industry.

But the industry cannot force the agenda. It needs to understand the pressures on its customers, the constraints consortia will have and how they will be measured. And it must gear its message and its joint working to those constraints and those objectives. Like any good marketer, industry professionals need to work back from the customer’s goal to define their approach and marketing strategy. In this case, of course, the customer has changed and so too have their goals. Our marketing strategies must change too.

The roles within industry, not least the field force, need to be redefined. In some parts, this is already happening. Almost all the progressive companies are reorienting their medical representative force. In fact, the term ‘sales force’ is actually outdated – if it were ever applicable. Representatives have only ever presented the offerings of the industry to their customers. Increasingly their customer-base includes people who are not prescribers but are instead ‘payers’. Demonstrating cost-effectiveness as well as clinical value is an imperative. The industry needs to deploy ‘value-oriented account executives’ rather than sales people. And they should be focusing on access – because that’s what they are there to ensure; to maximise the chance of the patient having access to the right products. The facilitation of joint working projects can become a crucial part of the role.

But for now we remain at base camp, and the ascent towards joint working becoming the rule rather than the exception will take time. As the NHS faces up to a significant reorganisation, the temptation to wait until the transition is complete is great. But caution now could prove costly. The time to shape attitudes is at the beginning. The industry, through the ABPI, should be engaging with the new commissioning consortia in order that attitudes are shaped healthily from the start.

It is vital that the new consortia, and any other structures that are created, see the industry as a partner in joint working to address the key disease burdens. And that we leave behind, both of us, the attitudes of the past.

Dr Richard Barker was Director General of the ABPI from August 2004 to May 2011.
A few years ago, I was interested in getting the pharmaceutical industry to take over responsibility for the whole range of diabetic care for Bexley’s patients. We explored a Programme Budget approach which would have enabled pharmaceutical companies to offer services, not just products, to diabetes patients. The industry was not interested – we did not receive a single offer. The companies were probably wise and, at that time, it was perhaps a good thing that we didn’t proceed along that route. But, as far as I can see, in a few years time that will be the way to go. And the industry will not be able to stand back. NHS reforms are moving us towards an environment where GPs in areas such as Bexley might wish to buy a seamless service for diabetic patients from one body that coordinates all elements of care. At that point, the industry is going to have to decide whether it is into service or product. At the moment, in terms of partnerships, the rhetoric is running ahead of the reality. There are a lot of things going on in the NHS that are mainstream, but joint working isn’t yet one of them. Why? Because despite it being in everyone’s best interests, the benefits of partnerships aren’t transparently obvious enough to everybody at present.

Here at Bexley, we are open to partnership. Like many PCTs, we’ve implemented all of the best practice policies that reflect the national guidance that has been issued around joint working. And we have provided a framework to help our clinicians to do it correctly. Although at this stage I cannot point to a myriad of examples, we support the principle and we are open for business.

Nonetheless, encouraging progress has been made. For example, in partnership with pharma, we’ve been developing a community model of diabetic care that has really helped to engage our patients. The new model means that none of Bexley’s diabetic patients need visit a hospital in future, except for one of eight complications. And if they do need to visit a hospital, it will most likely be a teaching one. Everything else they can get from a General Practice near their homes.

Bexley recognised that a critical aspect of building a community-focused diabetes service was the need to improve our patient education. We invited pharmaceutical companies to work alongside us and, in that instance, Novo Nordisk came forward and agreed to work with us to improve patient information and education. They have been a great partner for the health

“It’s about the patient, stupid”

If historical adversarial relationships between industry and the NHS have blighted the progress of joint working, the lack of a clear definition of partnership has further complicated its development. But, as Anthony McKeever explains, the driver for joint working is not only simple, it goes beyond the politics of traditional industry/NHS relationships. It’s about the patient, stupid.
service and its patients in this part of the world, and have helped us introduce a revolutionary way of delivering patient education. We've seen around a 20% increase in take-up and outcomes that are way above the national average. Figures show that, nationally, there is something like a 3% improvement in patients' HbA1c levels after they have been through a patient education programme. In Bexley, HbA1c levels have improved by 15%. And that's attributable to how well the patient education was done. We could not have achieved that without a pharmaceutical partner. And Novo's people are on line for a bonus themselves – because their own pay is linked to delivering agreed results for the NHS and its patients.

Likewise, we have made real progress in COPD and smoking cessation working in partnership with Pfizer. As with the diabetes example, the industry has brought with it knowledge about patients and pathways, social marketing and a whole range of expertise that has helped us improve what we do for our patients – and been great partners in that way. In both examples, the industry has provided skills and resources in areas where the NHS has traditionally not been strong – and they've been good partners because we've worked with each other like grown-ups.

One barrier to ensuring that the benefits of partnership are transparent and obvious to everyone is, perhaps, defining what it is. At the moment, despite the guidance and initiatives such as the ABPDH Joint Working Toolkit, there is no settled definition. This has potentially created a confusion that betrays the opportunity. My view is that the definition is a simple one. Partnership is about doing stuff together that works for patients and is successful and rewarding. That's a very basic definition and human-speak for something quite complicated in management terms. But I actually think that we need something as simple as that. Whatever the definition, the need for joint working has never been greater. Make no mistake, in the current environment partnership is vital. It will soon be about success and survival. Partnership isn't a grace-note on the edge of an orchestra playing: it's the song. "It's about the patients, stupid." In my view, we should be talking to (and working with) anybody that wants to engage on improving things for patients, providing they aren't trying to take advantage inappropriately from it. And it doesn't matter who it is – whether it's the police, the LAS, hospitals, pharmacy or drug companies – the NHS can't afford hang-ups; we must talk to anyone who can help us improve things for patients.

It would be churlish to suggest that Bexley is exceptional at joint working – or anything else, except perhaps putting GPs in the driving seat. I don't think it is. We've set the conditions, are trying to make some headway and have made some progress. But there is much more to be done. The challenge is to 'put the want' into people's work, and to show all the stakeholders how partnership is in their best interests.

In terms of the industry engaging with clinicians, there are four key drivers. Pharma professionals need to demonstrate:

1. How a partnership is going to help clinicians improve the quality of care they deliver for patients
2. How it is going to improve their working life by taking time pressures off them, rather than giving them more to do
3. How joint working will reward them in terms of the respect of their peers
4. How it will improve the resources available to them – both in terms of the local health budget and their personal finances.

The same drivers apply from a medical representative's point of view. If we could come at joint working in this way, whereby both parties are able to see how working in partnership can improve patient care, make their working lives easier, enhance their reputation and deliver personal and professional rewards, it would help provide a common focus. We then end up with partnerships that work for patients, make everyone better at their jobs, give individuals credit for doing things that work and that pay financially. And this is the clichéd win-win that the rhetoric keeps on promising. To get there, though, requires adult conversations.

It is clear to me that in order for joint working to really take off, it's got to be seen to be in everyone's interest. One of the things that could be done to help it along would be to create a safe space to do it in – so that anybody who wants to build respect through results can do it through a safe channel. Somebody needs to create that channel. A kind of Clinical Commissioning Collaborative that produces results, 'business to business'. That would encourage people to step out, focus on it properly and drive things forward. What's more, it will enable Pathfinders who want to get things done to step into that space with the industry. The timing could not be better.

The industry is rapidly approaching a crossroads where it needs to decide whether it is indeed into selling products or delivering services, where products are part of a package of care. Joint working could be the perfect lever to create new opportunities for the NHS, the industry and, critically, patients."

"The industry needs to decide whether it is into selling products or delivering services where products are part of a package of care. Joint working could be the perfect lever to create new opportunities for the NHS, the industry and, critically, patients.

Anthony McKeever is Chief Executive, Bexley Care Trust."
It is also possible to access a copy of Partnership in Practice in digital format, for viewing on devices such as iPad and other tablet devices, or in page-turning PDF format on your laptop or PC.

To download your copy, visit www.pharmafield.co.uk or www.clinicalpharmacy.org.uk

Time to wake up

The current paradigm for joint working is not fit for purpose. The proposals outlined in the Health & Social Care Bill are driving a new transactional model for the NHS and provider agencies. To reflect this, the Joint Working movement must adapt and embrace more commercial principles. Omar Ali outlines why, in a competitive world, it’s time for pharma and the NHS to wake up and do business. Before the chickens come home to roost.
As widespread changes from the NHS implementation begin to take shape, it’s clear that the ‘payer customer’ is a key one for pharma. Although the Health & Social Care Bill will be reforming the transactional relationship payers have with their associated Healthcare Organisation – PCT/Medicines Management into GP Consortia and Hospital/Formulary Pharmacist into Foundation Trust or any willing provider – their role will essentially remain the same. The payer, as the name suggests, often holds the budget and subsequent final intentions for financial flow and commissioning (of prescribing and other related activities). Joint working with the payer can be fraught with tension and misunderstanding, and yet when harmonised, can deliver substantial returns to all parties and patients within the health economy. But there is significant work to be done to achieve a harmonious relationship with the payer – without which, life will be tough for all stakeholders.

**Why the poor history?**

For a moment let’s just leave the orchestra of joint working between pharma and payer and look at the simplest tenet of joint working: access. We see that despite pharma’s attempts at restructuring sales forces, introducing new levels of NHS liaisons and non-promotional scientific personnel, even simple ‘access’ to payers – in the world of prescribing, this will be PCT Medicines Management – has been a significant challenge. There are numerous cost models, rebates, discounts, partnership dossiers, value propositions and formulary packs – many of which will never enter into the sight of Medicines Management & D&T Formulary Pharmacists – having seen some of these, I can understand why, but at least I’ve seen them – many of my colleagues won’t even entertain this. We first need to look at why before we move on to how.

**Impartial, suspicion, prejudice & ignorance**

The NHS payer frequently fails to see the intended benefit of joint working. One Medicines Management Pharmacist once said to me, “I don’t need to meet the manufacturer of each breakfast cereal in order to make a choice of which product is the best for me.” This may be true, but given that most of us make this purchase without feeling the need to do so, there is a point: I eat this stuff every morning, I buy it for myself and all my family and I am fairly health conscious – but I still can decide for myself. The general message from medicines management appears to be: “I don’t need to be unduly influenced”. It acknowledges that they could well be influenced – but it also reflects a general ‘pushback’ from the payer to the manufacturer. “Just because I buy/or choose not to buy your product, I don’t see the need for a face-to-face with the sales rep.” For many, to entertain the first appointment regarding a new product, only to be told ‘I can’t discuss finance/economics/services now – you need to make another appointment at least 24 hours later’ is something that takes too long to understand, explain or be explained. This begs the question ‘how does this help joint working?’

If joint working is to be a success in the new NHS understanding roles and incentives is key. Trust is a game we haven’t yet won. Mutual gain is also open to deliberation. Many payers don’t see where the mutual gain is and even fear from mutual gain reflecting inappropriate reward. So despite numerous attempts at joint working documents, we are still biting the same old apple and for many, it tastes too sharp, too bitter or looks too stale to even attempt.

**Who promotes joint working?**

I find this levels the playing field. Who, in the end, really wants this? Like a bride at the altar, waiting, wanting, seeking – and with no groom in sight, it always appears that it is pharma that promotes joint working and puts in all the effort, trying to convince the payer it’s worth opening the door to it. Why don’t NHS payers promote it?

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**Like a bride at the alter, waiting, wanting, seeking – and with no groom in sight, it always appears that it is pharma that promotes joint working and puts in all the effort, trying to convince the payer it’s worth opening the door to it. Why don’t NHS payers promote it?**

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**Health reforms & the NHS payer**

In a nutshell, the NHS Payer – I’m focussing on Medicines Management for this article, but there are many other categories – is moving house. With PCTs set to dissolve over the next 12-18months, there is no PCT to employ the current Medicines Management teams. So who will be their employer? There are four emerging answers:

1. **Self-employed / GP Consortia (GPC)** employed – offering one-to-one medicines management services to GP consortia or practices or both
2. **MM team, project-based** – the MM team stays together, few losses, but essentially the GPCs ‘buy projects’ from the MM team
3. **Small company / LLP / Social Enterprise** – 2 or 3 of the MM team form a company or similar private agency and offer MM services to GPCs
4. **Big corporate** – the following companies are currently hiring PCT pharmacists in order to offer...
GPCs MM services at a corporate level: Ernst & Young, KPMG, Virgin Healthcare, Boots, Lloyds, AXA Medical and a number of US based HMO-modelled healthcare companies.

So here’s the deal – approximately 75% of the PCT advisers you now see will re-emerge in some form or other within the local healthcare economy, providing medicines management advice to GPCs under a contractual/transactional relationship (compared with the old model where the NHS budget was top sliced and subsequently funded MM teams). This means the pharmaceutical advisers are working for the GPCs rather than the ‘NHS’ in broad terms. This accountability means two things:

1. GPCs have more influence on direction and scope of MM team activities.
2. GPCs will be far more compliant to pharmaceutical advisers – they will be paying them very good money for advice – so you can be granted, they will follow the advice!

So how does joint working sit within this new financial arrangement? In my view, poorly. The current arrangement is not fit for purpose – it leaves innovative payers and pharma looking for new ways to work in order to bring about partnerships to reflect the new transactional nature of the New White Paper – and leaves others behind in a complicated and frustrating maze of paperwork, rules, and discord.

What needs to change & why
The NHS is becoming increasingly transactional. All GPCs need to be cash driven (not budgets) – they need to form as companies. All hospitals also need to be cash driven – they need to become Foundation Trusts or they will be taken over by one. The door to competition has been opened – the lowering and removal of the lower tariff collar on provider services and ‘any willing provider’ will stimulate alternative private providers for those GPCs ready to flex their muscles. The framework for patient co-payment, patient top-ups and insurance liability has increased dramatically and will be in place for Value Based Pricing (at the same time NICE loses its powers) in 2014.

Hence we now have a healthcare system that runs on cash, has no indicative budgets (ie you can’t be overspent, you just run out of money) and has a transactional framework. Within this framework, what has effectively happened is we are all now commercial organisations. Some have commented that the White Paper is privatisation through the back door – anyone who has read the White Paper, grasped it and is living and breathing the rapid changes can see clearly there is nothing ‘back door’ about it – it’s well and truly by the front door!

Now – in this arena – what does joint working look like? Well it’s no longer a cuddly, “Hi, I work for pharma, do you want to buy my drug?” It’s now transactional. It’s now commercial. It’s no longer about ‘saving NHS money’ (even the term NHS will slowly become a devolved ‘brand’) but more about income generation. Widespread NHS costs are a primary ethereal consideration – the drilling down will centre around two health economic models – provider & commissioner – and it’s at this level where new joint working needs to be aimed. It needs to be commercial and it needs to be transactional.

When a pharma company comes to see me they will be saying, “Hi, my name is X, I work for Y, and we are a commercial organisation”. In reply, I will be saying: “Hi, my name is Omar Ali, I work for X Foundation Trust or Y GPC Ltd or Z Corporation Medicines Management Services, and we too are a commercial organisation. And like you, we too are in the business of generating income – let’s do business.”

Until we can get to this point from both directions I fear for joint working, I truly do. It’s always viewed that pharma is here to help the NHS treat patients. The Payer then took it to the level where pharma was happy to state they could ‘save us money’. The Bill is finally commercial to commercial. We will both be working for companies. We will both be looking at income generation. You’re no longer selling anything to me – you need to be part of my business plan. And to do this – you need to help me generate income. This (rightly or wrongly) is what healthcare will become. And if you’re an FT or a GPC Pathfinder, it already has.

NHS Compacts
As we start dealing with many private providers in healthcare, the NHS needs a transactional template. Many of us are not sure how to proceed – many have had no experience of working directly with corporate agencies in such an intrinsic fashion. The ‘Compact’ has been developed to facilitate the NHS and corporate world to ensure there is a clear transactional contract with clear delivery and outcomes that form an ‘accountability agreement’. It’s all about effective partnership working but currently in the context of various healthcare organisations commissioning to/delivering for commercial agencies.

The seven effective dimensions of partnership working within a compact are as follows:

i) Culture
ii) Strategy
iii) Learning
iv) Leadership
v) Organisation
vi) Resources
vii) Programmes

It becomes a commissioning partnership – with understanding of roles and clear
lines of accountability. Historically and currently, joint working fails at the first hurdle. It seems we are not allowed to be explicit as to what we want – let alone be accountable to it. And if the framework doesn’t allow it – may I be so bold to say, the framework needs to go. NHS payers have no problems working ‘Compacts’ with commercial organisations as the transactional nature is clear, what each is to deliver is clear and accountability to deliver precise objectives is clear. Whilst I have worked some joint projects with these in mind, never have they been clear in transactional terms. That’s why the payer is reluctant. They want terms and conditions. And sometimes the ‘framework’ (ABPI, Company Compliance, etc) doesn’t allow it.

A few weeks ago, a good GPC chair of mine was being woned and dined at the Dorchester by a US-based health management company who, amongst other things, was offering to run their ‘prescribing formula’ for them at the price of a multiple 7-digit annual fee. This will become the way of the commissioning world. I myself have recently formed a medicines management provider company with three PCT advisers which, when the time is right, will be investing in GPC corporate educational events at venues which I have no doubt currently do not fall within any ‘code’ as we know it. None of these new providers are under any such constraints (and although all declaring interests will be stated). The world has just become the oyster for setting the canvas on which many a business proposition will be painted.

What worries me is that during these changing times, pharma and the ABPI have huddled in a corner (having no doubt considered all the environmental, systematic and procedural aspects) and have come out from their ‘enclave’ announcing the following new dimension to joint working as a shining light for all to follow:

no pads & no pens

From my humble perspective & viewpoint – this is an opinion piece remember – I have a one-word reply to this new announcement which in my mind reflects where I am with the current thinking on what’s being proposed as new joint working…

Irrelevant

Unless someone takes charge and leads on this in a real and commercial direction, reflecting the new transactional nature of the NHS and provider agencies, pharma will be left way behind (and I really mean way behind) as a relevant stakeholder within tomorrow’s healthcare.

Wake up, look around, and change the paradigm. Most of the barriers we payers create are around perception and trust. The ones you bring to the table are real, and like shackles – they will soon become unworkable and irrelevant. It’s time for urgent change.

Omar Ali is Formulary Development Pharmacist for Surrey & Sussex Healthcare NHS Trust.
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Remember, it’s a jungle out there...

Stalking in

new territories?
Securing reimbursement and early market access is a priority for cross-functional brand teams. Success depends not only on the communication of marketing messages to target customers in and around the launch phase, but also, more crucially, upon effective clinical trial design and patient recruitment many years before it. Supply and demand views of product development must be linked in order to target drug development expenditure intelligently.

Pharma’s battle to contain R&D costs and accelerate speed to market predates the current era of austerity, but despite widespread efforts to improve drug development, identifiable inefficiencies in the process still remain. Much time and money can be wasted if brand teams do not engage effectively with all of their key stakeholders; ultimately, this has an impact on time to market and market share. But, to secure competitive advantage, such multi-disciplinary engagement must begin ahead of clinical trial design. And it must include all of pharma’s key customers. Too often, it does not.

One customer-group commonly overlooked during early discussions around trial design is hospital pharmacy. The industry does, of course, recognise that specialist hospital and clinical pharmacists are key influencers in the uptake of its products in the pre-launch and post-launch phase, and engages with them accordingly. But, in partnership with them, there are opportunities to improve product development, speed to market and, critically, patient care. Hospital pharmacists can play an important role in helping to create the right evidence base at the clinical trial stage and facilitating effective and efficient execution of the trial. They can also provide insight into the service delivery of a product at the latter stages of clinical trials and how it fits into the patient care pathway. More often than not, however, pharmacy’s voice is heard too late – with expensive repercussions for pharma companies and a lamentable impact on patient access to new therapies.

Undoubtedly, the industry can unlock substantial cost-efficiencies in the drug development process simply by involving all the right stakeholders at the right time. By engaging proactively, effectively and holistically, companies can accelerate patient recruitment, get products to market faster, drive a quicker return and, ultimately, improve patient outcomes. But, to date, the industry has yet to capitalise fully on the valuable role hospital pharmacy can play in helping ensure innovative treatments and technologies are timely and accessible to patients.

**Protocol design**
Pharmacy can make a major contribution to the design of clinical trial protocols. Industry could work proactively with pharmacy in these early discussions and during the latter stages of drug development – improving patient recruitment and associated costs to gain best value for patients.

A standard clinical trial protocol is typically a long and detailed document that includes aspects such as:

- **Summary of objectives; rationale for the trial**
- The main research question; the hypothesis to be tested
- **Description of the treatment under investigation (and comparators)**

Partnerships between pharma and hospital pharmacy are a rare commodity. But it’s time things changed. Mark Harries outlines why the industry needs to be more proactive in its engagement with hospital pharmacy.
Traditionally, industry has focused much of its early attention for protocol design on engaging with clinicians; liaising with specialist doctors working in the therapy area, talking with regulatory authorities to establish the kind of study that may secure approval, identifying key opinion leaders and investigators to help run the trial. But discussions often do not capture the practical input from a clinical pharmacy perspective to improve trial efficiency and patient experience. As a result, pharmacy’s first glimpse of the protocol is often when it is going through the hospital’s ethics committee for approval. This is far too late.

**An impractical guide**

On occasions, information outlined in protocol designs can appear to have been developed without true comprehension of the practicalities of the hospital environment and how a drug needs to be prepared. For example, a protocol may describe a light-sensitive infusional drug that has to be prepared under limited lighting conditions! These limits are not easily applied in a controlled aseptic environment, and pose many risks for the operator and the accuracy required to measure the dose. Aseptic feasibility – which generally applies to intravenous or injectable drugs – is another key consideration. The regulations for aseptic preparation can vary significantly between Europe and the US; Europe, in particular the UK, has much stricter regulation. Some protocols describe how the pharmacy aseptic preparation process for the investigation medicinal product should be performed on the ward – but certain methods would not be allowed under UK quality control regulations. Similarly, a protocol may stipulate a drug reconstituted to a specified final volume of diluent, of which only a proportion would be administered to the patient requiring the infusion to be stopped so the remainder is not accidentally infused. This poses a clinical governance risk for safety in administration. The requirement is driven from a pharmacokinetic research perspective, and requires better collaboration to address the drug administration protocol and identify a safer approach in delivery methods to patients.

Stability data is another major issue. It is widely recognised that at early stages of development, stability data may not be available and, as such, drugs have short expiry times. However, stating this in the protocol is not a get-out clause that permits impracticality. To illustrate, a protocol may describe a product that, once prepared, would only be stable for one hour. In practice, other factors to consider in this case include length of time to aseptically prepare the infusion and transport it to the patient, which compounds impracticality with the specified duration of the drug infusion being over thirty minutes! In all instances, there is an opportunity for the industry to invest more time in early engagement with pharmacy about these practical issues, to avoid inevitable delays in trial recruitment.

The importance of being practical goes beyond the clinical trial process. When it comes to using a licensed drug in the reality of the market place, practical elements relating to the logistics or cost of administering the drug can significantly impact the uptake of a product that is of benefit to patients. Clearly, therefore, the early involvement of pharmacy in this area alone can dramatically enhance the likelihood of a product achieving market penetration.

**Value**

Early engagement with hospital pharmacy has clear benefits for drug companies in the development of new technologies and will increase even further in the case of gene therapies for example. But its value is not restricted simply to issues around preparation, toxicity and stability. Pharmacy is not just about making medicine – it can also provide invaluable insights into how products can make a contribution to the patient care pathway, and help build the financial endpoints into clinical trial design. What information should be captured in terms of data for cost-effectiveness arguments? What are the true costs of preparing a drug? What levels of resource are required? What are the implications of adverse events and how can they be managed? Pharmacy can provide a clearer picture of these costs, and also offer an assessment of the current care pathway and the impact and cost implications of a new drug.

Despite this, surprisingly, much of industry has so far failed to exploit the opportunity. In turn, pharmacy must accept its complicity in nurturing such a sub-optimal relationship. But, in the developing era of partnership, there is a true opportunity for collaboration. Patient care is the shared objective that should unite the efforts of industry and health care professionals. The goal to develop effective treatments and ensure patients gain access to them is a collective one. The industry, therefore, needs to be more proactive in its engagement with all of the stakeholders that can influence the uptake of a product – and to recognise that this process must begin long before that product wins its license.

Despite long-standing efforts to improve pharmaceutical R&D, the drug development process is still bedevilled with inefficiencies. Containing cost and accelerating product to market remains a holy grail for pharmaceutical companies – yet tremendous amounts of time and resource are wasted fixing problems after the event. Hospital pharmacy expertise could play a vital role in helping industry identify and address some of these issues at the outset and is willing to do so. Getting it right up front not only means that companies get their products to market earlier and achieve market uptake, but more importantly, it also means that patients get to benefit from them sooner.

This would be true partnership.

**Mark Harries is Managing Director at WG Consulting.**
Will the NHS reforms lead to a stampede of pharmaceutical company key account managers breaking down the doors of GP consortia in the rush to set up joint-working agreements? Will GP practices be happy to work with pharmaceutical companies in any willing provider partnerships? And how far can any of these potential scenarios take the NHS in reaching its ambitious goal of achieving national cost-savings of £20 billion, whilst at the same time improving innovation and quality in the delivery of healthcare to the nation?

Packer Forbes, the UK specialist healthcare communications agency, has been consulting with a range of stakeholders to try to separate hysteria, rhetoric and fact, all of which have been witnessed since the NHS White Paper, Equity and excellence: Liberating the NHS, was launched back in July 2010. Through a series of workshops, Packer Forbes and its clients have been hearing from the experts working in the NHS, at both strategic and local level, to gain a perspective on how improved collaboration between the NHS and the pharmaceutical industry can go some way to achieving a healthcare service that offers, in the words of Andrew Lansley: “health outcomes – and quality services that will make the NHS a truly world-class service.”

Working in partnership – is it really that radical?
The one thing that is certain in the current environment is that these are uncertain times for the future of healthcare in England, with the reforms having been called the most radical re-design of healthcare since the inception of the NHS, and debates raging around the details laid out in the Health and Social Care Bill. However, some of the proposals under discussion, including those which suggest that GP practices open up their doors to working in partnership with the pharmaceutical industry, are not completely new; nor are they a major shake-up. There are numerous historical examples of pharmaceutical companies working locally with Trusts and Practices to deliver improvements in healthcare services. Unfortunately, there are also as many, if not more examples, of failed partnership attempts, which promulgates the reluctance of many primary care health practitioners to even enter into a discussion with the pharmaceutical industry about addressing a healthcare challenge in partnership.

What is needed is a fresh, new approach, based on solid insights; evidence of understanding the challenge and clear opportunities to find a potential solution. Crucially, the instigator needs to use its emotional intelligence to initiate and progress the relationship by engaging the right people at the right level; pacing discussions and ensuring ongoing agreement and buy-in; investing in nurturing and growing the relationship and agreeing up-front working practices, such as openness and transparency, governance and sharing best practice.

The NHS and pharma are preparing to reinvent the way they do business together. But, without good communication and trust between the people who can make change happen, the benefits of innovative joint working will never truly materialise. Anna Gibbins looks at the maturing relationship between industry and the NHS.
How can the pharma industry help bridge the £20 billion funding gap?

In previous eras of governments, white papers and health bills, the choice to engage in partnerships was very much down to the health authority, PCT or practice to decide if this was their preferred route to achieving service delivery. However, in the current climate this may not be such an individual choice.

It is accepted that, with the current service structure, there will never be enough money to fund actual need. Without this proposed radical service redesign the NHS would have to start restricting access to services and high cost medicines. The pharmaceutical industry is dealing with its own pressures of dwindling pipelines, global pricing restrictions, patent expires and a UK customer base that has its own severe budget challenges. The Quality, Innovation, Productivity and Prevention (QIPP) agenda challenges consortia to start thinking about how they can improve patient outcomes using innovative ways of delivering quality healthcare with cost efficiencies.

The only part of the NHS where there are accurate, measurable data is on the cost of medicines, so this has always been a natural target for cost-cutting. However, it is widely recognised that even with the best medicines management programme in place, this is not going to get close to bridging the national £20 billion gap that every GP consortium is challenged with. In addition, best practice preventative prescribing sometimes requires an increase in prescribing in order to ensure patients are able to be treated in the community and kept out of costly secondary care settings. With a typical GP consortium currently spending two-thirds of its budget on secondary care referrals and treatment – its highest expenditure by far – and 14% on medicines, enlightened GP consortia and forward-thinking pharmaceutical companies will need to strategically refocus their attention to where the real cost-savings can be made, i.e. reducing expensive hospital treatments and disease prevention.

Developing and fostering this new mind-set should be a focus for both pharmaceutical companies and the NHS, who need to work together in true strategic partnership to help reduce overall budgets. Potential joint working to develop a disease management pathway that prevents or delays secondary care referrals, will positively impact the overall consortia budget and will resonate with the QIPP agenda.

Indeed, the NHS as a body has already recognised the benefits that true partnership working with life science companies (pharmaceutical, biotech, diagnostics and devices), can provide and has set up a board to promote joint working arrangements. The NHS Life Sciences Innovation and Delivery Board is a unique partnership between senior NHS leaders, regulators, including NICE, and senior policy makers with representation from the pharmaceutical industry. To work in collaboration for the benefit of patients is the challenge that the Board has been given and members are currently looking at a number of ways of achieving this.

Innovation and collaboration has to be at the top of the agenda in order to shape a business-to-business relationship that is based on strong trust.

As for the industry, it needs to change its working model to match that of its main customer, the NHS. The NHS is already doing this – the industry has some catching up to do. Critically, it needs to feel comfortable working on programmes that may not have an immediate return on investment (ROI) for its medicines and accept that ROI for the company would be equally valuable in this new environment, where levels of trust are low. The pharmaceutical industry must start to communicate beyond brand if it is to successfully work with the NHS. For example, cost-saving models will no longer resonate with GPs if the model only looks at brands and competitors. Savings made by improved community-based care and delivered in joint working agreements would resonate with QIPP and evoke interest from consortia.

So what is stopping innovation through partnership working?

This brings us full circle. Conceptually the idea of partnership working makes perfect sense, but the reality is that the NHS and pharmaceutical companies have historically had an uneasy relationship; at least a relationship that lacks complete trust. The NHS is still incredibly wary of the commercial motivation behind all pharma’s good intentions and the pharma industry can be over-eager and too forthright in its attempts to engage with NHS organisations and, once engaged, often don’t have an pre-agreed and effective exit strategy in place, which can create additional complications.

This can be resolved if both the NHS and pharma are prepared to reinvent the way they do business together. The bedrock is good communication between the people who can make change happen; understanding each other’s needs and helping to solve each other’s problems; committing to easy access and responsiveness and ensuring personal contact. The next step is to understand each other’s strategy and ensure contacts are made at every level and across all functions within the organisation. If both parties commit to this structured approach to relationship building then a genuine strategic partnership can be built, based on trust and integrity and a shared vision.

This is going to be a landscape of significant change for primary care. GP consortia are going to appreciate some partnership support and areas where pharmaceutical industry collaboration could be seen as vital are already being flagged. This might include development of business cases to enable first-class commissioning of services that also include an element of joint-risk sharing; benchmarking and auditing results of interventions; chronic disease management solutions (eg in asthma and diabetes where the pharmaceutical industry could consider offering holistic healthcare solutions) and provision of education and ancillary services alongside therapeutic interventions of choice. QIPP-focused collaborative projects where success is already being seen include a pharmacy-led stable angina service; improved screening for COPD patients; marketing smoking cessation programmes and implementing NICE guidance for long-acting reversible contraceptives.

Where does that leave us?

So what is the bottom line? Well there isn’t enough money to fund actual need within the NHS. Partnerships either providing total service delivery or a joint working approach do work if they are set up effectively from the outset and guidance is given to help with the relationship journey. This promises to provide an ideal solution to healthcare delivery in the twenty-first century, where GP consortia can provide quality and cost-effective healthcare to their communities; the pharmaceutical companies can move from being perceived as simply a supplier of medicines to a provider of holistic healthcare solutions and patients will ultimately benefit from an innovative and realistic solution to their healthcare needs.

Anna Gibbins is Managing Director, Packer Forbes.
Getting real – opportunities for joint working

The NHS cannot hope to solve its problems all on its own. Collaboration between the health service and the life sciences industry is fast-becoming an essential component of success. Jean-Francois Delas presents the story so far and assesses what needs to happen to ensure the promise of joint working becomes a reality.

There is no question that Joint Working will be central to delivering the NHS agenda over the next few years. In an increasingly cash-strapped NHS, looking at more effective ways to provide care to patients and ultimately improve health outcomes is crucial. This is the current remit of the QIPP (Quality, Innovation, Productivity and Prevention) whose leadership will also transition from SHAs and PCTs to GP Consortia. There is also recognition that the NHS cannot solve all of its problems only from within and that innovation will come from collaboration with the industry and sharing knowledge and ideas. This is also an opportunity for the industry to deepen its knowledge of customers.

Structures and tools are being put in place for its implementation. A joint working framework between the ABPI/NHS had been first developed in 2009 and further enhanced in August with the provision of an interactive toolkit. New bodies are being set-up to facilitate collaboration, such as recently LifeSciences UK, regrouping four industry trade associations including the ABPI or the NHS Life Sciences Innovation Delivery Board (LSIDB). Joint working is also central to the political agenda as enabler of the Government’s Big Society drive. A new Life Sciences business adviser, Chris Brinsmead, has also been appointed to work closely with the industry.

If joint working is not yet widespread (e.g. 55% of NHS professionals unaware in a recent survey), successful examples already exist across the whole care continuum from which we can learn and expand.

**Why is it important?**
The QIPP programme challenges the NHS to deliver an ambitious £20bn efficiencies target over the next four years and the Life Sciences industry has been encouraged to put forward ideas that will drive improvement in treatment of priority areas and support the NHS in delivering ‘more for less’.

In the light of the recent NHS White Paper and publication of the Health bill, it is also clear that the onus will fall on GP Consortia to drive much of this agenda as SHAs and PCTs are being phased out and management costs are being cut. This is adding to the current stretch on their role as care providers and soon as commissioners.

In this context of increasingly constrained and limited public resources, delivering against targets will without any doubt imply reaching out. This is a key principle of the Big Society agenda.

As such the industry has a key role and duty to work jointly and to form partnerships with other stakeholders in this new healthcare ecosystem likely to involve local authorities, charities and private organisation in addition to traditional public health authorities.

One of the lessons from other countries is that high performing healthcare systems require general managers to work alongside clinical leaders to deliver improvements in patient care. This is an opportunity for the industry to contribute and, by the same token, to get closer to their customers and change its current negative image. But what are the opportunities for joint working?

**Defining the scope**
If the scope for joint working is not defined, it should ultimately be focused on delivering the NHS agenda, namely:
- Putting the patient first
- Improving health outcomes
- Devolving autonomy and accountability to the ‘front line’
- Cutting bureaucracy and improving efficiency.

Opportunities are wide ranging and exist across the whole care continuum – see below examples.

These priorities will also have different realities for the different stakeholders and successful joint-working will therefore imply a good understanding of their roles and requirements. Figure 1 is a high level illustration what are the likely changes.

**Successful examples**

**Disease awareness:**
- Pfizer/NHS Central Lancashire: The Stop Smoking project led to a 30% rise in referrals and helped with staff development and best use of medicines
- Joint initiative between NHS Blackburn and Darwen and ABPI (Novo Nordisk, Takeda, sanofi-aventis, Lilly, MSD) for educational meeting with mosque leaders for diabetes
- Pfizer/GSK funded the world’s first charity application for meningitis

**Access to medicine:**
Patients Access Schemes (PAS) and other similar Risk/Reward incentives are being worked out between the NHS and the industry to provide early access of
medicines. It is likely to continue under the new Value Based Pricing system.

AstraZeneca worked with the Manchester Cancer Research Centre, NHS Foundation Trust, key schools and universities and the Paterson Institute for Cancer Research giving patients in Manchester access to clinical trials and new drugs.

**Development of ‘integrated’ services/ pathway for disease management:** Lundbeck partnered with the Depression Alliance to raise the profile of depression and anxiety by detailing through an integrated best practice pathway for commissioners and demonstrating how its impact is not limited to health, but affects employment too.

GSK/StHealth PbC consortium brought consultants and GPs together for designing a new integrated care pathways for COPD.

**Support HCPs to provide better services:**

Janssen-Cilag ‘translated its marketing know-how’ into an education programme for foundation trusts (FTs) and others. This provided Janssen-Cilag with a platform to engage NHS executives at a time when an understanding of strategic marketing is becoming essential for trusts to survive and thrive.

**Management of long-term conditions:**

New joint venture between the Nottingham PCT, NHS Trust, Diabetes UK, AZ, Lilly, Novartis, Novo Nordisk, MSD, sanofi-aventis and Pfizer to improve diabetes care and reduce unplanned admissions.

GSK/NHS Salford partnered on COPD with joint objectives to improve COPD management, up-skill for all clinical staff and to reduce inappropriate hospital admissions and referrals. The programme included automated patient audit point and deployment of COPD nursing resources.

GSK/Amgen partnered with experts and patients groups to improve patient outcomes and care for women affected by osteoporosis.

**Adherence programme:**

It is likely that adherence/disease management programmes initiated by pharmaceutical companies are likely to become routine as it is aligned with NHS Outcomes Framework’s objectives.

**Key success factors**

The move towards collaboration is not easy though and will require novel approaches and mindset from both parties. Trust between pharma, NHS partners and patients is an overwhelming pre-condition for developing an effective partnership. It will come through a systemic approach to work together, including:

- Initial joint events and meetings to discuss joint working opportunities
- Clear and shared objectives for the partnership aligned on ultimately improving health outcomes
- Inclusive approach with all key stakeholders involved (e.g. acute, community, primary care)
- Clear financial basis for entering the partnership including business case and return on investment
- Shared investment (time, resources and money) from all parties as a sign of commitment.

These principles are also in-line with the revision of the ABPI Code of Practice putting emphasis on transparency and the absence of promotional bias. The ABPI has also developed guidance and tools to support joint working.

Finally, new technologies and social media could provide great opportunity to enable collaboration. Some examples already exist in the field of HIV where NHS London worked with the London Sexual Health programme on a campaign to improve the Sexual Health of Londoners. They used an online community (eVillage) to engage with patients, providing a forum to openly discuss issues in a context where traditionally stigma is attached to the disease causing denial of risk in turn preventing early testing.

**The way forward**

Whilst the agenda and opportunities are now clearly set for joint working, it is clearly up to partners to make it happen. Instead of being discrete (successful), examples like the ones described above, it should become a new way of working, in-line with a move from traditional transactional relationship to forming true partnerships. A necessary first step should be respective understanding of each other and alignment around common objectives, with the improvement of health outcomes front of mind.

Recent NHS White and Consultation Papers, the new NHS Operating Framework for 2011/12 and the recent Health Bill are providing all necessary information for that. The rest will naturally flow...

Jean-Francois Delas is a Vice President at Kinapse Ltd.
Improving care in COPD

The environment

The British Lung Foundation’s “Invisible Lives” report ranked Sunderland PCT 6th in its table of UK healthcare regions facing the greatest challenge from COPD – and number 1 in the North East. People here are 51% more likely to be admitted to hospital with COPD than the UK average. The area has a strong industrial heritage, and Sunderland was at one stage the world’s biggest shipbuilding town, owing to the wealth generated by Wearside coal and the need to transport it.

Locally, Wearside Consortium serves a population of 104,508 people – 37% of Sunderland PCT’s population – through 23 practices. Wearside Consortium has a COPD prevalence rate of 2.8%, which equates to 2,916 COPD patients. COPD presents a significant cost burden to Wearside Consortium, with spend on COPD hospital admissions reaching £1.1m in 2008/09.

The project was set up to improve the quality of the annual COPD review and adherence to NICE COPD guidelines and ensure equity of care. Additional goals were to:

- Increase patients’ confidence and ability to self-manage their condition
- Improve the capability of Health Care Professionals to ensure high-quality COPD care for all
- Enable more appropriate use of resources, e.g. reduction in unplanned admissions to secondary care, driving ‘care closer to home’
- Increase use of appropriate respiratory medicines, including GSK medicines, in line with NICE guidelines
- Demonstrate the value GSK can bring to patients and the NHS through GSK’s extensive skills and experience in COPD management and alignment with the QIPP agenda.

Project

A joint working project between Wearside PBC & GSK to improve the quality of COPD care

The Business Case

The benefits of the project for all parties were as follows:

**The Patient:**

Has the opportunity to:
- Be appropriately diagnosed earlier
- Reduce exacerbations of COPD and improve quality of life
- Receive more localised care closer to home
- Receive a consistent standard of care across the PBC group
- Better understand the need to manage their condition
- Improve the patient’s experience of the health system and potentially improve patient outcomes.

**Wearside Consortium:**

- Up-skilled, motivated healthcare professionals will be:
  a. Better able to diagnose COPD, reduce exacerbations, manage in-line with agreed pathways and potentially reduce hospital related costs.
  b. Empowered to manage more COPD patients in primary care.
  c. More able to consistently record important COPD clinical data.
- Member practices will be able to enhance patient care by adopting a whole practice approach.
- The development of an agreed best practice patient pathway and treatment protocol.
- The efficient use of existing services across all practices.
- Implementation of a patient screening programme to case find at risk or undiagnosed patients.

**GlaxoSmithKline:**

- Market expansion for COPD through increased appropriate patient diagnosis, patient review and optimal medical management in line with NICE Guidance. This may result in a proportionate increase in the number of opportunities to use medicines, including appropriate use of GSK medicines.
- Increased acknowledgement of the role of GSK in supporting Practice Based Commissioning.
- A case study to demonstrate how joint working between GSK and Wearside Consortium has improved COPD patient management.

The value of contribution by Wearside PBC was £162,300, with GSK contributing £91,000 of resource. Resources from both parties came in varied forms, including people, expertise, equipment, communicational channels, information technology and finance.
Implementation proceeded as follows:

- A treatment protocol was developed by Wearside Consortium, in line with NICE COPD guidelines and agreed with secondary care and Sunderland PCT.
- There was development and consistent use of a review template to ensure equity across all practices in delivery of care and measurement.
- The POINTS* patient audit tool was installed in all practices, to enable effective prioritisation of COPD patients for review, and the measurement of change from QoF to NICE standard of care.
- A practice-by-practice analysis of training needs was undertaken, based on the POINTS baseline, which informed the development of practice COPD action plans, supported by the GSK Respiratory Care Associate (RCA) in line with NICE COPD guidelines.
- A bespoke, consortium-wide training programme was delivered to up-skill healthcare professionals to deliver NICE COPD standards of care. This training programme was developed by GSK and Wearside Consortium together with local respiratory specialists.
- A Wearside Consortium incentive scheme of 40p per patient per practice in each financial year, encouraged achievement of pre-specified COPD objectives.
- A patient experience survey was conducted to measure the quality of the patients’ annual COPD review, to review areas of strength as well as those in which improvements could be made.

Outcomes

- 18% improvement in the quality of patient review, moving from QoF to NICE standards.
- The percentage of patients receiving an annual COPD review increased from 44% to 74%.
- An increase in patient understanding of their condition was seen from 64% to 76%, with 50% of patients reporting that their understanding of what to do if their symptoms get worse had increased as a result of their lung check-up.
- 9/10 patients were satisfied with the level of service given to them during the check-up, and felt the review was thorough.
- A 12% reduction in year-on-year COPD admissions was seen in the period July 2009 to June 2010.
- 42 Healthcare Professionals (a GP and Practice Nurse Respiratory Lead from each practice) attended three half-day COPD updates, in addition to the training and mentoring delivered through practice-by-practice bespoke action plans.
- There has been a 6% increase in the proportion of patients receiving combinations, in line with NICE COPD guidelines.
- Research with key project stakeholders has confirmed the strong working relationship between Wearside and GSK, and an enthusiasm to work together in a joint working partnership: “We couldn’t have achieved what we have without the support of GSK”.

Perspectives

- A comprehensive business plan, jointly devised by GSK and Wearside Consortium, provided a solid foundation for true partnership working with shared roles and responsibilities across every aspect of the project.
- POINTS underpinned the Wearside Consortium’s annual plan for COPD and associated incentive payments by enabling exact measurement of practice and consortium performance against set objectives.
- Wearside Consortium’s ‘bottom-up’ approach to individual practice action plans, and its ‘ownership’ of POINTS data, resulted in a high degree of engagement and motivation among local practices.

* The Patient Outcomes and Information Service (POINTS) is provided by Glaxosmithkline (UK) Ltd (GSK) and is delivered on behalf of GSK by Quintiles.

References

4. POINTS data reports for 17 practices, 2,836 patients. Collected and supplied by Quintiles, data analysis by GSK, September 2010.
5. COPD patient experience survey. Data collected from 216 patients and analysed by Ipsos MORI, September 2010.
6. SUS data based on HRG DZ21. Data provided by NHS Sunderland PCT and analysed by GSK, August 2010.
7. Stakeholder Survey, data collected and analysed by Ipsos MORI, March 2010.
Background

The health of people in Yorkshire and the Humber (Y&H) remains worse than the average in England.1 Levels of deprivation are higher and life expectancy for both men and women is lower than the average in England.1 Likewise, the health of children in the region generally falls beneath the average in England.1 The prevalence of diabetes is known to be higher in areas experiencing deprivation.2 Y&H has high levels of poor diet and obesity, along with other factors that put the population at greater risk of developing long-term conditions such as diabetes and its associated complications.1

Y&H SHA has more than 237,000 patients registered with diabetes, a figure tipped to rise to 479,000 by 2020.3 The SHA currently spends around £100m on diabetes services each year and expects this figure to grow significantly as prevalence increases.4 Despite this, there remains unacceptable levels of variation in treatment outcomes for diabetes patients across the region.4 Emergency admissions due to and diabetic ketoacidosis are twice as high in some areas of Y&H and there is also large variation in lower limb amputations between PCTs.4 Only 15% of young people are achieving national recommended Hba1c control of 7.5%.5

Y&H SHA has pledged to help its patients “live with, not suffer from” diabetes and halve the number of preventable admissions from this condition.4 In line with this, Getting Sorted, a joint working project between NHS Diabetes, Leeds Metropolitan University and Novo Nordisk has been developed. The project has been piloted within five PCTs in Y&H, including North Yorkshire and York (NYY) PCT.

North Yorkshire is the largest county in England with the most diverse landscape. Its PCT includes four hospital Trusts that provide services for diabetes. The 2008/09 unadjusted prevalence of diabetes in NYY is significantly higher than the England average.6 Prevalence is uneven across the PCT,7 which aims to reduce Hba1c for patients with diabetes to within QOF target parameters.7

Project

Getting sorted is a self care programme for young people aged 12-17 with Type 1 diabetes, designed to enable them to manage their condition. The unique programme has been developed ‘by young people for young people’ to meet the needs of young people rather than adults.

Getting Sorted sets out to engage young people at every stage of their development. At the centre of the project, young facilitators with type 1 diabetes deliver five interactive workshop programmes to help young people increase their understanding of the disease, self manage their diabetes and thereby reduce the risk of long-term complications. The principle objective is to establish the equivalent of the Expert

Programme for Patients and children and young people with type 1 diabetes – and to help Y&H SHA achieve its outcome goals.

The three organisations involved in the joint working project have clear and specific responsibilities. The educational programme has been developed, and is delivered, by Leeds Metropolitan University. It is implemented using the NHS Diabetes Leading Change Framework. NHS Diabetes provides commissioning expertise to help inform and develop the project. Novo Nordisk is responsible for project management, to ensure it is aligned with the Leading Change Framework. As a leading global player in diabetes care, Novo Nordisk also provides in-depth therapeutic knowledge.

The Business Case

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References

2. Demographic characteristics and predictive factors for diabetes: North Yorkshire and York PCT (p2) http://yhpho.york.ac.uk/diabetesprofiles/default.aspx
Implementation

Getting Sorted was developed by Liz Webster (Carnegie Faculty, Leeds Metropolitan University) and piloted in type 1 diabetes\(^8\) and asthma\(^9\) between 2006-2008. With diabetes acknowledged as key priority for Y&H SHA, five PCTs across the region were identified to further develop Getting Sorted pilot programmes in diabetes – to create a more effective approach to diabetes care and to establish a personalised care planning model focused on young people.

NHS Diabetes, through Kate Mackay, played a pivotal role in the development of the initiative, providing commissioning expertise through its Leading Change Programme.

In 2010, Getting Sorted was granted Regional Innovation Funding (RIF) to enable it to be rolled out across NYY PCT.\(^10\)

The Getting Sorted team chose Novo Nordisk as its partner, in recognition that its determination to improve diabetes care reflected the ethos of the Getting Sorted programme. Tracey Clay (Healthcare Development Executive, Novo Nordisk) – a former Diabetes Specialist Nurse – was invited to help develop the joint working project in NYY. Tracey’s work involved assisting with needs analysis and engaging with stakeholders from across the region; consultants, Public Health, Commissioners and other local payers. Subsequently, Tracey has been developing diagnostics/mapping tools to ensure the project delivers its agreed outcomes. An ongoing aim is to create a user-friendly audit tool for the PCT to use beyond 2012.

A Steering Committee for the project involving all key parties meets regularly to monitor progress and assess outcomes.

Outcomes

The SHA pilot is ongoing and has so far captured the views of more than 100 young people with diabetes; workshops have been adapted and developed based on participant feedback. The project is committed to the collation of quantitative information to demonstrate clinical outcomes – from both a commissioning and patient perspective – by 2012. The pilot is therefore working towards clear and measurable objectives, to an agreed timetable.

Objectives include:\(^10\)

- A 20% increase in patients moving from poorly managed (HbA1c > 9.5%) to moderately managed (HbA1c of 7.5% to 9.5%) levels and a 10% increase in those moving from moderately to well managed levels (HbA1c < 7.5%).
- Increasing young people’s self-confidence to balance managing their diabetes against getting on with and enjoying life.
- Encouraging young people to take active control of their diabetes and apply problem-solving skills to meet new challenges.
- Equipping young people with knowledge and skills to set personal goals and develop effective strategies for achieving them.
- Enabling young people to explore and develop existing relationships with others and be accepting of their condition so they feel more in control.
- A reduction in inpatient and outpatient activity.
- Ongoing evaluation of the children and young people self reported behaviour change as a result of the workshops.
- An increase in the number of commissioning bodies who adopt this model of self care.

A wider aim is to see Getting Sorted embedded within mainstream service provision across the SHA.

Perspectives

“This project has seen three partners – the NHS, industry and academia – work together to achieve a common goal. Each partner has brought different skills and expertise to the table, with NHS Diabetes providing the commissioning expertise through our Leading Change programme; Novo Nordisk bringing commercial efficiency and urgency, and academic rigour being provided by the University. The new health landscape is calling for us all to work harder and smarter and collaborations like this show how this can be done. Getting Sorted is an excellent example of partnership working where all partners have been genuinely committed to putting young people with diabetes first.”

Kate Mackay, NHS Diabetes, Project Manager, Leading Change Programme Yorkshire & Humber

“A Getting Sorted model that is integrated into mainstream care across the whole region has the potential to improve outcomes by developing self-management skills amongst young people with diabetes with an aim to and reduce long term complications. The project is designed to help reduce diabetes-related hospital admissions and unnecessary, as well as costly, treatment.”

Tracey Clay, Healthcare Development Executive, Novo Nordisk

References

10. NHS Yorkshire and the Humber Innovation Fund 2009/2010 Application Form

Novo Nordisk would like to thank NHS Diabetes and Yorkshire & Humber and Leeds Metropolitan University for their hard work and commitment to this joint project.

Date of preparation: April 2011
Commissioning for outcomes - the Balanced Scorecard

Background

Wakefield Integrated Substance Misuse Services (WISMS) is an NHS health service provider, delivering treatment services for substance misusers, including illicit drugs and alcohol. WISMS covers the Wakefield PCT area, serving a total population of 320,000. The WISMS services focus on substance misusers themselves, but also reach out to support their carers, families and other vulnerable people in the community in which they live.

Dr Linda Harris, the Clinical Director of WISMS is an advocate for improving services to tackle substance misuse and was keen to look beyond the traditional, rather limited performance targets which were used to measure the treatment of drug dependency. Dr Harris wanted to develop a tool by which WISMS could demonstrate that they had provided real value for money, more personalised services and delivered demonstrable improved health outcomes for those who used their services.

In addition, improved outcome measures for services would allow wider agendas to be addressed and to demonstrate that investment in substance misuse treatment programmes could deliver societal benefits, such as a reduction in local crime, a safer community and more appropriate use of scarce healthcare resources for those in WISMS care.

As such, non-NHS partners, including MSD, were invited to the table, to support Dr Harris’s plan with practical skills, such as training, project management and commercial experience and, at this point, the Balanced Scorecard project was born.

Project

Wakefield Integrated Substance Misuse Services (WISMS). A joint working project between Wakefield PCT and MSD

The Business Case

The single most important aim was to provide a first class substance misuse service, providing exemplar, personalised care for patients and a service in which local Commissioners would want to invest. All partners shared the objective that WISMS should be able to demonstrate improved services for patients, with better clinical and social outcomes, improved adherence to medication programmes and an improvement in how communities are impacted by local drug misuse problems, including reduction in crime and a greater feeling of general safety and wellbeing.

Dr Harris approached MSD (then Schering-Plough) to offer support to the project, in which the objective would be to develop a performance measurement tool allowing a more informed insight into how service users, their families and the wider community were benefiting from substance misuse treatment programmes. The idea was to develop a “Balanced Scorecard” containing a range of parameters which would facilitate a broader evaluation of treatment outcomes.

In order to implement the project, WISMS requested support from MSD in a number of areas in which they felt that a commercial organisation could best compliment their public sector and clinical expertise. Following discussions regarding the desired outcomes of the project and undertaking a project needs analysis, it was agreed that both parties would contribute skills and support which would bring the most value and benefit both for the project and ultimately WISMS Service Users.

MSD Support:

- MSD senior manager to be a member of the Steering Committee.
- Provision of a project manager to act as Chair for the Economic Benefit sub group.
- Independent market research support to conduct staff and service user surveys.
- Initial funding to cover project start-up costs, such as management skills training.
- MSD employee to become a member of the Service User Experience project group.
- MSD patient research manager to work with Service Users to better understand their needs and life experiences.

NHS Support:

- Staff time, from several service managers and support workers.
- Administrative and secretarial support.
- Meeting venue expenses.
- Long term (2 years) project funding from both Wakefield PCT and the Department of Health.
Dr Harris established a Steering Committee, with representatives from all partners and key stakeholders, including Service Users themselves, to ensure that a range of topic areas were chosen which would best reflect the performance parameters which would be positively impacted by an exemplar drug treatment service. The four areas chosen were:

1. Economic Benefit
2. Service User Experience
3. Individual Health & Well-being
4. Families & Communities

The Steering Group established four project sub-groups. The members of each project group were from a wide range of organisations, including a number of Service Users, which brought a wider variety of backgrounds and experiences to the table. The project groups met 6 times each and the Chair of each group collated the conclusions and final recommendations, before submitting these to the Steering Committee. Following an overall review, the Balanced Scorecard was defined by twelve different performance benchmarks.

Overall the process took 6 months, with some additional time required to seek access to a range of data sources. For example, data was required from a number of disparate sources, such as the local Acute Trust, West Yorkshire Police and Social Care organisations.

At the end of the project, the Steering Committee reviewed the Balanced Scorecard data and agreed the Key Performance Indicator, or target, for each measure, therefore defining exactly what success would look like, in terms of the performance outcomes.

As a direct result of the innovative partnership working within the Balanced Scorecard Project, WISMS applied for and were granted a prestigious “Integrated Care Pilot” award from the Department of Health. Under this ICO Pilot scheme, WISMS will continue to improve the delivery of substance misuse and associated services in the Wakefield area, to drive forward quality, make improvements for service users, families and communities and to further develop workforce skills.

"The WISMS ICO is committed to ensuring that various population groups…can access information in a way that is relevant to them. This is at the heart of the Balanced Scorecard, a dashboard of outcomes measuring the success of our ambition in respect of social reintegration for substance misusers."

Dr Linda Harris, Clinical Lead, WISMS Pilot

"MSD fully supports the WISMS integrated care pilot. Our experience of working with the service has been very positive, and we particularly welcome the coordinated approach that has developed between such a wide variety of local stakeholders. The ambition to provide a cost effective service with a genuine focus on quality outcomes for the service users is in our opinion entirely appropriate, and will set new standards of measurement and assessment of substance misuse services in the UK."

Mr Simon Nicholson, Head of Partnership Development, MSD

The Balanced Scorecard:

<table>
<thead>
<tr>
<th>Economic Benefit</th>
<th>Service User Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in local crime rate</td>
<td>Supporting individuals to make choices</td>
</tr>
<tr>
<td>Reduction in attendances at A&amp;E</td>
<td>Getting more people into training/education</td>
</tr>
<tr>
<td>Reduction in benefits paid</td>
<td>More people productively occupied</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Health &amp; Well-being</th>
<th>Families &amp; Communities</th>
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</thead>
<tbody>
<tr>
<td>Improvement in physical health</td>
<td>Better access to family support</td>
</tr>
<tr>
<td>Better integration into society</td>
<td>More people in settled accommodation</td>
</tr>
<tr>
<td>More stable financially</td>
<td>Improvement in community perceptions</td>
</tr>
</tbody>
</table>

Outcomes

WISMS are now collating this data and information for each parameter on a monthly basis and it is possible to demonstrate how these outcomes change and improve over time, as the treatment services provided by WISMS and its dedicated team are restructured and refocused.

For example, there are already indications that more Service Users are choosing and benefiting from a “Well-Being” assessment and that more than ever are productively occupied in community projects. In addition, the WISMS team are now more aware when Service Users are regularly attending local A&E departments, enabling the support team to design a more appropriate care plan for each individual, which provides more bespoke individual care and is more efficient use of scarce NHS resources, therefore adding benefit for the community as a whole.
WORKING IN PARTNERSHIP
LUNDBECK LEADS FRONT LINE CHANGE TO MEET CHANGING NHS

LUNDBECK FOCUSES ON PSYCHIATRY AND NEUROLOGY.

As well as developing world-class pharmaceuticals, Lundbeck places great emphasis on increasing knowledge by offering educational and support initiatives to health care providers, patients and their relatives.

Lundbeck, the UK’s leading CNS pharmaceutical company, is already successfully contributing to the redesign of care pathways and provision of education for HCPs to improve patient outcomes and help deliver the QIPP agenda. 2011 will see Lundbeck further enhance the way it works with the NHS by radically restructuring its sales force in a way that positions the company at the front line of change in the UK healthcare market.

The bold changes have seen Lundbeck dispense with the traditional sales force model in favour of an innovative new structure headed up by 21 Directors of Healthcare Development (DHDs) that will be the company’s key interface with the NHS across the UK. The new roles will enable Lundbeck to move decision making and budgets closer to its customers. By empowering its teams to work locally it will meet the needs of its primary customers proactively through partnership initiatives, enabling its customers to deliver their local agenda.

“Our new DHD structure ensures that the people we put in front of our customers not only have the skills and knowledge to understand the customer agenda but can also make decisions and have the budget to back them up. We are going to significantly speed up the process and make working with Lundbeck fast, efficient and effective for all our customers.” Stephen Turley UK Managing Director of Lundbeck.

Unlike a current pharmaceutical Key Account Manager, Lundbeck’s DHDs will have the autonomy to create local business plans, in line with local needs, the ability to allocate resources to achieve those business plans and importantly will not be measured on simple sales figures; they will have responsibility for full profit and loss for their respective areas of responsibility.

How will this work in practice?

Case Study: Lundbeck working in partnership with SouthWest Essex PCT & Res Consortium

Aim: To improve the medicines management of people with dementia with focus on antipsychotic prescribing

In summary: Development of validated integrated performance framework for care homes using best practice in dementia care, including prescribing protocol for the management of Behavioural & Psychological Symptoms of Dementia (BPSD)

Outputs: Highlighted antipsychotic prescribing as a key issue and provided tools to change situation:

- Establishment of key stakeholder reference group across South West Essex health economy (including social services)
- Consolidation of best practice literature & practice into single framework & protocol
- Piloting & testing of framework & protocol on selected care home site with subsequent rollout across SW Essex care home cohort.


“What sets this project apart from other similar projects is that this is making a significant difference to improving person centered Quality of Care for people with dementia in Residential/Care Homes.” Irene Lewsey, Senior Mental Health Commissioner, NHS South West Essex

“This project demonstrates how partnership projects between the NHS & forward thinking pharmaceutical companies (Lundbeck) can make a real difference to local quality of care. As a direct supplier to the NHS of business support, working in association with Lundbeck has allowed us to deliver innovative cost effective projects in the field of dementia which the NHS may not otherwise have been able to access.” Mark Davies, Director, Res Consortium

Working with Lundbeck in 2011 and beyond

Anyone interested in exploring opportunities of working with Lundbeck can email partnershipworking@lundbeck.com (quoting ref 0015) or visit www.lundbeckpartnershipworking.co.uk for more information.
The common misconception that industry and NHS are ‘not allowed’ to work together has long plagued the progress of the partnership agenda. But guidelines to regulate joint working are now in place. A new section of the ABPI Code has been specifically written to enable and encourage industry and the NHS to work on projects together. Steven Gray reports.

The industry and the NHS have had an interesting historical relationship. Some healthcare professionals are suspicious of the motives of the pharmaceutical industry when it offers support. Other healthcare professionals are frustrated that a seemingly obvious and simple form of interaction is caught up in ‘red tape’. The same frustrations exist on the part of the industry. In fact, healthcare professionals may be surprised to learn that the rules that apply to the industry are stricter than the rules that apply to the NHS itself!

This is partly owing to the fact that true partnership working has always been difficult to achieve owing to the regulations that affect the pharmaceutical industry – there are actually important rules on both sides of the intended partnership, however it’s usually the pharma rules that are discussed and blamed when things don’t work out. Historically, the industry has only been able to provide services and support that are completely unconnected with individual products.

This is because clause 18 of the Code of Practice of the Association of the British Pharmaceutical Industry (ABPI Code) allows the industry to provide support to its customers in the form of services and money, but only on the very strictly applied conditions that the support benefits patient care (or benefits the NHS without harming patient care). Any connection between the service and any form of quid pro quo or even the mention of a specific product within the literature is deemed to turn the support into a product-specific promotional activity and will fall foul of the Code. The body which regulates the ABPI Code takes a dim view of any company or activity that breaches this requirement.

For some projects, this separation is fine because the NHS only wants financial support. However, it may limit the range of projects that the industry can support because the compliance teams are always looking for hidden connections and will block projects that appear to cross the boundary. But what if the project would benefit from a deeper level of integration between industry and NHS; or if the opportunity is connected with a product? The old rules meant that the NHS was on its own – specifically because pharma was banned from engaging in projects where it would directly benefit! (Bizarre to some, but true).

Now there is a new section of clause 18 that has been specifically written to enable and indeed encourage industry and NHS to work on projects together. The industry term is “joint working”.

The Department of Health defined joint working as: “Situations where, for the benefit of patients, one or more pharmaceutical companies and the NHS pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery”.

Partnership in Practice 2011
There are still rules of course – however, the crucial difference is that the industry can engage in projects that involve product, so long as the primary motivation is still patient care. In fact there is a requirement for industry to publicly state its commercial interest in the project. Joint working has actually been around for a couple of years, however it is the latest 2011 version of the ABPI Code that has really opened the door to its widespread adoption. Until now, the rules surrounding joint working have been difficult to interpret owing to the fact that it had not been formally adopted into the Code. The few projects that did take place were usually large and therefore smaller companies tended to think that Joint Working was the purview of big pharma, which meant that some aspects of speciality medicine could not benefit from the type of interaction that, say, cardiology did – early examples of joint working involved large cardiovascular screening projects, for example. There was also considerable uncertainty regarding which projects were acceptable within the context of the ABPI Code.

The 2011 edition outlines specific requirements which make it much more likely that a wide range of companies will feel able to engage. In particular, the Code specifically states that it is acceptable to assist with the implementation of national treatment guidelines, even if they mention specific products. It also states that companies can target their involvement with projects where they are most likely to be of benefit to the company – for example, if the product is already on the formulary. A quid pro quo is still not allowed – a company cannot insist on having its product included on the formulary as a condition of joint working, for example. Over 10 years ago, the NHS issued a document relating to the acceptance of commercial sponsorship from industry. In essence, it says that the support must be unconnected with personal gain and that industry involvement must be publicly declared by the NHS. Which is just as well, because this is also a key requirement of the ABPI’s joint working rules. The industry must declare on the relevant company website the nature of the joint working project and its aims, etc. This must be done before the project begins. There must also be a publication following the conclusion of the project such that the patient outcomes are declared.

What of the NHS?

The Department of Health worked with the industry on the development of a toolkit to aid joint working, however, it has not been widely publicised, despite the fact it was updated only last summer. HQIP has recently issued guidance notes specifically regarding the implementation of clinical audit when industry is involved. An earlier (2002) publication outlined how industry and the NHS could work together on implementing National Service Frameworks, so working together is certainly nothing new – and the DH has been willing to work with industry for some time. There are also specific recommendations for the NHS in Scotland – A Common Understanding: Guidance on Joint Working between NHS Scotland and the Pharmaceutical Industry (2003) and Wales (WHC(2005)0016 Guidance for Partnership Working between NHS Organisations, Primary Care Contractors, the Pharmaceutical Industry and the Allied Commercial Sector in Wales.

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So, in the new world of joint working, the NHS and industry can work together to drive projects which will improve patient care, free of (some of) the restraints that have previously been stopping pharma from engaging in certain activities just because they included a focus on actual treatment (ie use of product). The rules regarding joint working are still substantial however, given the patient-focused objectives of joint working, that is absolutely appropriate.

All that remains now is identification, implementation and assessment of the joint working project that best suits local need. In these days of budget awareness, joint working might enable key projects to succeed where previously industry involvement has been treated cautiously. The rules exist to protect patients, the NHS and industry. Within that framework could exist the potential for some real benefits to patient care. Exciting times.

Steven Gray is Managing Director of Compliance Hub.

Reference

1. Department of Health (DH) & ABPI Joint Working Toolkit, “Moving Beyond Sponsorship: joint working between the NHS and the pharmaceutical industry” (2008)
At MSD, we work hard to keep the world well through providing people all around the globe with innovative prescription medicines, vaccines, and consumer care and animal health products.

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