Vital Signs: Decoding UK Payers

May 2026

Methodology

Research Overview

- 50 senior NHS payers (100% completion rate)
- 13 structured questions
- ICB commissioners, MO leads, hospital pharmacists, GPs
- Conducted April 2026

Focus Areas

- Communication and messaging disconnects
- Definitions of value and evidence requirements
- Effective vs ineffective collaboration behaviours
- Operational burden and implementation timelines
- Engagement under ongoing NHS system reform

Critical Context

This research was conducted at a defining moment for NHS-industry engagement. ICBs are entering a period of structural reform with workforce reductions of up to 50%, NHS England is being reabsorbed into the Department of Health, and the NHS 10-Year Health Plan is reshaping commissioning priorities around prevention, neighbourhood-based care, and population health management.

Against this backdrop, financial pressures on Trusts and ICBs are intensifying, the move toward strategic commissioning is shifting decision authority, and a single national formulary is emerging as a future possibility.

All 50 respondents are senior decision-makers actively involved in formulary, pathway and commissioning decisions. Research was conducted via the Accessus Chat platform in full compliance with BHBIA guidelines.

Executive Summary

The pharma-NHS relationship is under strain but not broken - payers describe where engagement falls short and exactly what better looks like. This is a clear, deliverable agenda for change.

1

Industry messaging is misaligned with NHS operational reality and the consequence is disengagement

Payers describe industry as product-focused while the NHS is system-focused. The mismatch produces solutions that look attractive clinically but are not implementable locally.

2

Value is multidimensional in the NHS - clinical efficacy alone no longer earns a hearing

Payers define value across total system cost, workforce capacity, pathway impact, equity, and sustainability. A clinical case without a system case is increasingly an incomplete case.

3

Implementation burden falls overwhelmingly on the NHS - and 42 of 50 payers say so

Formulary, governance, education, pathway redesign and monitoring all sit with NHS teams. Industry timelines assume momentum the NHS does not have, and only 3 in 50 payers consider those timelines realistic.

4

Relationship quality is an organisational capability, not a representative-level asset

Cumulative experience shapes appetite for engagement. Consistency, NHS literacy, and problem-led conversations build access. Pushy sales tactics, churn of contacts, and NICE-only messaging erode it system-wide.

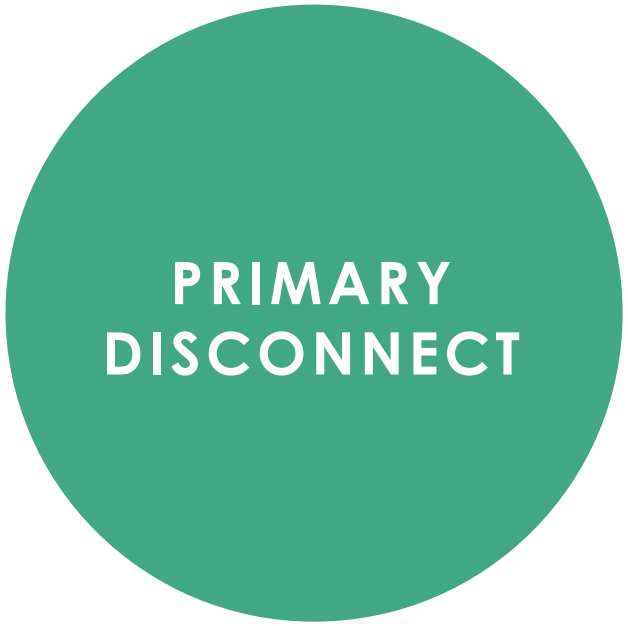
5

System reform is creating both risk and opportunity - and the bar for engagement is rising

ICB cuts, NHS England reabsorption and the move to strategic commissioning will reduce capacity to engage. Companies that bring NHS-ready analysis and absorb implementation effort will pull decisively ahead.

It is not that Industry has the Wrong Products - it is Telling the Wrong Story

The disconnect is not clinical, it is structural and it shapes everything that follows.



Product-Led, Not Problem-Led

Industry arrives with the next innovation. Payers want help solving the problems they already have.

Affordability vs Innovation

Industry frames value through clinical breakthrough. The NHS frames value through whether it can be delivered within capacity.

Pace and Cadence Mismatch

Industry works in commercial quarters. The NHS works in governance cycles. The friction lives in the gap between.

"The biggest disconnect is misalignment between industry messaging and NHS operational reality. Industry often focuses on clinical innovation, efficacy data, and headline outcomes, while the NHS is primarily concerned with capacity, affordability, workforce impact, and deliverability at scale."

→ **Manufacturers who reframe engagement around NHS problems - capacity, equity, deliverability - earn an audience that product-first conversations no longer reach.**

There are Two Definitions of Value in this Conversation. Only One of Them Buys Adoption

Industry talks about clinical efficacy. The NHS talks about whole-system impact. The gap is where adoption stalls.

Industry Definition of Value	NHS Definition of Value
• Clinical trial efficacy data	• Total system cost across primary and secondary care
• Cost per QALY against comparators	• Operational feasibility within current workforce
• Innovation and mechanism differentiation	• Impact on monitoring burden and downstream demand
• Population-level cost-effectiveness	• Equity of access across patient populations
• Acquisition cost vs current standard of care	• Long-term sustainability under ring-fenced budgets

"A medicine can be high value on paper but low value operationally if it increases workload or creates unfunded activity."

→ **Industry that arrives with NHS-ready whole-system analysis is not just more persuasive - it is removing the primary barrier to its own products being adopted.**

42 of 50 Payers Say Implementation Burden Falls Mostly or Entirely on the NHS

Approval is the start of the work, not the end of it - and industry rarely sees what comes next.

What Industry Sees	NICE approval and national commissioning - the visible portion of the work.
What the NHS Absorbs	Formulary applications, DTC submissions, governance approvals, risk assessments, EPR builds, electronic prescribing and Blueteq workflows.
What This Costs	Pathway redesign, clinical guideline updates, prescriber and MDT education, patient identification, monitoring protocols, homecare setup and service reconfiguration.

"Once a drug is approved nationally, that approval is only the starting point. Multiple layers of local governance follow before it can be used safely - formulary approval, pathway redesign, EPS builds, funding flows, staff training, and risk assessment."

→ **Implementation support is no longer an optional commercial extension - it is the entry fee. Manufacturers who absorb a meaningful share of the burden differentiate materially.**

Only 3 in 50 Payers Consider Industry's Timeline Expectations Realistic

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Industry arrives with momentum. The NHS operates on governance cycles. The gap defines the friction.

1. **Reasonable / realistic - only 3 of 50**
   An exceptionally thin minority view. Industry timelines as currently constructed are not credible to the people responsible for delivering them.

2. **Unreasonable / unrealistic - 20 of 50**
   Forty percent of senior payers actively reject industry timeline expectations as misaligned with NHS governance and capacity reality.

3. **Neutral / unsure - 25 of 50**
   The largest single group. This is a persuadable cohort, but not an endorsement - payers in this group describe doubt rather than agreement.

4. **Why timelines feel wrong on the ground**
   Formulary committees meet monthly or quarterly. Governance approvals require pharmacy, finance and clinical sign-off. EPR builds add weeks.

5. **What payers are asking for instead**
   Realistic expectation-setting. Engagement that respects committee schedules. Co-developed business cases. Pathway-modelling support that compresses implementation, not approval.

→ **The companies achieving better outcomes are not pushing harder against governance - they are absorbing the burden of pathway, evidence and business case work that compresses implementation, not approval.**

Effective Collaboration has a Recognisable Shape and Payers Describe it Consistently

When industry behaves like a system partner rather than a vendor, the conversation changes and so does the outcome.

Listens First, Sells Later

The most positively described engagements began with the NHS team's priorities and pressures, not a product proposition. Sequencing changes everything that follows.

Engages the Whole MDT

Pharmacy, medicines optimisation and commissioning engaged from the outset - not after clinicians are sold. Decisions are committee-made, and the committee sees the early effort.

Brings Analysis, Not Just Data

Budget impact models calibrated to local commissioning. Pathway analysis reflecting workforce constraints. Honest assessment of implementation complexity.

Invests in Consistency

Long-term, repeated contact with the same individuals. Institutional knowledge built over years. Relationships sustained beyond product cycles. Not optional.

"Effective collaboration happens when industry behaves like a system partner with shared values and goals, instead of a vendor."

→ **These behaviours are not soft skills - they are organisational capabilities. Companies that build them systematically convert clinical evidence into adoption faster than those who do not.**

Trust is Eroded in Predictable Ways - and Payers have Long Memories

Distrust is rarely the result of a single bad meeting. It is cumulative, transferable across companies, and slow to repair.

What Erodes Trust

- Repeated sales pressure despite stated constraints - emails, calls, repeat visits during clinic
- Bypassing pharmacy and going direct to clinicians, ignoring the gatekeeper role
- Promises not kept, especially on supply - stock guarantees that fail, drugs withdrawn shortly after formulary inclusion
- Educational cover for promotional intent - projects that disproportionately switch patients to the sponsor's product
- Misrepresentation of local approval status - quoting NHS individuals, promoting drugs as 'ready to use' before formulary

What Builds Trust

- Consistency of contact over time - same individuals, longitudinal relationships, institutional memory
- Genuine familiarity with local context - formulary, pathway, ICB structure, workforce constraints
- Transparency about evidence limitations and honest acknowledgement of uncertainty
- Willingness to engage with NHS problems rather than simply present product solutions
- Implementation support that absorbs effort - pathway co-design, business cases, prescriber education, homecare

"A medicine was added to our formulary only to be discontinued a month later. The organisation will not be communicating with that pharma company again."

→ **Distrust transfers - a single negative experience colours appetite for the broader industry. The defensive posture this creates is the single biggest tax on commercial productivity.**

NHS and Industry Define Success Differently - and the Gap is where Collaboration Stalls

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Until the definition of a successful collaboration is shared at the outset, both parties measure progress in different currencies.

Dimension	NHS Success Looks Like	Industry Success Looks Like
Time horizon	Sustainable change embedded across multiple budget cycles	Adoption rate within the launch window
Outcome metric	Patient outcomes measured at population level	Prescribing volume and persistence on therapy
Workload effect	Reduced - net workforce burden decreases	Visibility - partnership profile and engagement metrics
Pathway impact	Embedded change with staff upskilling and legacy	Formulary inclusion and pathway placement
Budget logic	Total system cost across primary and secondary care	Cost-effectiveness vs comparators

→ **Setting expectations explicitly at the outset - through SLAs, joint working agreements, or simple memoranda of understanding - closes more of this gap than any amount of post-hoc relationship management.**

Misalignment Compounds the Disengagement Loop that Costs Industry Access

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Each iteration of misaligned engagement increases the friction tax on the next interaction.

STAGE 1: INDUSTRY LEADS WITH THE PRODUCT

Clinical efficacy is presented before NHS context is understood. Engagement is sequenced product-first, not problem-first.

STAGE 2: NHS RECOGNISES OPERATIONAL MISFIT

Workforce, pathway or capacity barriers surface in the room. Time-poor payers identify constraints that the industry case has not addressed.

STAGE 3: ENGAGEMENT IS DEPRIORITISED

Payers redirect attention to higher-value conversations. Silence is the polite response to engagement that has not been earned.

STAGE 4: INDUSTRY INTERPRETS SILENCE AS INERTIA

Re-engages harder, often via different reps. Entrenches the problem, deepens defensive posture, and accelerates the loop.

→ Breaking the loop requires intervention at stage 1 - sequencing contextual understanding ahead of product narrative. Every other intervention is downstream patchwork.

System Reform is Raising the Bar for Engagement, not Lowering it

ICB restructuring, NHSE reabsorption, and the move to strategic commissioning create both risk and opportunity for industry.

MACRO

Structural Reform

- ICB workforce reductions of up to 50%.
- NHS England absorbed into DHSC.
- NHS 10-Year Plan reframing commissioning. Single national formulary on the horizon.

MESO

Operational Pressure

- Strategic commissioning replacing transactional purchasing.
- Population health framing.
- Capacity-stretched MO teams.
- Decision authority shifting and contacts churning.

MICRO

What Industry Must Do

- Map decision-makers afresh.
- Bring NHS-ready analysis to every engagement.
- Be patient with slower decision cycles. Position as system-supportive, not product-centric.

→ **The companies that succeed in this environment will not be those with the strongest pipelines - they will be those that have made the organisational investment to engage on the system's terms.**

What 'Good' Looks Like: A Five-Element Framework Drawn from the Research

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The signals from 50 payers are consistent enough to constitute a workable framework for engagement that earns its audience.

1 **Start With the System, Not the Product**

Sequence context-building ahead of product narrative. Receptiveness is shaped at the first sentence.

2 **Engage Earlier and Across the Full Decision Landscape**

Trial design. Pharmacy. Medicines optimisation. Commissioning. Clinicians alongside, not in isolation.

3 **Provide Analysis, Not Just Data**

Budget impact models calibrated locally. Pathway analyses reflecting real capacity. Translation work done.

4 **Demonstrate System Fluency**

ICB structures. NHS 10-Year Plan. Population health framing. Neighbourhood care. Not peripheral context - the operating frame.

5 **Invest in Consistency**

Long-term contacts. Relationships sustained beyond product cycles. Institutional memory as competitive advantage.

→ **Each element on its own is recognisable. The companies that differentiate are those that operationalise all five together, consistently, over time.**

The Strategic Picture

What this research tells us about the NHS Engagement Market

1

Relationship quality is now the binding constraint, not clinical evidence

Across the research, the determinant of access is no longer the strength of the product case - it is the cumulative quality of prior interactions. Companies competing on relationship will pull ahead of those competing on dossier.

2

Whole-system value is the new threshold for serious consideration

Clinical efficacy is the entry ticket, not the case. NHS-ready analysis covering total cost, capacity, pathway and equity is what advances products through governance. Without it, the burden falls on the NHS and adoption stalls.

3

Implementation effort is the most undervalued commercial lever in industry's playbook

42 of 50 payers say burden falls on the NHS. The companies absorbing pathway, education, and business case work are not being charitable - they are buying competitive advantage that price reductions cannot match.

4

System reform creates a one-time advantage for organisations engaging on the new terms

Strategic commissioning, neighbourhood-based care, single national formulary, ICB consolidation - the operating model is being rewritten. The engagement model that succeeded in the last decade will not work in the next.

Strategic Recommendations

Considerations for Action - What to do next

1

Build NHS-ready value packages, not promotional dossiers

Standardise: locally-adjustable budget impact models, pathway maps reflecting workforce constraints, honest implementation timelines. Designed to land directly into a Trust or ICB business case - not a sales meeting.

2

Co-fund implementation infrastructure, especially in neighbourhood and homecare settings

Pharma-funded prescribers, training programmes, homecare logistics, digital monitoring, capacity for early diagnosis. The 10-Year Plan creates the demand; manufacturers who supply it will own the pathway.

3

Sustain consistent contacts across product cycles

Reduce account team churn. Invest in NHS literacy as a hiring criterion. Build longitudinal relationships at ICB and Trust level that survive product launches. Continuity is competitive advantage.

4

Set explicit shared outcomes at the start of every collaboration

Simple memoranda of understanding or joint working agreements that define what success looks like for both parties. The cost is minutes; the upside is avoiding the friction of mismatched expectations months later.

Question Summary

13 questions, 50 NHS payer respondents

Q1: Where are the Biggest Communication and Messaging Disconnects?

Key Insights

- Industry messaging is product-led; NHS decision-making is system-led, with capacity, workforce and affordability dominating the agenda over clinical innovation
- Engagement is too often clinician-focused, with pharmacy, medicines optimisation and commissioning brought in late and resistance surfacing only at formulary stage
- Pace and timeline expectations diverge: industry works in commercial quarters while NHS operates on governance cycles, committee schedules and ring-fenced budgets
- Local variation is consistently underestimated - formularies, pathways and commissioning processes differ by ICB, PCN and Trust, defying one-size-fits-all approaches
- Sales-driven contact and unsolicited promotional emails are routinely ignored, with payers describing repeated visits and pressure as actively counterproductive to engagement
- The consequence is slower adoption, missed collaboration opportunities, and reputational drag that affects not just the company in question but appetite for industry generally

Payer Perspectives

"Industry understandably focuses on the product, i.e., clinical data, innovation and launch timelines. Whereas the NHS is focused on system impact: capacity, workforce, funding, governance and the operational risk."

"The biggest disconnect is misalignment between industry messaging and NHS operational reality. Industry often focuses on clinical innovation, efficacy data, and headline outcomes, while the NHS is primarily concerned with capacity, affordability, workforce impact, and deliverability at scale."

"It would be good if pharma came to understand problems in the NHS rather than sell their latest innovation as a solution to a problem they have identified."

"Industry messaging is often too generic and NICE-focused, whereas prescribing decisions in primary care are made at PCN and ICB level and are heavily influenced by local workload, operational impact, and health inequalities."

→ The disconnect is structural, not stylistic. Manufacturers who reframe engagement around NHS problems - capacity, equity, deliverability - earn an audience that product-first conversations no longer reach.

Q2: What Does 'Value' Mean when Assessing Medicines for Adoption?

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Key Insights

- NHS value extends well beyond acquisition cost and clinical efficacy to include workforce capacity, monitoring burden, pathway impact and downstream service demand
- Total system cost - administration time, nursing input, homecare logistics, monitoring requirements - is consistently cited as invisible in industry's value framing
- Equity of access and population-level sustainability are NHS-specific dimensions that industry's individual-product framing rarely captures or quantifies
- Real-world effectiveness, persistence and adherence in unselected NHS populations are weighted more heavily than trial efficacy in selected cohorts
- Operational feasibility - can the medicine be delivered safely and reliably within current workforce and infrastructure - is increasingly a gating criterion, not a secondary one
- Industry is described as better at presenting cost-effectiveness modelling but weaker at engaging with NHS-specific operational, workforce and equity dimensions of value

Payer Perspectives

"For the NHS, value means patient outcomes and safety, service capacity, total system cost, deliverability at scale, equity of access and long-term sustainability. A medicine can be high value on paper but low value operationally if it increases workload or creates unfunded activity."

"Value comes down to whether a medicine improves outcomes and safety compared with what we already use within the pathway and whether we can actually deliver it reliably in practice."

"Value isn't just about cost of the product but the benefits to the patient and to the NHS as a whole - for example reduced side effects, quicker resolution of symptoms or increased safety."

"The NHS evaluates value at a population and system level, whereas industry often emphasises value at an individual product level. Bridging this gap requires earlier and more transparent dialogue around implementation, service impact, and sustainability."

→ Whole-system value framing is no longer a 'nice-to-have', it is the threshold for serious consideration. Companies that arrive with NHS-ready analysis remove the primary barrier to their own products being adopted.

Q3: What Behaviours make Industry Collaboration Effective or Ineffective?

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Key Insights

- Effective collaboration consistently begins with industry listening to NHS needs first, before introducing any product proposition or commercial framing
- Long-term, consistent contact with the same individuals builds institutional knowledge and trust - payers describe relationship longevity as a competitive advantage
- Practical implementation support - pathway co-design, business case development, stakeholder alignment, prescriber education - differentiates effective partners materially
- Engaging the full MDT (clinicians, pharmacy, MO, commissioners) early signals system fluency; clinician-only targeting is interpreted as bypassing governance
- Ineffective behaviours cluster around sales pressure: repeated unsolicited contact, multiple reps for the same drug, unannounced visits, badgering during clinical hours
- Educational events that double as launch promotion, and 'optimisation' projects that disproportionately switch patients to the sponsor's product, materially erode trust

Payer Perspectives

"Effective collaboration happens when industry behaves like a system partner with shared values and goals, instead of a vendor. There is an expectation of intellectual honesty, risk assessments, and genuine care for humanity."

"Helpful: early engagement before launch, transparency on costs and assumptions, involvement of implementation expertise (not just commercial teams), willingness to co-design pathways and share risk, realistic understanding of governance timelines."

"Collaboration becomes ineffective when interactions feel sales driven, overly optimistic about capacity or timelines, or disconnected from operational realities, which can quickly reduce trust and engagement."

"Effective approaches include providing high-quality patient education tools that directly support consultations, improve patient understanding, and reduce clinical workload. Ineffective collaboration tends to involve overly sales-driven interactions or one-size-fits-all solutions."

→ **Industry behaviour, not industry product, is the single biggest determinant of how a collaboration is received. Companies that embed NHS literacy as an organisational capability earn access that price and pipeline cannot buy.**

Q4: Frustration, Wasted Time, Distrust - what has Shaped how Teams Respond Today?

Accessus CHAT

Key Insights

- Repeated, persistent contact through multiple channels and reps is the single most cited source of frustration, often when explicit signals of disengagement have been given
- Specific breaches of trust - drugs withdrawn shortly after formulary inclusion, supply guarantees that fail, undisclosed third-party switching projects - produce lasting reputational damage
- Bypassing pharmacy and going direct to clinicians is interpreted as a deliberate attempt to circumvent governance and creates significant institutional resistance
- Promoting drugs as 'ready to use' before formulary inclusion, or quoting NHS individuals to GPs, are recurring patterns that undermine credibility across the wider industry
- Aggressive commercial behaviour during recognised NHS pressure points - clinic times, holiday periods, governance cycles - actively reduces appetite for any future engagement
- The cumulative effect is a defensive posture: junior staff trained on how to manage industry contact, insistence on formal channels, and reduced willingness to engage at all

Payer Perspectives

"Persistent and unclear meeting requests with repeated approaches from different teams. Proposals that ignore existing contracts or funding structures and understanding of local context. I will disengage as I have many competing priorities."

"A medicine was added to our formulary only to be discontinued a month later. This caused immense frustration and embarrassment for the local NHS. As such, the organisation will not be communicating with that pharma company again."

"Pharmacists employed by a pharmaceutical company were used to initiate patients on injectable lipid-lowering therapies. This approach felt more commercially driven than clinically appropriate. As a result, GP practices had to spend additional time reviewing and contacting patients to offer statins instead."

"When I was quoted, with my name being mentioned to GPs, that I had told them the product is in the formulary and they should prescribe. This was untrue and unethical. These bad experiences impact future engagements and tarnish the reputation of the whole industry."

→ **Distrust is cumulative, transferable across companies, and slow to repair. The defensive posture this creates is the single biggest tax on industry's commercial productivity in the NHS.**

Q5: Realistic Outcomes: What does the NHS Actually want from Collaboration?

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Key Insights

- NHS success criteria centre on tangible patient outcomes, reduced workload, embedded change with staff legacy, and pathway efficiency that survives the launch window
- Industry success is measured in adoption rate, formulary placement, prescribing volume and continuity of orders - payers recognise this but describe the gap as friction-generating
- When expectations are not aligned at the outset, collaborations stall: the NHS perceives commercial pressure, industry perceives unjustified slowness
- Payers actively want partnerships that deliver system-level value (capacity, infrastructure, education) rather than transactional product uptake
- Joint working agreements, MOUs and explicit success criteria at engagement outset are repeatedly cited as the single biggest under-used tool to close the gap
- When industry adapts measurement to system impact - admissions avoided, capacity freed, equity improved - the gap closes and engagement becomes self-reinforcing

Payer Perspectives

"The NHS wants tangible patient benefit, system efficiency (reduced workload and cost savings). Industry expects outcomes closer to commercial value like quicker access decisions, formulary wins. Success is often tracked through adoption metrics rather than system outcomes."

"NHS teams can disengage when collaboration feels outcome-driven for industry but process-heavy for the NHS. To avoid the risk of friction or disengagement there should be clear expectations set at the outset, such as a simple memorandum of understanding."

"The NHS views value as practical service improvement, reduced pressure on clinicians, measurable system benefit. Industry often expects faster uptake, advocacy or sponsorship, influence over pathway design - this gap creates friction."

"We want it in a way that leaves a legacy and improves patients outcomes by staff education and improvement. The complex rules around working with pharma often cause projects to be difficult and take a long time to get off the ground."

→ Setting shared success criteria at the start of every collaboration costs minutes and avoids the friction of mismatched expectations months later. It is the single most under-used tool in the engagement playbook.

Q6: Looking Ahead 12 Months: Most Important Considerations Under System Reform?

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Key Insights

- ICB workforce reductions and structural mergers are creating capacity loss precisely where industry needs decision-maker access - patience and realism are required
- NHS England absorption into DHSC is reshaping where commissioning authority sits; engagement strategies built on the old ICS landscape will increasingly miss the room
- Strategic commissioning is replacing transactional purchasing - value framing must shift from drug acquisition cost to pathway redesign and population health impact
- The NHS 10-Year Plan agenda (prevention, neighbourhood-based care, digital, equity) is the new strategic framework; companies that align with it earn relevance, those who don't lose it
- A possible single national formulary is on the horizon, requiring industry to demonstrate value to a wider geography while maintaining local relevance and adaptability
- Implementation infrastructure - homecare, prescriber capacity, digital monitoring, primary care upskilling - is where industry investment now generates disproportionate return

Payer Perspectives

"ICBs are going to be cut by half in terms of staff. Meds opt teams are part of this cut. They are going to struggle to do the day job. Showing areas of spend reduction not previously thought of are where it's at."

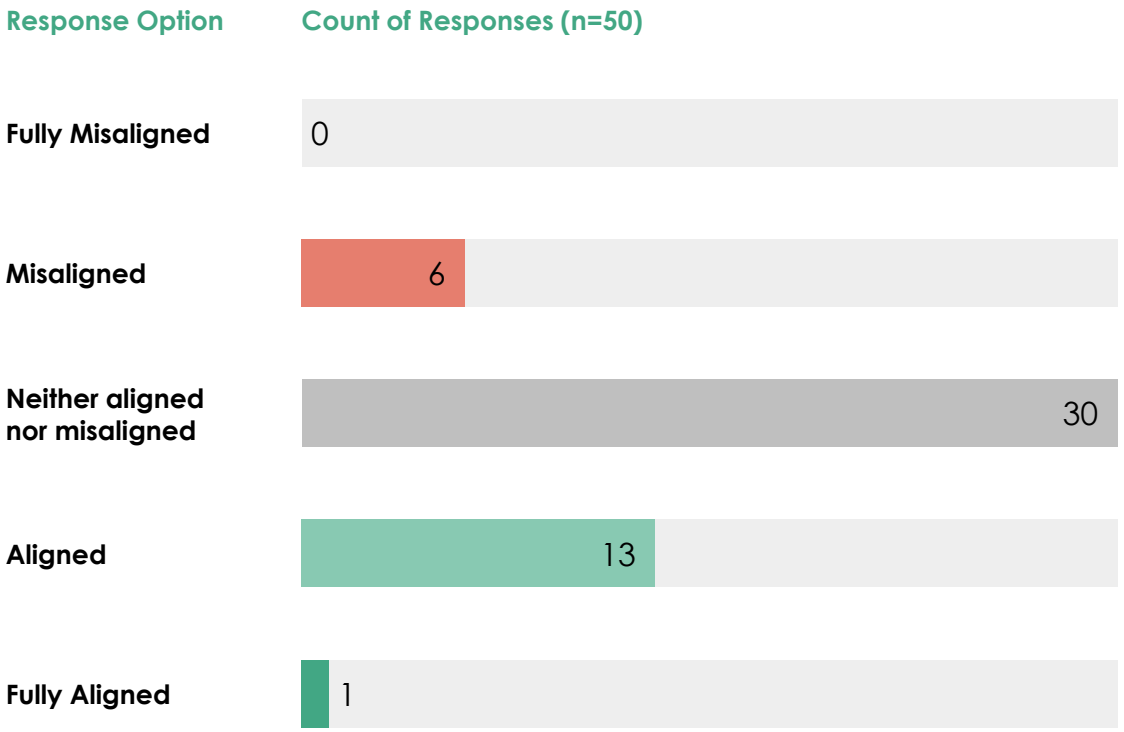
"The NHS is moving towards focus for population health, system-wide value and pathway redesign. As ICBs mature they will be shifting from transactional purchasing to strategic commissioning, meaning that decisions will be based on how medications contribute to broader outcomes."

"Companies will need to be much sharper on value, credible cost-effectiveness, implementability, and support for safe, best-value prescribing and medicines optimisation priorities that ICBs are already expected to deliver."

"The biggest problem facing the NHS in the next 12 months is finance and waiting list times. Instead of industry trying to sell a product, they need to collaboratively work with Trusts to help them solve problems they are facing. This relationship can no longer be transactional."

→ The operating model is being rewritten. The engagement model that succeeded in the last decade will not succeed in the next - companies that adapt first will hold a one-time structural advantage.

Q7: How Well Aligned is Industry with Current NHS Priorities?



Response Option	Count	% of Total
Fully Misaligned	0	0%
Misaligned	6	12%
Neither aligned nor misaligned	30	60%
Aligned	13	26%
Fully Aligned	1	2%
Total	**50**	**100%**

→ 60% of payers cluster at neutral and only 1 of 50 sees full alignment - ambivalence is the dominant verdict and the space industry must close to convert engagement effort into commercial outcomes.

Q7: How Well Aligned is Industry with Current NHS Priorities?

Accessus CHAT

Key Insights

- Of 50 senior NHS payers, only 1 considers industry 'Fully Aligned' with current NHS priorities - a striking signal of how few see the relationship as functioning at full effectiveness
- 13 payers consider industry 'Aligned' - meaning 14 of 50 (28%) sit in the positive half of the scale on alignment with waiting lists, workforce, pathways and savings
- 30 payers - the largest single group at 60% - report 'Neither aligned nor misaligned', indicating that the dominant payer view is ambivalence rather than active endorsement
- 6 payers report active 'Misalignment' - a smaller group, but one with disproportionate influence given their role in formulary, governance and commissioning decisions
- The clustering at the neutral midpoint suggests that industry is recognised as making effort, but is not yet seen as a reliable, consistent partner in NHS strategic priorities
- The gap between zero strong endorsement and meaningful active misalignment is the space industry must close to convert engagement effort into commercial outcomes

Payer Perspectives

"I would have selected Partially Aligned if it was an option. Industry is more aware of NHS priorities, but engagement would improve with greater focus on pathway simplification, workforce impact, reducing clinic activity and operational cost avoidance."

"There is some alignment, particularly where industry recognises pressures around pathways and system efficiency but it can be inconsistent. NHS priorities such as workforce constraints, waiting lists and cost pressures are acknowledged but not fully reflected in how solutions are presented."

"The industry is directionally aligned with NHS priorities, but operational alignment is still patchy. The biggest gaps are workforce impact and short-term affordability."

"I think at the moment there is scope for improvement and there are a lot of interesting things being developed in industry but it is unclear how they are helping with savings and waiting lists."

→ Ambivalence is not an opportunity - it is a verdict. 60% of senior payers do not see industry as actively aligned with NHS priorities, and the cost of that perception is a smaller share of voice on every decision.

Q7a: Why?

Key Insights

- Industry is seen as directionally aligned but operationally patchy - the principle is acknowledged, but the execution against workforce, capacity and affordability is inconsistent
- Workforce impact is the most consistently cited gap: payers cannot see what industry is doing to address NHS workforce shortages or build delivery capacity
- Short-term affordability is the second most cited gap - payers want value framed in this year's budget, not modelled long-term savings that don't release cash
- Industry messaging is described as 'national' when payers need 'local' - generic positioning that ignores ICB-level variation, formulary differences and local commissioning realities
- Industry is recognised as engaging on pathways but largely silent on prevention, early diagnosis and the population-health framing the NHS 10-Year Plan now demands
- Where alignment is reported as good, it is consistently linked to specific representatives or specific projects - alignment is recognised at the individual level more than the company level

Payer Perspectives

"I can't see anything industry does to support the workforce for example, but see a real shift in work around pathways. Savings on only drug costs is often a false economy but more economic analysis would be beneficial."

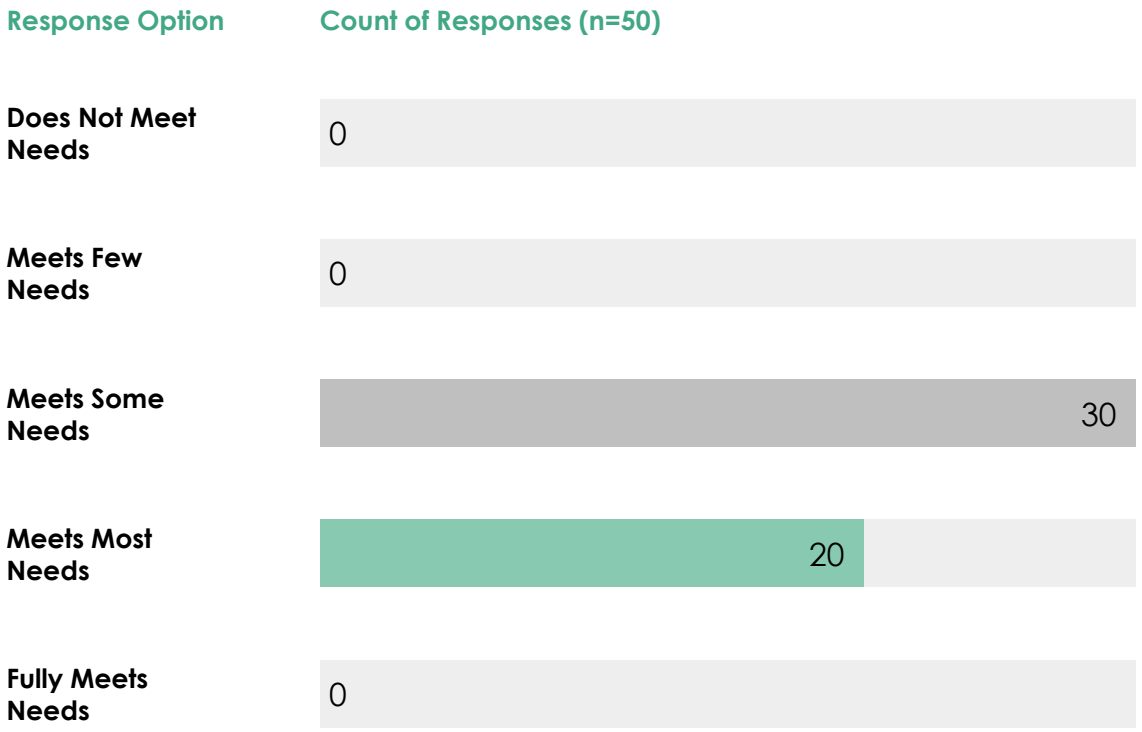
"Industry is aligned with the priority of reducing waiting lists through rapid innovation. However, uptake in the NHS is often slow due to approval waiting times. Industry has to cover R&D costs and develop a profit while the NHS is working within financial constraints."

"I think the biggest gaps are workforce impact and short-term affordability. The NHS would feel more aligned right now if NHS problems were addressed and not the assets. Translating the benefits into time saved, steps removed and decisions simplified would reduce the brain fog."

"Targeted emails sometimes reference savings and where a product can be used but needs to be more at system level so looking across primary and secondary care. A more holistic picture would be better. A lot of work is going into prevention and I haven't seen much of this in comms from industry."

→ Alignment is not an aspiration — it is a measurable practice. Companies that translate their offering into NHS time saved, steps removed and capacity freed will close the gap that messaging alone cannot.

Q9: How well does Industry Evidence meet NHS Decision-Making Needs?



Response Option	Count	% of Total
Does Not Meet Needs	0	0%
Meets Few Needs	0	0%
Meets Some Needs	30	60%
Meets Most Needs	20	40%
Fully Meets Needs	0	0%
Total	**50**	**100%**

→ No payer says industry evidence fully meets NHS needs - the verdict is partial, not absent. The 60/40 split between 'some' and 'most' shows evidence is strong on clinical efficacy, weaker on operational and budget dimensions.

Q9: How well does Industry Evidence meet NHS Decision-Making Needs?

Key Insights

- Of 50 payers, 30 (60%) say industry evidence 'Meets some needs' and 20 (40%) say it 'Meets most needs' - no respondent selected 'Fully meets' or 'Does not meet'
- The verdict is therefore consistent: industry evidence is partial, not absent - strong on clinical efficacy, weaker on operational and budget impact
- Trial efficacy data is universally well-presented; what is missing is real-world effectiveness, persistence and comparative data in unselected NHS populations
- Budget impact models exist but are rarely calibrated to local commissioning structures, ring-fenced budget lines, or the specific cost flows of an ICB or Trust
- Pathway and workforce implications are routinely under-modelled - industry analysis stops at the prescribing decision rather than running through to delivery and monitoring
- Comparative effectiveness data - head-to-head or NMA - is identified as the highest-leverage gap, particularly in crowded therapeutic areas

Payer Perspectives

"Real world data is very valuable. Real world persistence, speed of onset, and comparative data are decisive commercial variables."

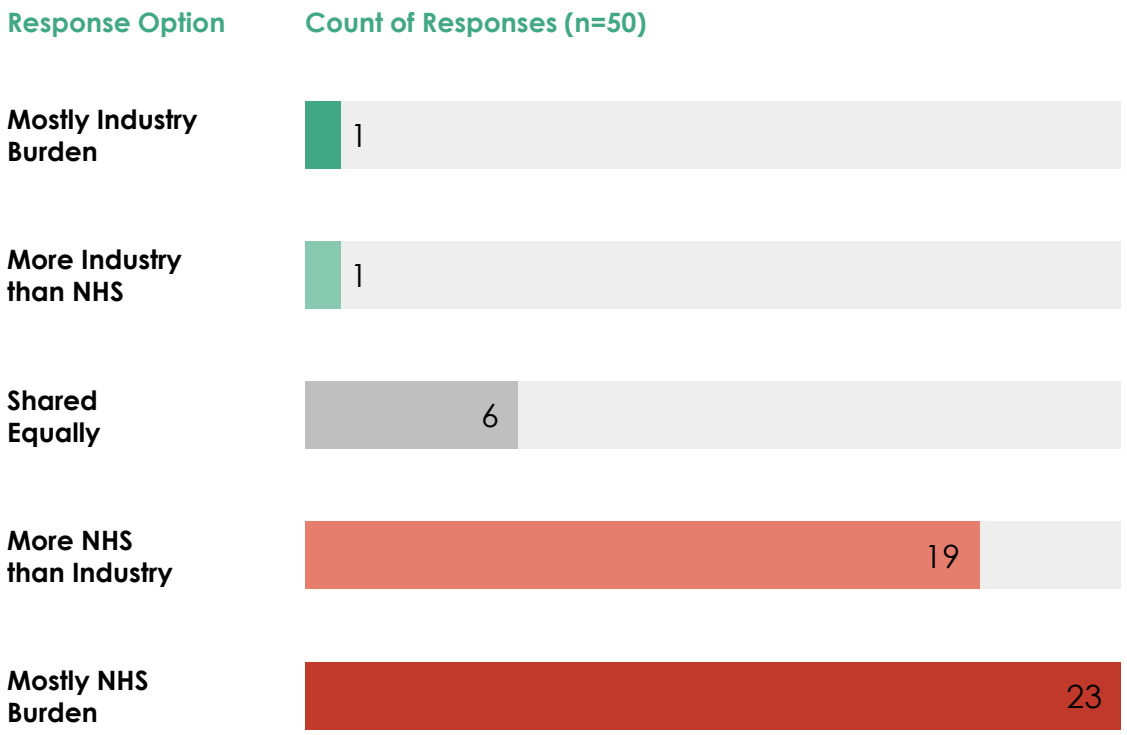
"Trial data is helpful but it doesn't always show how the medicine performs in the real-world NHS population we serve. We need data that reflects our patients, our pathways and our capacity, not idealised cohorts."

"Budget impact models calibrated to local commissioning structures, pathway analyses that reflect real workforce constraints, and honest assessments of implementation complexity are consistently more useful than comprehensive clinical packages."

"Industry produces data that's often very good clinically but stops short of answering the questions we actually need answered - what does adoption cost the system, can we deliver it, what does it do to the rest of the pathway."

→ Evidence completeness is now a commercial differentiator. The gap between trial evidence and NHS-decision-ready analysis is where adoption stalls - and where the next generation of competitive advantage will be built.

Q10: When New Products are Introduced, who Bears the Operational Burden?



Response Option	Count	% of Total
Mostly Industry Burden	1	2%
More Industry than NHS	1	2%
Shared Equally	6	12%
More NHS than Industry	19	38%
Mostly NHS Burden	23	46%
Total	**50**	**100%**

→ 84% of payers (42 of 50) report the burden falling on the NHS - the asymmetry is structural, not exceptional. Implementation support is the most undervalued commercial lever industry has available.

Q10: When New Products are Introduced, who Bears the Operational Burden?

Accessus CHAT

Key Insights

- 23 of 50 payers (46%) say burden is 'Mostly NHS' and 19 (38%) say 'More NHS than industry' — together, 84% report the NHS carrying disproportionate implementation effort
- Only 2 of 50 payers describe burden falling more on industry - the asymmetry is structural, not exceptional, and consistent across primary, secondary and specialised care
- Formulary applications, governance approvals, clinical guideline updates and prescriber education sit overwhelmingly within NHS workflows
- Patient identification, monitoring protocols, EPR builds and electronic prescribing changes generate substantial NHS technical effort that is rarely supported by industry resource
- Pathway redesign and service reconfiguration following adoption are almost universally NHS-borne, even when the new product is the explicit driver of the redesign
- Where industry does absorb burden - homecare logistics, prescriber capacity, digital monitoring, joint funding for non-medical prescriber roles - it is described as transformative and differentiating

Payer Perspectives

"Once a drug is approved nationally, that approval is only the starting point. In oncology, medicines go through multiple layers of local governance — formulary approval, pathway redesign, electronic prescribing builds, funding flows, staff training, and risk assessment."

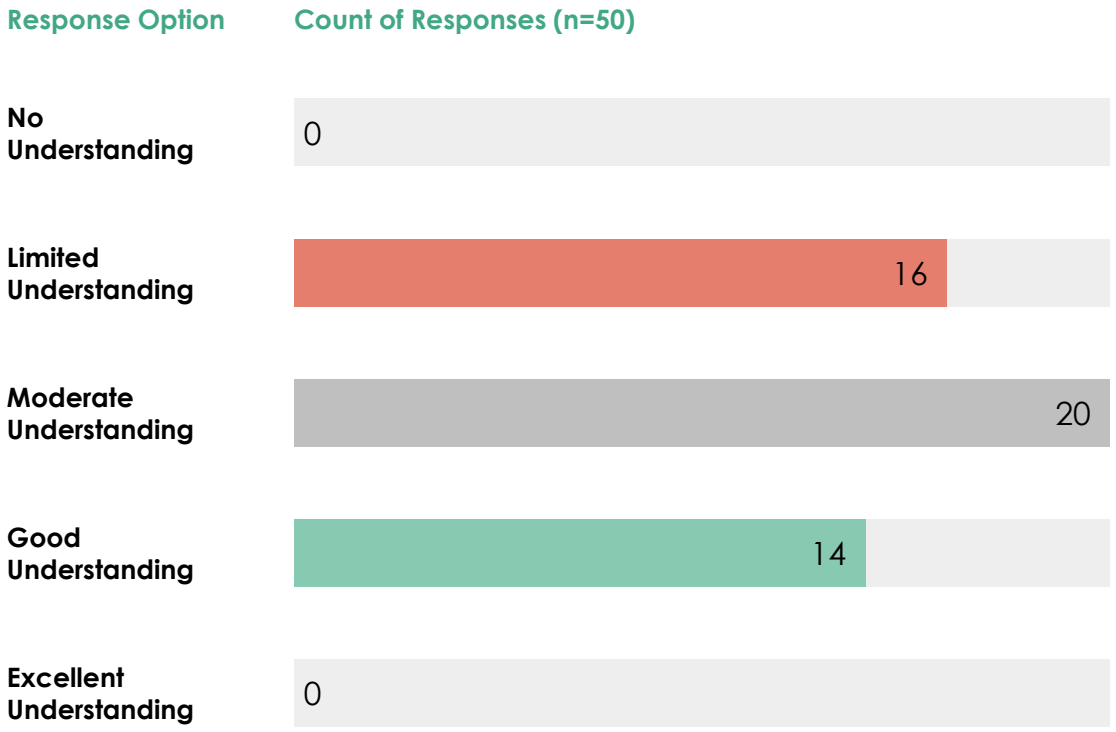
"Industry proposals can sometimes assume a level of resource or flexibility that simply doesn't exist within the NHS. For example, adding monitoring requirements, complex manufacturing of drugs, short expiry of compounded drugs without fully recognising the operational impact on frontline teams."

"Effective collaboration is when industry brings practical implementation support - protocols, risk assessments, checklists, flow charts, training support - and stays engaged through the full implementation cycle, not just the launch."

"My trust has a new jointly industry-funded non-medical prescriber role embedded within an oncology sub-specialist team, designed to strengthen prescribing capacity and support the safe introduction of increasingly complex treatments."

→ Implementation support is the single most undervalued commercial lever. Companies that absorb a meaningful share of the burden differentiate themselves materially from those that do not - and earn faster, more durable adoption.

Q11: How well does Industry Understand NHS Financial Structures and Approval Pathways?



Response Option	Count	% of Total
No Understanding	0	0%
Limited Understanding	16	32%
Moderate Understanding	20	40%
Good Understanding	14	28%
Excellent Understanding	0	0%
Total	**50**	**100%**

→ No payer rates industry understanding as 'Excellent'. The modal answer is 'Moderate' - industry is informed enough to engage, but not informed enough to navigate commissioning architecture fluently.

Q11: How well does Industry Understand NHS Financial Structures and Approval Pathways?

Accessus CHAT

Key Insights

- Of 50 payers, 16 (32%) report 'Limited understanding', 20 (40%) report 'Moderate' and 14 (28%) report 'Good' - no respondent selected 'Excellent'
- The modal answer is therefore 'Moderate' - industry is seen as informed enough to engage but not informed enough to navigate the financial and approval system fluently
- Block contracting, tariff-funded vs cost-and-volume drug commissioning, and ring-fenced budget rules are repeatedly cited as poorly grasped by industry account teams
- Differentiation between national (NHSE-commissioned) and local (ICB-commissioned) drug funding flows is described as a frequent source of avoidable friction
- ICB-level variation in formulary and prescribing pathway processes is consistently underestimated - payers describe industry expectations as built around 'an NHS that does not exist'
- The NHS Long-Term Plan, ICS structures, and emerging strategic commissioning architecture are recognised by industry but rarely translated into account-level engagement strategy

Payer Perspectives

"Industry messaging is often too generic and NICE-focused, whereas prescribing decisions in primary care are made at PCN and ICB level and are heavily influenced by local workload, operational impact, and health inequalities."

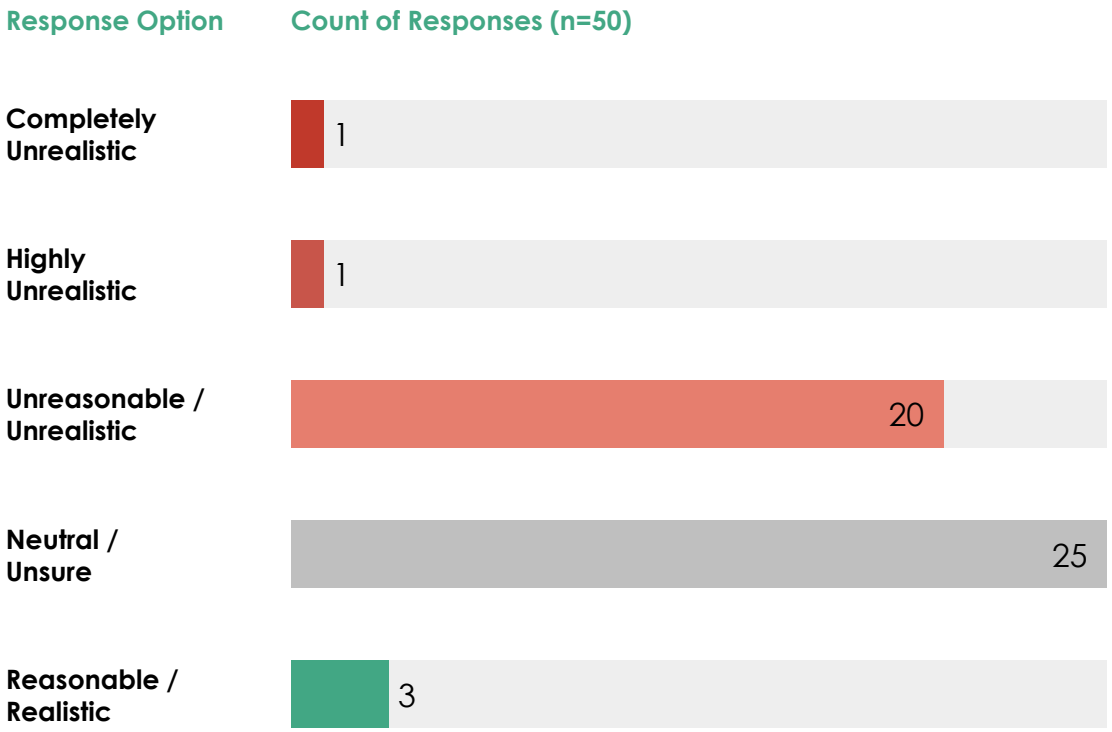
"Communication from industry can be naive to the more complex commissioning and funding pathways that exist in the NHS, and governance and implementation considerations. It is not as straightforward as just implementing a new medicine into clinical practice."

"Approval pathways can be different from region to region and this must be incredibly difficult to navigate, when access to those that know or control those pathways are difficult to access or communicate with."

"Not all high cost drugs are funded on a cost-and-volume basis by commissioners which will have an impact on decisions on prescribing. Trusts are largely on block contracts for the majority of activity and so in-year benefits should be maximised."

→ NHS financial fluency is now a commercial capability, not a back-office competence. Companies that build account-level understanding of commissioning architecture pull ahead of those still operating at NICE-only level.

Q12: Are Industry Timeline Expectations Realistic?



Response Option	Count	% of Total
Completely Unrealistic	1	2%
Highly Unrealistic	1	2%
Unreasonable / Unrealistic	20	40%
Neutral / Unsure	25	50%
Reasonable / Realistic	3	6%
Total	**50**	**100%**

→ Only 3 in 50 payers consider industry timelines realistic. Compressing real timelines requires absorbing implementation effort - not pressuring NHS decisions to move faster against governance cycles they cannot collapse.

Q12: Are Industry Timeline Expectations Realistic?

Key Insights

- Of 50 payers, only 3 (6%) consider industry timeline expectations 'Reasonable / realistic' - the most striking quantitative finding in the survey
- 20 of 50 (40%) describe industry timelines as 'Unreasonable / unrealistic', with 1 selecting the most critical option ('Highly unrealistic')
- 25 of 50 (50%) selected 'Neutral / unsure' - a substantial group that signals doubt rather than agreement, and represents the largest persuadable cohort
- Industry timelines are described as built around commercial launch windows rather than NHS governance cycles, formulary committee schedules and pathway redesign timeframes
- ICB restructuring and contact churn are compounding the gap - established relationships are dissolving precisely when industry is asking for accelerated decisions
- Where industry has succeeded in compressing real timelines, it has done so by absorbing implementation effort - not by pressuring NHS decisions to move faster

Payer Perspectives

"It's very important. If we don't understand the budget impact, clinical consequences and capacity burden before launch, we risk adopting something that looks good on paper but is difficult to deliver safely."

"Industry works at a much faster and competitive pace than the NHS. There is a lot of bureaucracy in the NHS where new treatments must go through layers of management and approval. Even then, due to continuous financial constraints, it is challenging for industry to quickly have their products available."

"The pace at which the NHS and industry work also differs. NHS focus on annual planning and strategies, whereas industry has more shorter timelines, seeking more swift turnaround. This can result in frustration and missed opportunities."

"Requests for rapid decisions despite months-long NHS approval processes - these experiences have made teams more cautious and sceptical, less willing to engage without clear purpose."

→ Compressing timelines requires absorbing implementation effort, not pressuring decisions. The companies that understand this run with the system; those that do not run against it - and lose.

Q13: Importance of Pre-Launch Insight into Budget, Clinical and Capacity Consequences

Accessus CHAT

Key Insights

- Pre-launch visibility into budget, clinical and capacity consequences is universally described as critical, particularly in oncology, biologics and high-cost specialised care
- Without early insight, payers describe adopting medicines that 'look good on paper' but generate avoidable downstream pressure on already-stretched services
- Pharmacy, manufacturing complexity, aseptic capacity, clinic flow, monitoring and training are all cited as cost dimensions invisible at acquisition-cost level
- Early industry engagement enables workforce and infrastructure planning, pathway adjustment, and identification of alternative pathways before launch - compressing real-world implementation
- Payers want this engagement to be honest, not promotional - including frank discussion of implementation complexity, contraindications, and operational unknowns
- Companies that engage 12-18 months pre-launch with whole-pathway analysis are described as differentiated; companies that arrive at launch are described as 'too late' for genuine collaboration

Payer Perspectives

"Within the oncology setting, when each new treatment is evaluated, the cost analysis not only factors in the drug acquisition cost but also pharmacy workload, manufacturing complexity, aseptic capacity, clinic flow, monitoring requirements and training needs."

"Very important to ensure complete business cases, clear funding routes and realistic service planning. It would be really helpful if the industry can support financial modelling, workforce and pathway impact all of which would be helpful before the launch."

"This is one of the most important things. As said previously it is all well and good having a cost effective medicine or product but if it cannot be implemented or it creates a lot of work for NHS teams to implement then this hinders the product reaching patients in a timely manner."

"The real benefit in engagement with industry is well before product achieves its commissioning status. By that time it's often too late to influence their decision - i.e. on development of delivery device or whether they are considering homecare for example."

→ Pre-launch engagement with NHS-ready analysis is now table stakes for high-cost or complex therapies. The window for industry input on delivery design closes at commissioning - and it does not reopen.