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HEALTH AND SOCIAL CARE

INSIGHTS

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A GK Strategy Publication

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Health

GK Strategy has a wealth of experience in the health and social care sector. Whether advising investors and management teams on both sell-side and buy-side in a transaction process, working with both businesses and public providers on their communications strategies and engagement with policy-makers, or providing ongoing support and advice on the political and regulatory environment to mitigate risk and create value, GK's experience extends across the market.

GK Strategy *Insights*

Phil Hope is a former Care Services Minister and visiting professor at Imperial College, London. He is co-author of the 2020 Health Devolution Commission report 'Building Back Better Health and Prosperity' and co-chair of the Future Social Care Coalition, and a trustee of housing and care charity Brunelcare.

THE HEALTH AND SOCIAL CARE LANDSCAPE IN 2021: FIVE THINGS TO LOOK OUT FOR

By Phil Hope // GK Strategic Adviser

2021 will be another year of significant change in the health and social care landscape due to COVID-19, as NHS England continues to implement its Long Term Plan and the Government decides how to respond to demand for social care reform. Here are five things to look out for:

1.

Direct impact of COVID-19

The pandemic has created a backlog in services that will continue in part to be filled by private sector health providers, funded from the additional £3bn winter support for the NHS announced prior to the Spending Review, but it is unclear how the £500m allocated to mental health services will be used. Remote GP consultations may become mainstream but mass vaccination programmes may reduce GP time on other services. Government resources will remain focused on reducing infections, and protecting the NHS and saving lives, with the test-and-trace system a top priority.

New NHS architecture

2.

The pandemic has exposed the gap between NHS, social care and public health services. Better collaboration between commissioners and providers across the NHS and social care developed during the pandemic will be more firmly embedded, but schemes like the Better Care Fund are now seen as 'papering over the cracks'. Fundamental reform in 2021, however, appears unlikely and the focus within NHSE will be implementation of the Long-Term Plan (LTP).

The Department of Health and Social Care (DHSC) also appears to want to take back some control over health from NHSE; there is a clear direction of travel within government away from decentralisation despite cross-party calls for greater devolution of health.

3.

Reform of primary care

Development of Primary Care Networks will continue. These provide a platform for integration within and between services. The use of new social prescriptions will grow quickly as 3 Link Workers are recruited to work in each PCN. The relationship between this new category of NHS worker and others will be an area to watch.

GK Strategy *Insights*

Workforce challenges

4.

The biggest challenge in 2021 may be the health and social care workforce. There are ongoing staff shortages in different areas, and a revised NHS People Plan could be published next summer. The social care workforce has additional challenges around pay and conditions. It is unclear what the combined impact on staffing will be of the predicted freeze on public sector pay, Brexit and the mass test, trace, and vaccinate campaign.

There will be a growing role for staffing bodies in making a case for change to resolve challenges in each sector. For example, the Future Social Care Coalition has recently called for an immediate pay rise for social care staff, followed by a workforce strategy covering pay, recruitment, training and development.

5.

Social care

The pandemic has led to calls for action to 'capture the moment' for improving social care, with recent significant contributions by the Health and Social Care Committee and the Care Quality Commission . A 'quick win' could be for the Government to enact the Dilnot reforms already embedded in legislation but not enacted. However, Treasury resistance is likely to be fierce despite a manifesto commitment to reform.

Each locality will work to new winter social care plans, which are likely to be extended into the spring and possibly the summer.

Useful Links

https://healthdevolution.org.uk

https://futuresocialcarecoalition.org

https://committees.parliament.uk/work/136/social-care-funding-and-workforce/

https://www.cqc.org.uk/publications/major-report/state-care

NHS SPENDING – A LOOK FORWARD

by Alistair Burt // Strategic Adviser

The current foundation of the NHS budget is the five-year funding announced by Theresa May's Government in 2018, which detailed a predicted cash rise in NHS budget of £33.9bn by 2023. This year's planned spend of £143bn was set before COVID-19, but increased by Rishi Sunak by an initial £31.9bn for health services in the 2020 Summer Statement for a variety of COVID-led demands. This was followed a few weeks later by a further £1.5bn for capital and a reserve of £3bn for revenue spending heading into the winter pressures.

The pressures on health budgets are widespread. Attention is focused on acute hospital treatment but there are many other demands upon it which can be too easily missed. What will also be important to look for is not just how immediate pressures are eased, but what long-term changes are being flagged up. What we have seen recently is a ruthless spotlight on things which have been exposed as failing, and people beginning to think not simply of dealing with instant demands, but working out what will not 'go back to normal' and therefore planning ahead.

£3bn has been announced for scans, elective surgery and up to one million treatments to acknowledge the backlog of demand caused by postponements.

Mental health will be boosted. This should see not just a response to current pressure, but also a welcome addressing of services which have been under pressure for many years, as appointments for young people are notoriously slow.

Community pharmacy should not be ignored. Pharmacy has performed excellently under pressure, highlighting the need for NHSE to revise their plans to convert more of it to an Amazon-style delivery service. At some cost to pharmacists themselves, they have stood by their customers and deserve recognition and the finance they need to stay afloat and continue to provide for the public.

Public Health should see a boost. Policy Exchange's Richard Sloggett, a former adviser at DHSC, argued in a paper just a couple of weeks ago that the over attention to the institution of the NHS had caused neglect to public health, and that the pandemic had highlighted obesity and inequalities as killers. He urges a stronger focus on public health and to use the new National Health Institute for Health Protection as an opportunity to recover a 'lost decade'. I expect to see a boost in funding there.

Finally, the complexities of health spending in England means that local government budgets cannot be ignored, due to their impact on social care. The Government must move urgently to resolve social care funding - there has never been greater pressure or a better time to get cross party agreement to what has been exposed as an area of risk for the public, and one which will not diminish in time with our ageing population. As we do not yet have a new answer to this, more money will have to be allocated to both the NHS and local government elements of this equation.

Attention is focused on acute hospital treatment but there are many other demands upon it which can be too easily missed.

Alistair served as Minister of State for Care at the Department of Health, overseeing primary and community care and mental health.

Alistair has held several ministerial roles over a 33-year career as a Conservative MP, including at the Foreign Office, Department for International Development and Department for Social Security. He left the Government and stepped down from Parliament in 2019.

HEALTH AND SOCIAL CARE REORGANISATION: LEGISLATIVE CHANGE IS COMING

Edward is a health and care policy specialist. He has worked with clients across the NHS, royal colleges, pharmaceuticals, health tech and private provider sectors. Prior to joining GK, Edward worked as a parliamentary assistant in the House of Commons.

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By Edward Jones // Senior Account Manager

Next year, the Government is due to publish proposed legislation which would re-organise the NHS. This is meant to be an evolution, rather than a revolution, accelerating the implementation of the NHS Long Term Plan, NHS England's own plan to make the health service better able to manage rising demand for services and chronic illnesses by more effectively joining up care and using the latest innovations. Any such legislative change will change the environment and the market for health and care service providers, product suppliers, consultancies, workforce membership bodies, pharmaceutical and health tech companies operating in the sector.

Department of Health and Social Care and Downing Street are still undecided on just how radical it is going to be.

The 'NHS Bill' was announced in the December 2019 Queen's Speech and initially due to be published in 2020, but due to the COVID-19 pandemic and concerns about potential political difficulties passing health legislation during winter pressures, it has been delayed until Spring 2021. Although the aims of the Bill are clear – co-ordinating decision making to join up care – the Department of Health and Social Care and Downing Street are still undecided on just how radical it is going to be. There's a range of possible outcomes for the content of the Bill, but we still have an idea of what each end of this range looks like – let's call these 'minimum legislation' and 'maximum legislation' models.

'Minimum Legislation'

The least radical option, the 'minimum legislation' model, would see the Government stick fairly tightly to the proposals for legislation put forward by NHS England in the Long Term Plan itself. Both NHS England and the Health and Social Care Select Committee have acknowledged the public desire to avoid a perceived costly "top down reorganisation of the NHS", an incentive to limit the scale of reform. These changes would effectively unpick specific parts of Andrew Lansley's Health and Social Care Act 2012 and aim "to free up different parts of the NHS to work together and with partners more easily". These changes would include:

1. ***Competition –*** Removing rules forcing automatic tendering of NHS services and the role of the Competition and Markets Authority in policing this. This is a symbol of a broader shift in the NHS management culture away from competition towards co-operation.
2. ***Commission and Tariffs –*** NHS England wants legal power to set a new 'blended tariff', combining block contracts with additional payment by procedure, to encourage innovation. It is also experimenting with tools such as Aligned Incentive Contracts, the provide financial bonuses for services which cut demand for other providers' health service, aligning the incentive to save money for the NHS overall. Legal changes will also health service commissioners to consider competing bids on quality and not solely on price.
3. ***Joint-Committees –*** To co-ordinate spending decisions to make sure the 'system' (rather than individual providers) gets best value, NHS England plans to establish joint decision-making committees of service providers (like NHS trusts and commissioners (usually Clinical Commissioning Groups, CCGs). These would meet and take decisions on a voluntary basis, with a CCGs implementing decisions. Like tariff reform, this would aim to encourage spending on services and products which provide a strong return on investment but not necessarily for the organisation spending the money (for instance, a community care provider may invest lots of money in a service which reduce admissions to the local hospital, but currently the hospital makes all of the savings while the community care provider would be out of pocket and not see the financial rewards).

4. ***Commissioning/Regulation Merger –*** NHS England (legally the Commissioning Board for England) has already merged with NHS Improvement (an amalgamation of statutory regulatory bodies) in practice to streamline governance, but legal restrictions create some barriers (for instance, both bodies have separate Chairs and CEOs on paper). This change will tidy up the governance arrangements but have little impact on day-to-day services or procurement.

> This may mean the end for Clinical Commissioning Groups as we know them and be a big step towards overcoming the three decade-old purchaser-provider split,

'Maximum Legislation'

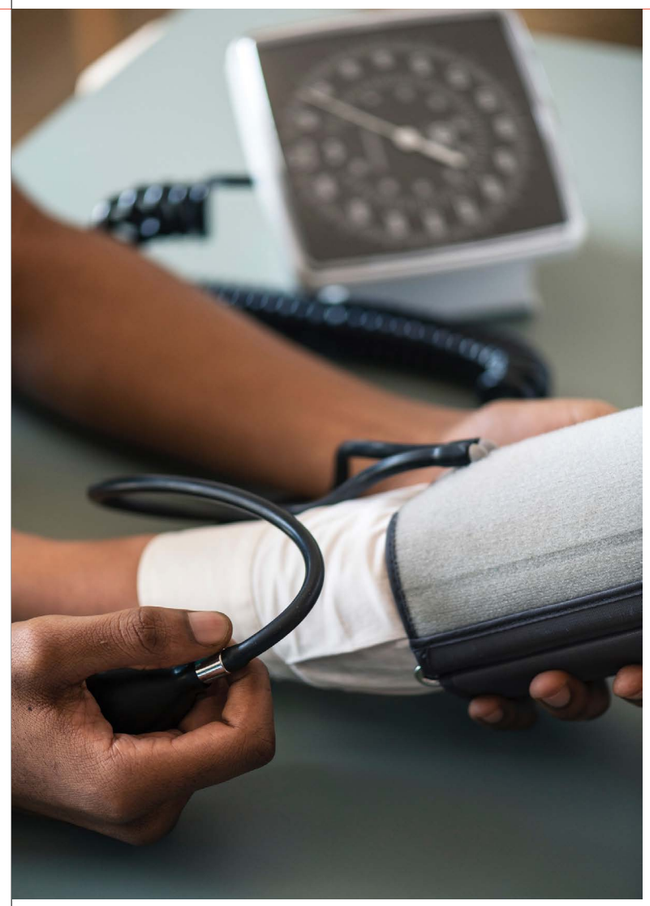
At the more radical end of the spectrum, the 'maximum legislation' would advance many changes already in motion to their logical end point but represent a more significant departure from the landscape set up in 2012, redesigning the healthcare architecture.

NHS England has already set a target for every part of England to be part of an 'Integrated Care System' (ICS) by April 2021. ICSs are partnerships of NHS commissioners and providers, also involving local councils, taking collective (although not legal) responsibility for managing resources in local areas and co-ordinating care.

5. ***Political Control –*** The Government, frustrated with its limited powers during the pandemic, may return greater power to the Secretary of State to direct NHS England, which currently has a high degree of autonomy and policy control, in effect increasing political control over the NHS. The Department of Health and Social Care would become a much more important stakeholder than at present for anyone seeking to shape health policy.

6. ***Commissioning Overhaul –*** There is growing momentum, including from NHS England and the Treasury, to make ICSs statutory organisations, rather than just partnerships, enabling them to hold budgets and maybe hire and fire. If ICSs become statutory finance holding bodies, this may mean the end for Clinical Commissioning Groups as we know them and be a big step towards overcoming the three decade-old purchaser-provider split, given the members of public healthcare provider organisations sit on ICSs governing bodies.

7. ***Public Health –*** The public health system, again set up by the 2012 Act, has been smashed by the Government's decision to abolish Public Health England and replace only some of its functions relating to infection control and pandemics with a new National Institute for Health Protection. This leaves out health promotion (such as health eating, weight loss or stop smoking efforts) which, having been part of its Long Term Plan, could be picked up by NHS England. Meanwhile cross-governmental responsibilities like air pollution could go back to the Department of Health and Social Care. Either way, the abolition of Public Health, a statutory body, and reallocation of its responsibilities will require primary legislation.



8. ***Social Care –*** Back in 2017, as Prime Minister Theresa May turned the Department of Health into the Department of Health and Social Care, but this remains a largely aesthetic change as budgets for social care are still control by the Ministry for Housing, Communities and Local Government, which is responsible for local authorities who are usually the local commissioners of social care (aside from funding pots like Continuing Care and the Better Care Fund). The new Bill might finally address the division between health and social care by moving responsibility and the £22.5bn in annual funding for social care services away from local authorities in England to NHS England. This would be designed to make it easier for care users to access all forms of social and nursing care and reduce pressure on hospitals and see the same people making decisions for commission both health and social care, joining up decision-making.

> Integrated Care Systems will increasingly become the locums for local decision-making

Conclusion

So, what does this all mean? There has still been no final decision on how radical the NHS Bill will be and the nuanced answer is that different changes will mean different things for different people. Service providers, product suppliers, consultancies, membership bodies, pharmaceutical and health tech companies will need to consider upcoming changes in light of their own business models. We can, however, still draw some sweeping conclusions. However far the Bill goes, Integrated Care Systems will increasingly become the locums for local decision-making, and the NHS might just begin to feel a bit more like a unified body, rather than fragmented smaller organisations. In future, changes in commissioning governance and payments systems will increasingly favour services and products whose benefits a felt across boundaries and siloed budgets and therefore historically may have struggled for investment. Out of hospital care – community health provision, telehealth technology – which can keep patients healthier and from going in or back into hospital should benefit from increased investment as they reduce demand on the most expensive parts of the health system.

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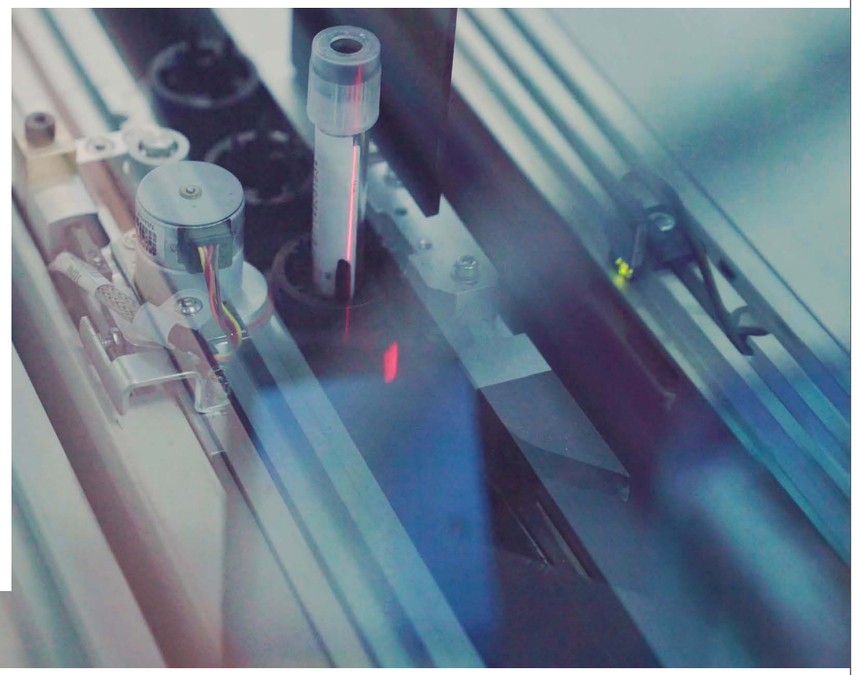

NEW RISKS AND OPPORTUNITIES FOR PRIVATE SECTOR PROVIDERS AND INVESTORS

By Martin Summers // Associate Director

COVID-19 has created new opportunities for the private sector as the NHS has reached for additional capacity to cope with the crisis. But the high political profile of COVID has also created new risks with additional scrutiny of the private sector as the Government has come under fire from the National Audit Office and politicians for how well it undertook COVID procurement. Meanwhile, COVID, Brexit and the US election have overshadowed some key other developments that will bring risk and opportunity.

So, what are the major risks and opportunities that will accompany private sector providers (and their backers)?

COVID-19 has created new opportunities for the private sector as the NHS has reached for additional capacity to cope with the crisis.

The first opportunity is that at a national and local level, a lot of political and cultural antipathy to the private sector has been overcome, as Trusts have turned to the private sector to provide increased capacity – whether it's through staffing, temporary facilities or clinical services (where private sector hospitals have enjoyed a boom in NHS business.)

There is, however an accompanying risk, driven less by problems with providers at a local level than with the heightened scrutiny of private sector providers driven by concerns about central government COVID procurement. Private providers should ensure they are well prepared to effectively address scrutiny of their fees and margins.

The NHS, like much of the public sector, has shown itself to be remarkably flexible in responding to COVID. Very different ways of working and boosting capacity have happened without the usual preliminary work of often top-down extensive consultation and strategy development.

The cause of local operational flexibility and relative operational autonomy may therefore gain an upper hand over centralising tendencies (though we may see more centralisation in some aspects of health care – *see Ed Jones' piece).*

Huge opportunities lie with the digital transformation of healthcare. The digital agenda for healthcare is more advanced and better funded than in other government departments. However, the true pace of the digital agenda is measured not by government announcements but by local NHS uptake.

Many trusts are still addressing basic issues like electronic patient records, so their capacity to embrace other big digital projects is limited by their ability to manage them well. However, opportunities abound for more discrete 'plug and play' applications which work with the grain of existing procedures (while transforming their speed and effectiveness).

Opportunities also lie with the Government's agenda on social value. Its important procurement notice from September on social value applies to all central government departments and executive agencies and now makes social value – the delivery of demonstrable social, economic and environmental benefits – a much higher priority than before in contract award criteria and also puts delivering COVID-related policy outcomes centre stage, (e.g. Help local communities to manage and recover from the impact of COVID-19). Competitive advantage can be gained from addressing this agenda.

The environment for private sector providers is fast moving and largely beneficial. It will most reward companies that can understand this change and see the bigger picture – rather than just more contract opportunities.

WHAT DOES THE END OF THE TRANSITION PERIOD MEAN FOR MEDICINES AND MEDICAL DEVICES?

By Joe Cormack // Account Director

Joe is a GK Account Director and health specialist and advises organisations operating in the life sciences sector including pharmaceuticals, medtech and clinical research.

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We are still unclear about the UK's future trading relationship with the EU, and this will impact organisations in the life sciences environment. Even if an agreement is negotiated, it will be a "thin" deal that diverges significantly from what the pharmaceutical and clinical research sectors were previously lobbying for.

Newly-created barriers to the movement of goods from 2021 have been well documented and the potential ramifications for the highly sensitive medicines supply chain are significant. There is concern that despite guidance set out in the Border Operating Model there will be additional logistical costs associated with the movement of many products (including medicines and medical devices). This is despite medicines and medical products coming under "Category 1" goods, meaning priority contingency planning is in place to ensure that imports remain as smooth as possible even in the event of a no deal.

Even if an agreement is negotiated, it will be a "thin" deal that diverges significantly from what the pharmaceutical and clinical research sectors were previously lobbying for.

Beyond the border, there are changes relating to medicines and clinical trials. These are enabled via the Medicines and Medical Devices Bill currently nearing the final stages of its progress through Parliament. The Bill transfers powers to the UK to regulate the safety and licensing of medicines and devices.

One of the effects of these changes is the Medicines and Healthcare Products Regulatory Agency (MHRA), the UK's medicines and medical devices regulator, is required to adapt and expand its role. In September, the

MHRA published new guidance relating to clinical trials, medical devices, licensing, importing and exporting and pharmacovigilance (the monitoring of licensed products).

The intention of the Department for Health and Social Care and the MHRA is to try and enable straightforward replication of the processes of the European Medicines Agency (EMA) and European Medical Device Regulation and enable a smooth transfer to the new requirements established in the UK. An example of this is the relative ease with which current EMA-authorised medicines can be grandfathered over to the UK system, enabling no regulatory delay in the use of these treatments from January.

The intention of the Department for Health and Social Care and the MHRA is to try and enable straightforward replication of the processes of the European Medicines Agency

New MHRA guidance has been welcomed but there remains uncertainty. For instance, as with the wider Brexit negotiations, the Northern Ireland protocol remains an issue and the MHRA are unable to give the certainty that industry would like. Northern Ireland will stay under the EU regulatory regime for medicines following the end of the transition period and this will have ramifications regarding links with Great Britain.

The Association of the British Pharmaceutical Industry (ABPI) recently gave evidence to Parliament on the impact of the end of the transition period in the Northern Ireland. New burdens in moving treatments between Great Britain and Northern Ireland and differences in licensing and monitoring approved medicines could mean that global companies develop and transport products for Northern Ireland via the Republic of Ireland, rather than from Great Britain.

Investors in medicines and medical products will want to assess what MHRA guidance means for market access and adapt business processes accordingly. The further clarity given as part of any movement on Brexit negotiations will also need to be considered.

2021 – FINALLY, A NEW FUTURE FOR SOCIAL CARE?

By Jack Sansum // Senior Account Executive

Social care. For successive leaders and political parties it has been a perennial political football which has been continually kicked down the halls of Whitehall. From Labour's 2010 "death tax" to Theresa May's "dementia tax", over recent years there have been a multitude of "white" and "green" papers, reviews, commissions and parliamentary inquiries.

Now, with financial pressures on local authorities increasing, and COVID-19 pushing the sector to the brink, will something finally give?

Fixing social care "once and for all"?

15 months have passed since Boris Johnson promised to "fix the crisis in social care once and for all." Johnson's administration pledged to begin cross-party talks to find a solution to find a solution within the new government's first 100 days, but this was superseded by the COVID-19 outbreak.

Even in a pre-COVID world, demand for adult social care would have likely continued to rise, and there appears to be little room left for local authorities to make further efficiencies. Quite simply, if the government wants to improve social care, then it will need to spend substantially more.

Whitehall rumours and ministerial musings

The Prime Minister has established a health and social care taskforce led by Baroness Cavendish, and including senior civil servants and advisers from Downing Street, the Treasury and the Department of Health and Social Care (DHSC) to review both health and social care in England . The taskforce will consider a number of reforms to the system.

> To engage with the Government's plans for reform effectively, organisations will need to understand the wider direction of health and social care policy.

Once option could see social care being brought under the control of NHS England, taking responsibility away from councils – together with £22.5bn in annual funding. The move, which would swell the NHS budget to £150bn, would see services commissioned and budgets controlled by embryonic integrated care systems (ICSs). However, this would require legislation.

The funding mechanism will be crucial in underpinning a long-term plan for care. In October, Johnson outlined a plan to bring "the magic of averages to the rescue of millions", implying a National Insurance style system to pay for care could be considered.

The Government is also said to be considering capping care costs, revisiting the 2011 Dilnot report which suggested there should be a limit on the amount which anyone should pay for their care in their lifetime, fixing the figure between £25,000 and £50,000.

Proposals into policy

With plans for reform of the sector likely to be on the agenda in 2021, the Government is due to publish a white paper outlining its proposals.

To engage with the Government's plans for reform effectively, organisations will need to understand the wider direction of health and social care policy. Health and social care is GK Strategy's largest policy area and we are expert at supporting organisations operating in highly regulated sectors, helping them to navigate complex markets and build relationships with key decision-makers.

With the Government signalling its intention to deliver on its commitment to shake up social care, there are plenty of opportunities for providers to benefit.

Jack has advised organisations across the breadth of the health and social care system during his three years at GK. A social care policy expert, he has developed a reputation for delivering policy and public affairs campaigns, working with clients to develop their political strategy and stakeholder engagement.

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2021: A RESET FOR NHS DIGITAL STRATEGY?

by Olivia Rohll // Senior Political Analyst

There has been much comment on the rapid pace with which health and care services have adopted digital solutions during the COVID-19 pandemic. The last year has highlighted the importance and benefits of digital transformation, from online GP appointments to remote working technology, and has transformed attitudes towards the private sector across the health service.

Going forward businesses in the health tech space should be prepared for a reversion to a more cautious pace of adoption, as the DHSC and NHS assess successes and failures, and update strategies to take account of the new digital health landscape. Future plans will be backed by a multi-year NHS capital spending deal, one of the most lavish pledges in a Spending Review mostly made up of single-year commitments. A well-funded and carefully considered strategy for 2021 onwards would offer much needed direction and clarity for the health tech sector.

The pandemic has come at a significant time for the NHS digital project. NHS capital spending (including on digital) has been in limbo since last year's one-year extension to the 2015-19 spending period. Meanwhile DHSC and NHS leaders have come under scrutiny over the perceived failure to achieve value for money from previous digital transformation efforts, with reports published by both the National Audit Office (NAO) and Public Accounts Committee (PAC).

Businesses in the health tech space should be prepared for a reversion to a more cautious pace of adoption, as the DHSC and NHS assess successes and failures, and update strategies to take account of the new digital health landscape.

The need to achieve value for money from future activity means leaders in the NHS and DHSC will be keen to get it right in 2021, creating opportunities for thoughtful Government engagement from businesses offering on-the-ground perspectives.

Influential stakeholders are already highlighting the need for a more measured approach to technology adoption than has been seen during the COVID-19 crisis. The Nuffield Trust has called for further work to understand the experiences of patients and clinicians taking part in remote consultations and therapies, pointing out the value of the social aspects of face-to-face contact with the health service. The think tank also explores the ways in which increased use of technology might exacerbate health inequalities – disadvantaging people with limited digital literacy or access to the internet or a smartphone.

The focus on frontline provision also obscures the underlying challenge of creating interoperable systems that allow seamless sharing of data and records. The uneven digital maturity among local health systems is currently a barrier to patients across the country benefiting equally from digital innovation. Similarly, it has become clear that care homes, nursing homes and the social care sector in general has been left behind on digital, and more work is needed to bring them up to speed.

As a result, businesses that demonstrate consciousness of the challenges associated with digitisation, and that offer innovative solutions to address them will be in a good position to benefit from a strategy reset, along with associated funding allocations over the coming years.

Olivia is a researcher covering a range of sectors for GK's political due diligence reports. She previously worked in the finance sector covering UK and European political developments, and also has first-hand experience of Parliament having worked in an MP's Westminster office.

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Jamie leads GK's policy work with a particular focus on due diligence and advisory work for private equity. He has undertaken due diligence on a number of investor-backed dental chains, as well as wider work in the health sector.

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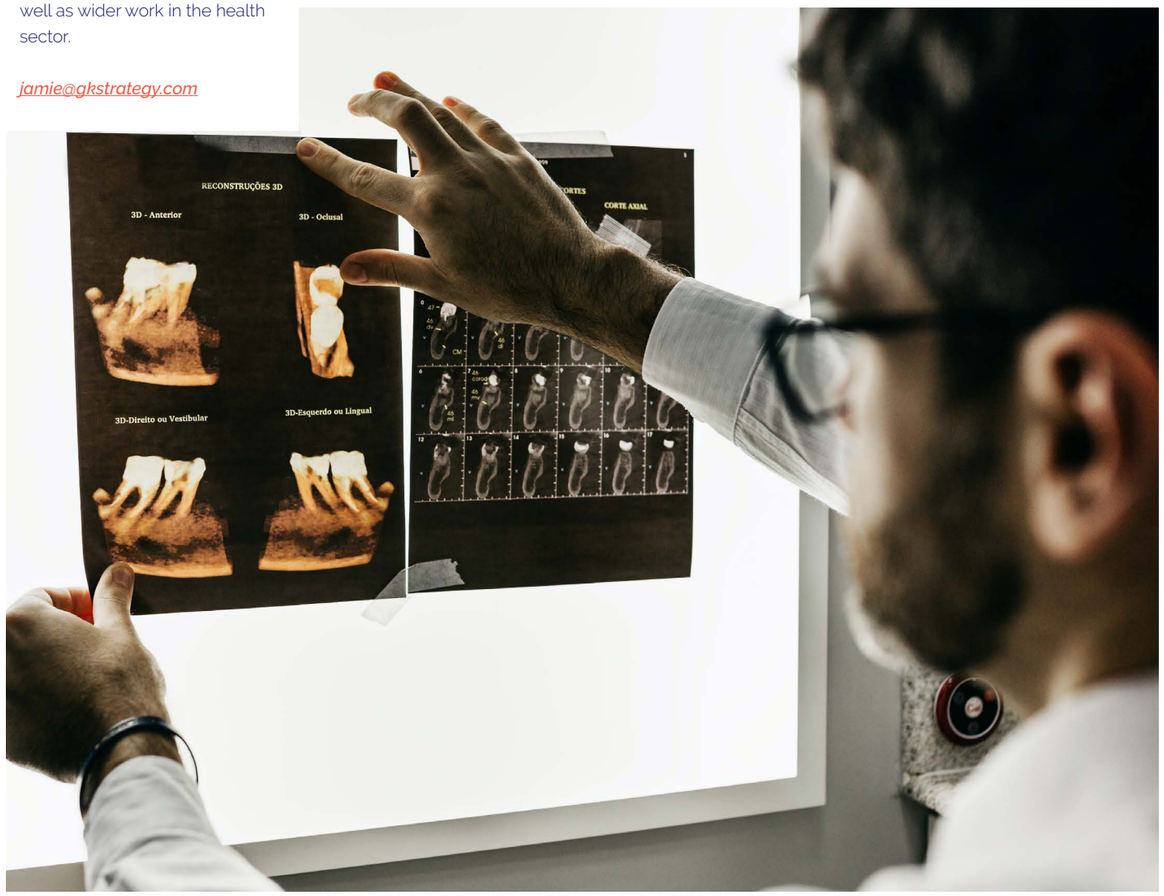
WHAT DOES THE PANDEMIC MEAN FOR THE FUTURE OF NHS DENTISTRY?

By Jamie Cater // Head of Policy



NHS dentistry is sometimes regarded as the 'Cinderella' of healthcare in England – often overlooked by politicians and policy-makers in favour of new investment and resource in other prominent services. Over much of the last decade, the Government, NHS England and the sector have been working to implement a new contract to determine the remuneration of NHS practices. Having been at the prototype stage of the process for a number of years – where some practices are testing two different models of the contract, while some remain on the former contract introduced in 2006 – COVID-19 has slowed this further.

Aside from years of slow progress on introducing a new contract, policy and funding for NHS dentistry tends to be relatively stable and predictable; however, as with many other sectors, COVID-19 has made long-term visibility of the future landscape a challenge for the dental sector.

During the pandemic, NHS dentistry has remained relatively well supported. NHS England continued to make monthly contract payments to practices both during lockdown and after they were permitted to re-open in June (subject to conditions on prioritising NHS provision, making employees available to take on other NHS work and paying all staff at the same level as prior to the pandemic), and are not subject to measurements of activity in the same way, effectively allowing an uplift in funding in order to offset the cost of personal protective equipment. Private dentistry – while able to access wider government financial support – has not benefitted from the same level of help and guidance as NHS services, with some uncertainty over when and how practices should re-open.

Aside from years of slow progress on introducing a new contract, policy and funding for NHS dentistry tends to be relatively stable and predictable; however, as with many other sectors, COVID-19 has made long-term visibility of the future landscape a challenge for the dental sector. While overall funding for dental services remains secure – if not the immediate priority for additional NHS resources – the process of implementing a new contract is likely to take longer still and may have to reflect how practices have adjusted to new ways of working.

The other potential impact relates to the dental workforce. As part of wider work undertaken by the Government to understand working patterns of self-employed and gig economy workers, HMRC had pursued investigations into the employment status of dental associates last year, questioning whether associates should be regarded as self-employed. This was largely on the assumption that associates would spend much – if not all – of their working time in the same practice, and were therefore subject to supervision and direction by a single employer; the criteria generally used to determine employment and tax status (including, for example, IR35 status). That NHS practice staff have been explicitly instructed to be available to work in other areas of the health service could have interesting implications for HMRC's work, especially as the sector more broadly contends with recruitment and retention of staff.

Many of the long-term policy issues facing NHS dentistry remain prevalent, with the added challenge of uncertainty created by COVID-19. Those with an interest in the sector should closely monitor how these issues develop over the coming weeks and months.

DIVIDING LINE? REASSESSING PHARMACY FUNDING

By Ioan Phillips // Senior Political Analyst

Ioan works in GK's investor services team. He previously worked as a researcher for a political party, after which he held a public affairs role with the National Pharmacy Association (NPA). Ioan's work at the NPA centred on issues around pharmacy funding and wider changes to NHS England (NHSE) commissioning structures.

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News the Government was warned in advance that its pharmacy funding settlement would create "winners" and "losers" has renewed debate about its long-term sustainability.

An impact assessment of the Community Pharmacy Contractual Framework (CPCF) conducted by the Department for Health and Social Care (DHSC) concluded that the £13 billion package – which runs until 2024 – would make some pharmacies "financially unviable".

When the CPCF was launched in July 2019, it was pointed out that the £2.6 billion per annum allocated by the new framework failed to offset cuts made to pharmacy funding by previous governments. Indeed, while the CPCF does not introduce any new reductions, it only keeps funding static at 2017/18 levels.

This restraint is at odds with the Government's desire to expand the range of services offered by pharmacies. The Secretary of State for Health and Social Care, Matt Hancock, says "pharmacists can do far more" – and before the COVID-19, pharmacies were beginning to deliver the new services outlined in the CPCF. Save for a one-off £370 million advance payments package, it is unclear where extra funding can be built into the existing framework.

Without further funding, the CPCF will fast create more "losers". Data suggests that ~30-40% of England's 11,500 pharmacies are running deficits. This total is expected to increase to nearly two-thirds (~64%) of the pharmacy network by 2024 under current financial arrangements.

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Such endemic deficits are anticipated to hit independent single pharmacies and smaller multiples the hardest. Although these businesses have seen their proprietors working unremunerated and have cut operating hours, rising fixed costs in areas such as business rates and wages will likely push increasing number of them out the market altogether.

It is an open secret that the Government sees a hub-and-spoke operating model as the way of unlocking further efficiencies in the pharmacy sector. Under this system, the prescription is assembled in a central "hub" before being distributed to a "spoke" pharmacy, which then makes the final supply to the patient.

The law currently stipulates that "hubs" and "spokes" must belong to the same business. Unsurprisingly, only large multiples have been able to absorb the cost burden of rolling out the model. However, the Medicines and Medical Devices Bill 2020 looks set to allow hub-and-spoke dispensing between different pharmacies.

On paper at least, hub-and-spoke dispensing makes sense. Pharmacy dispensing rates are increasing year-on-year. If the sector is to take on the additional clinical responsibilities envisioned by the Government, it must have the time to provide them. Yet data suggests hub-and-spoke actually adds new costs (such as investment in robotic equipment needed for remote dispensing), while increasing existing ones.

This jarring combination of continued financial squeeze and structural change has the potential to further exacerbate the gap between sectoral "winners" and "losers" in the years ahead.

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