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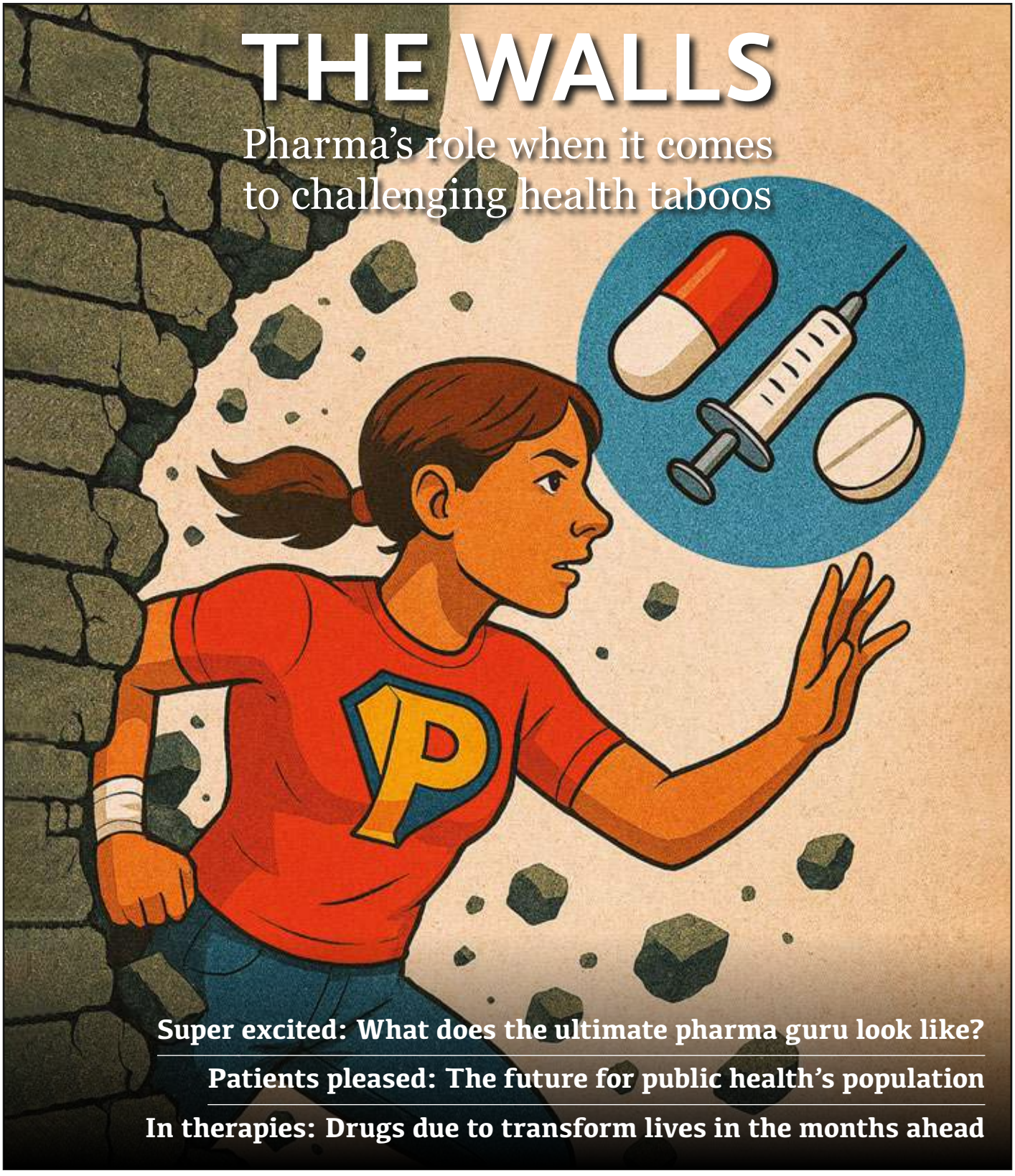
KICKSTARTING HEALTHCARE CONVERSATIONS

THE WALLS

Pharma's role when it comes to challenging health taboos



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In therapies: Drugs due to transform lives in the months ahead

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Hard to stomach

The gut is a biological cesspit that can, mercifully, be left to do its own thing – this often involves some pretty revolting but necessary functions.

It is why we should be very suspicious about any figures of speech that imply the gut, metaphorically or otherwise, can be relied on for important decision-making.

'Gut instinct', 'listening to your gut' or 'trusting your gut' have all climbed into the lexicon of linguistics in recent years.

The latter is used relentlessly in the hit television series *The Traitors*, when some of the utterly clueless participants feel they have no choice but to rely on an entirely unproven method of instinct, curiously hidden away in the echelons of their digestive system.

It is not only gross but grossly misguided. Their guts fail unfailingly. Shortly thereafter they report feelings of being 'literally gutted'.

It is precisely the sort of feeling Keir Starmer has when he recklessly relies on his gut rather than what is blazingly obvious.

The wretched record of 'gut instincts' could even be linked to the slew of unscientific products claiming to improve gut health.

Maybe people are so convinced by the role of non-brain-based knowledge that they are prepared to consume minute portions of fancily packaged yogurt in order to expel all manner of gibberish and hidden prejudices.

Style over content? Bile over content.

It is a reminder that clinical trials and data-driven conclusions are here for a reason.

Pharma would never have hired the former Ambassador to America because it would have asked the question about integrity 10,000 times and the answer would always have been no.

Enjoy the mag,

John Pinching
editor

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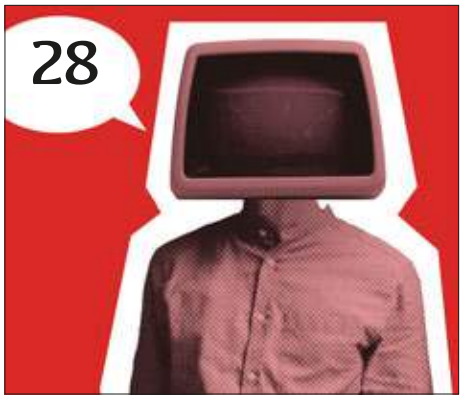


Features

Analysis

Smart People

Strong clinical data for Breye lead asset danegaptide

Breye Therapeutics has reported promising early clinical findings for its lead oral therapy danegaptide, following a presentation at the Angiogenesis, Exudation and Degeneration 2026 symposium.

The data, presented by Prof Carl Regillo, detailed results from a phase 1b study involving 24 patients with non-proliferative diabetic retinopathy (NPDR) and associated macular oedema.

The multi-centre, open label trial, conducted across 11 sites in the UK, Germany and the US, assessed safety, tolerability, pharmacokinetics and early biological activity.

Danegaptide is described as a first-in-class oral small molecule designed to stabilise the vasculature and protect against retinal capillary breakdown and vascular leakage caused by hyperglycaemia.

According to Breye, the treatment was well tolerated and produced plasma levels within the targeted therapeutic range.

More than half of participants showed retinal imaging data consistent with reductions in vascular leakage, a key pathology in NPDR, and several patients demonstrated notable anatomical improvements after four weeks of treatment. By study end, a statistically significant reduction in oedema measures had been recorded.

These findings support Breye's plans to initiate a phase 2 randomised clinical trial in NPDR, using improvements in Diabetic Retinopathy Severity Scale scores as the regulatory endpoint. The company is currently preparing for this next stage and is fundraising to support development.

Prof Regillo said: "The clinical data are encouraging and support the pursuit of danegaptide as an oral, non-invasive treatment solution. Danegaptide has the potential to be a medicine capable of treating diabetic retinopathy from its earlier, NPDR stages.

"This would create new options for how diabetic retinopathy is treated – opening the door to halting or even reversing disease and treating it before the risk emerges of disease progression to advanced forms. As an oral therapy, it would enable treatment intervention earlier than what is possible today."

Corcept's relacorilant plus nab-paclitaxel shows positive results

Corcept Therapeutics, a pharmaceutical company specialising in cortisol-modulating medications, has announced that its relacorilant plus nab-paclitaxel combination treatment has shown positive results in patients with platinum-resistant ovarian cancer.

The results were shown in the phase 3 ROSELLA trial. The trial found that patients receiving the combination treatment had a 35% reduction in risk of death compared with the group receiving only nab-paclitaxel.

Patients receiving combination treatment had a median overall survival (OS) of 16 months, while those receiving nab-paclitaxel alone had a median OS of 11.9 months.

The combination was found to have a favourable tolerability and safety profile, with comparable numbers of adverse events between the combination and monotherapy arms of the study.

This data builds on Corcept's previous announcement of improved progression-free survival (PFS) rates in the ROSELLA trial. The trial found that patients treated with the combination therapy had a 30% reduction in risk of disease progression.

Complete results from the ROSELLA trial are expected to be presented at an upcoming medical meeting.

Ovarian cancer is the fifth leading cause of deaths from cancer in women. Many patients see their disease become either sensitive or resistant to platinum-containing chemotherapy, leaving them with limited therapeutic options.

Each year, in the US, around 20,000 women with platinum-resistant ovarian cancer and 13,000 women with platinum-sensitive ovarian cancer are candidates to begin new treatments, with the number of women in Europe equalling or exceeding this.

Alexander B Olawaiye, director of gynaecological cancer research at Magee-Women's Hospital of the University of Pittsburgh and principal investigator in the ROSELLA trial, said: "ROSELLA's findings compel us to evaluate relacorilant as a treatment for earlier stages of ovarian cancer and for other tumours that express the glucocorticoid receptor, such as endometrial and cervical cancer."

Corcept is working to build a pipeline of cortisol-modulating treatments for severe endocrinologic, oncologic, metabolic and neurologic diseases.

BioMed X launches kidney disease project with Barbados

BioMed X, a leading innovation hub for pharma, has announced the launch of its first research project in partnership with the Government of Barbados and with support from the European Union's PharmaNext Programme.

The new global call for research proposals, entitled 'AI-Enabled Therapy of Early Diabetic Kidney Disease in Barbados', addresses one of the most pressing and underexplored challenges in cardiometabolic disease: the biological heterogeneity of early diabetic kidney disease in the Barbadian population.

The objective of this project is to understand the molecular mechanisms driving early diabetic kidney disease in individuals with Type 2 Diabetes in Barbados through deep molecular profiling and advanced AI-based modelling.

By combining multilayer molecular characterisation of Barbadian patients and healthy controls with AI-driven modelling, the project aims to construct a population-specific digital African twin. This model is intended to enable refined patient stratification, improved biomarker discovery and adaptive, data-driven therapeutic strategies.

Leisel Juman, CEO of BioMed X Barbados, commented: "By partnering directly with the Government of Barbados and with support from the European Union, we are applying our global talent-sourcing and incubation model to a real-world public health challenge in an underrepresented population."

The initiative marks an important milestone for BioMed X, extending its established collaboration model into a direct partnership with a national government. Jonathan Reid, Minister of Innovation, Industry, Science and Technology, added: "This launch reflects our commitment to positioning science and technology at the heart of Barbados' future."

Fiona Ramsey, EU Ambassador to Barbados, explained: "Through the PharmaNext Programme, the European Union is committed to supporting innovative research partnerships that address global health challenges while strengthening scientific capacity."

AAX Biotech and Vascurie announce new neuro-oncology collaboration

AAX Biotech, a biotechnology company specialising in antibody therapeutics, and Vascurie, a biopharmaceutical company developing treatments for central nervous system tumours, have announced a new collaboration in the field of neuro-oncology.

The collaboration will use AAX's Seqitope platform and automation infrastructure to speed up the characterisation of therapeutic antibodies. AAX will use Seqitope, which has the capacity for high-throughput epitope mapping, to characterise Vascurie's established antibody candidates against CD93, a new neuro-oncology drug target.

Seqitope integrates both amino acid-level epitope insights and the capability to process a significant number of antibodies simultaneously. This aids and accelerates the development of new therapies. Additionally, following demand for technologies that accelerate drug discovery, AAX has installed an advanced automation robot to assist with data workflows.

The newly announced collaboration with Vascurie will utilise all of AAX's expanded capabilities in antibody characterisation.

Daniel X Johansson, CEO and Chief Scientific Officer of AAX, said: "The ability to generate high-resolution epitope data at true high-throughput represents a significant advance for antibody discovery and development. With Seqitope and our new robotic platform, we can now characterise up to 100 antibodies in parallel, providing Vascurie with rapid, high-quality insights to support its neuro-oncology programmes."

Vascurie's lead candidate VDL-309, which targets CD93, is currently undergoing preclinical studies and could be used to treat high-grade gliomas and brain metastases. The company aims to submit Investigational New Drug (IND) and Clinical Trial Applications (CTA) to the US Food and Drug Administration (FDA) for VDL-309 in 2027.

"This collaboration strategically accelerates our initiative to develop monoclonal antibodies targeting CD93," said Jonas Ekblom, CEO of Vascurie. "By enabling multiplex parallel analysis of our proprietary molecules, this comprehensive approach will rapidly generate critical insights into the molecular pharmacology of our lead candidate, VDL-309, and other antibodies with distinct biomedical properties."

CERo reports encouraging early data from phase 1 trial of CER 1236

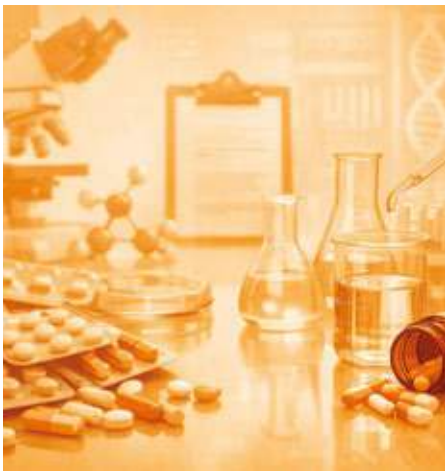
CERo has released new findings from its ongoing phase 1 CertainT 1 study evaluating CER 1236, a first-in-human chimeric engulfment receptor T-cell therapy being tested in patients with acute myeloid leukaemia.

Investigators have completed the dose-limiting toxicity observation period in the first cohort and reported cell expansion with no cytokine release syndrome, no ICANS and no treatment-related adverse events so far, marking a positive early safety indication for an engineered T-cell approach in AML.

A notable observation was recorded in a second patient whose myelodysplastic syndrome had progressed to AML. Investigators reported a 61-day platelet transfusion free interval after treatment with CER 1236, surpassing the commonly referenced eight week benchmark used in studies assessing platelet transfusion independence.

The result was achieved in a patient with advanced disease, including an inv3 chromosomal abnormality.

In response to these early findings, CERo has amended the CertainT 1 protocol to widen enrolment beyond AML to include advanced MDS and myelofibrosis, a move that broadens the potential clinical relevance of the platform. The company continues to escalate dosing while gathering systematic safety and early efficacy data.



CER 1236 has been engineered to combine features of both adaptive and innate immunity.

ENA Respiratory begins dosing in phase 2 study of INNA 051 nasal spray

ENA Respiratory has started dosing participants in its phase 2 community study of INNA 051, a dry powder nasal spray designed to strengthen the body's natural antiviral defences and reduce the impact of symptomatic viral respiratory infections.

The company confirmed that the first participants have now received the investigational treatment.

INNA 051 is a once-weekly, virus agnostic therapy intended to prime immune responses in the nose, where viruses such as colds, flu, RSV and coronaviruses typically enter. The aim is to help the body respond more rapidly to infection and lower the risk of complications in people more vulnerable to severe illness.

The POSITS study will evaluate the safety, tolerability and efficacy of up to three months of treatment with INNA 051. It will also assess the spray's effect on the incidence, duration and severity of symptomatic infections caused by common respiratory viruses in young adults at increased risk due to living or working in crowded environments.

Up to 1,100 generally healthy male and female participants will be enrolled. A 200 participant safety phase A is under way during the current North American respiratory virus season, with weekly dosing for four weeks. A larger 900 participant phase B will follow next season, with dosing over three months.

HOT & NOT

ErVimmune has announced a total of 17m euros in new funding, allowing it to advance its cancer vaccine candidate.

The company's lead candidate, ErVac01, is a heterologous vaccine formulation containing a collection of human endogenous retrovirus-derived epitopes, designed to cover the majority of the worldwide population in terms of HLA alleles.

Otsuka has announced that its Dawnzera (donidalorsen) has received approval from the European Commission (EC) for the prevention of recurrent attacks of hereditary angioedema (HAE) in adults and adolescents aged 12 years and older.

Around half of HAE patients first experience symptoms before the age of ten. The majority of patients also experience their first HAE attack before reaching adulthood.

En Carta Diagnostics, a start-up company developing molecular diagnostics kits, has announced that its EC Pocket Lyme test has received Breakthrough Device Designation from the US FDA.

The goal of EC Pocket Lyme is to detect Borrelia bacteria in interstitial fluid samples taken from the skin of people with signs of tick bites or erythema migrans.

IBSA launches Perovial for the treatment of acute Peyronie's disease

IBSA UK&I has announced the launch of Perovial, a treatment for the management of acute Peyronie's disease (PD).

PD is a chronic, progressive condition caused by the formation of plaque in the tunica albuginea. Characteristic symptoms include penile curvature, deformity, pain and erectile dysfunction. It is estimated that between 0.3% and 13.1% of men worldwide live with PD, but underdiagnosis, symptom delay and embarrassment mean that the true number is likely to be higher.

Approximately 60% of men with Peyronie's disease see the disease negatively impact their quality of life. Early recognition of symptoms is vital, since, once the disease reaches the acute phase, treatment options are limited. Intervention during the acute phase could, however, inhibit the progression of scarring and deformity from the disease.

Perovial is the first ever hyaluronic acid injectable treatment to be licensed in this indication. It is delivered via injection over 10 to 12 weeks of treatment, and the hyaluronic acid it contains is intended to soften plaque and encourage the remodelling of tissue.

Clinical trials of Perovial have demonstrated improvements in plaque size, penile curvature and erectile function, as well as a tolerable safety profile.

EURneffy receives positive opinion for anaphylaxis treatment in children

ALK has announced that its EURneffy 1mg nasal adrenaline spray has received a positive opinion from the Committee for Medicinal Products for Human Use (CHMP) of the European Medicines Agency (EMA) for emergency anaphylaxis treatment in children aged four years and older with a bodyweight between 15 and 30kg.

Anaphylaxis is the most serious type of allergic reaction, occurring in one to 761 in every 100,000 children each year in Europe. It is more common in boys. Food allergies account for over two-thirds of anaphylaxis cases, with food allergy-related hospitalisations on the rise.

The CHMP's positive opinion of EURneffy encompasses anaphylaxis caused by insect stings and bites, foods, medications and other common allergens.

The European Commission (EC) previously granted marketing authorisation in September 2024 to EURneffy 2mg, for the treatment of anaphylaxis in adults and children weighing more than 30kg.

EURneffy has been found to be rapidly absorbed, and to perform as well as traditional injectable forms of anaphylaxis treatment. It also has a favourable tolerability and safety profile.

The positive opinion expressed by the CHMP will be reviewed by the EC with a view to authorisation of EURneffy 1mg. The authorisation, if granted, would apply to all EU member states and Iceland, Liechtenstein and Norway.

Kahimmune Therapeutics has entered an exclusive licensing agreement with Gustave Roussy and Société d'Accélération du Transfert de Technologies Paris-Saclay. Kahimmune was created in late 2025, building on immunology discoveries related to the dark genome, which has lately been seeing more study. The licensing agreement grants Kahimmune exclusive licence to the technology behind its Kahinomics platform, as well as the neoantigens – known as Kahigens – produced by the platform.

Responding to the publication of a Mumsnet survey alongside the Future Minds report on transforming young people's mental health, Rebecca Gray, from the **NHS Confederation**, said:

"Anxiety in childhood often persists into adolescence and is linked to developing depression in later life. Early intervention can change the trajectory of children's lives by preventing problems from becoming more serious."

Resident doctors in England have voted decisively to continue industrial action for a further six months, extending one of the most prolonged disputes the NHS has faced in recent years. The **British Medical Association** confirmed that 93% of those who voted backed renewed strike action, reflecting deep frustration over pay erosion and a shortage of training posts.

Through the barricades

Dismantling health stigma in 2026 – examining the role for pharma and how the sector can help break taboos

Sexual health, personality disorders, incontinence, infertility, addiction, end-of-life care and chronic pain are some of the messy, painful and complicated realities of being human.

Too often, people suffer in silence because of deeply rooted taboos around certain health conditions.

While these stigmas are invisible, their consequences are very real. They appear in missed GP appointments, avoided treatments, fractured relationships and the heavy burdens of shame and fear.

According to the *Oxford Research Encyclopedia of Communication*, stigma is the leading yet least understood barrier to health.

The evidence suggests that taboos persist because they are woven into society and community norms. However, they are not immutable.

They can be dismantled – and we have seen this happen through concerted effort by powerful actors. Few sectors are as well placed and resourced as pharma to lead this work.

Impact through education

Taboos thrive in the gap between people's experience and their understanding of why it is happening. One of the most effective ways to dismantle a taboo is to explain the science behind it.

When patients believe their symptoms stem from personal failure or a lack of willpower, they stay silent. When they understand the biological processes involved, the shame begins to evaporate.

In 2026, a major role for pharma comms is to fill these knowledge gaps. This means moving beyond awareness raising and focusing on the 'why' and 'how' of a condition and its management.

We need to work closely with healthcare professionals, educators and patient groups to co-create accessible content that demystifies both the condition and the route to recovery.

By framing a condition as a manageable biological reality, we give patients permission to seek help without feeling judged and, crucially, we give them validation and hope.

Meeting communities where they are

Whatever your campaign goals, the old model of pushing a message from the top down is gone. Gen Z and Gen Alpha – including the new generation of healthcare professionals – operate on a flatter hierarchy of trust.

'Taboos thrive in the gap between a people's experience and their understanding of why it is happening'

They are just as likely to trust a specialist creator or a peer in a closed digital community as an institutional authoritative voice.

This matters in our quest to confront taboos and debunk false narratives. It means we must go where conversations are already happening.

Partnership should be the watchword. By collaborating with community groups and lived experience influencers who are already showing how taboo health comms should be done, we can reach audiences where they are and in a language they understand.

Supporting the frontline

Often, a pharmacist or practice nurse is the first person a patient approaches with a sensitive issue. These familiar faces are gatekeepers to care, yet they are frequently left to navigate difficult conversations without the right skills and resources.

We must be more intentional about the language and tools we provide to healthcare professionals working on the frontlines of health taboos.

Supporting these HCPs through education and providing tailored consultation resources – and even alternative packaging options – can be transformative. It can be the difference between a patient completing treatment or abandoning it because the interaction felt too awkward or exposing.

Visibility as a virtue

Pharma has much to learn from the wellness sector, where campaigns around menstrual health, hair loss and obesity management have embraced humour, modern design and punchy language that people actually engage with.

These brands do not hide behind medicalised language or euphemisms. They are not afraid to place a bold poster about erectile dysfunction or menopause on the London Underground, confronting commuters and sparking conversations.

At the same time, effective taboo-busting comms require embracing diverse, patient-first narratives that reflect the reality of living with stigmatised conditions in 2026.

This means retiring the stock photo patient. We need representation that reflects the UK today: different ages; ethnicities and gender identities, all speaking openly about the hurdles they face.

When we feature real people discussing how they overcame the social anxiety of a diagnosis, we provide a blueprint for others to follow.

Building bridges with tech

Technology is a powerful ally in the fight against stigma. For many, the fear of being seen in a waiting room or having a face to face conversation with a GP is the primary barrier to care.

Digital tools offer a level of privacy that traditional clinical settings cannot match.

Pharma companies can invest in high-quality, privacy-focused digital tools and get them into the hands of the patients who need them most.

These might include anonymous symptom checkers and telehealth integrations that allow users to test the waters from the privacy of their own homes. Such tools act as a bridge, guiding someone from silent worry to a formal consultation without the pressure of a public encounter.

Pharma should also use its corporate weight to influence policy in the places where people spend most of their lives: at work, in school and in the community.

Many health taboos are reinforced by environments that do not know how to accommodate them.

By advocating for these conditions to be recognised and supported in offices and classrooms, and by providing the resources and lobbying power to achieve this, we help dismantle stigma at its source and prevent it from persisting into future generations.

A bolder, more human future

In 2026, a treatment's efficacy is irrelevant if misconceptions and stigmas prevent it from reaching the patients who need it.

For pharma, the access puzzle is now as much a psychological challenge as a logistical one, but the opportunities for impact have never been greater.

Our sector has the resources, networks and creative skills required to make real and lasting change.

By retiring clinical euphemisms and stock photo sterility, and investing in accessible education and empowering influencers embedded in hard to reach communities, we can consign stigma to the past. ▲

Jess Farmery is Senior Account Director at Lexington Communications

Ahead of the curve

Oncology in the NHS – pharma's moment?

The NHS in 2026 is facing a familiar but intensifying oncology challenge. Our data at HSJ Information shows rising incidence, workforce strain, diagnostic bottlenecks and stark inequalities in outcomes.

Yet this is also a moment of opportunity for pharma.

The recently published NHS Cancer Plan sets out a reform agenda centred on earlier diagnosis, smarter use of data, faster access to innovation and system-wide collaboration through Cancer Alliances and Integrated Care Boards (ICBs).

Our work with pharma clients consistently shows the industry has a lot to offer the NHS. But here's the thing we constantly rediscover.

It is about how credibly, compliantly and constructively it can progress a service that needs more capacity and better outcomes, not simply about advancing products, whatever their claims.

State of play

Cancer incidence continues to climb as the population ages and screening improves.

At the same time, the NHS remains under pressure on the constitutional 62-day referral-to-treatment target and on diagnostic waiting times.

Workforce shortages, particularly in radiology, pathology and specialist oncology nursing, constrain throughput.

The NHS Cancer Plan doubles down on three themes:

- Earlier and faster diagnosis, including expansion of Community Diagnostic Centres (CDCs), risk stratification tools and targeted screening
- Reduction in inequalities, with a sharper focus on deprivation, mental health comorbidity, rurality and ethnicity
- Innovation adoption, accelerating uptake of advanced medicines, precision diagnostics and digital tools that improve pathway efficiency.

And it is precisely in these areas that pharma can align most effectively.

They are not abstract ambitions and our work has shown what collaboration can do.

In lung cancer, for example, stage at diagnosis remains highly correlated with deprivation.

Patients with serious mental illness are significantly more likely to present via emergency routes, which is associated with worse outcomes. Reducing that emergency presentation gap is both a clinical and moral imperative.

A snapshot of the oncology market

The UK oncology market is one of the most dynamic in Europe.

Immuno-oncology, targeted therapies, antibody–drug conjugates and personalised medicine approaches are reshaping standards of care across lung, breast, colorectal and haematological malignancies.

At the same time, the NHS is demanding:

- Real-world evidence of value
- Budget impact clarity
- Service redesign support
- Data on inequalities and pathway variation.

In other words, innovation must be embedded in system thinking.

A new therapy that reduces progression-free survival by months is welcome. A therapy that reduces hospital admissions, supports community care, shortens diagnostic odysseys or narrows deprivation gaps is transformative.

The oncology market can offer the NHS three broad assets:

1. Advanced medicines that meaningfully alter survival curves
2. Diagnostic and digital technologies that streamline triage, stratification and monitoring
3. Pathway partnership capability, working with Cancer Alliances and ICBs to make services more resilient and sustainable.

The last of these is increasingly where differentiation lies.

Where data meets delivery

Lung cancer provides a clear lens through which to view the opportunity.

Variation in stage at diagnosis between ICBs remains marked. In some systems, high proportions of patients from deprived backgrounds or with mental health conditions present at Stage III or IV. Rural geographies may see longer travel times to diagnostic hubs.

Understanding that variation allows targeting resource intelligently.

We have engaged in granular analysis of inequalities and pathway variation, so can highlight:

- Which ICBs have disproportionate emergency presentation rates
- Where travel distance may be a barrier to timely diagnosis
- Where variations in treatment rates are across tumour types
- Deprivation-linked stage disparities.

For industry field teams, this is a conversation enabler. Are system leaders aware of the inequality in their population? What initiatives are underway? Where might additional diagnostic or service support make the greatest difference?

By shining a light on variation, for example pockets of inequality in lung cancer stage at diagnosis, companies can approach Cancer Alliances as supportive partners rather than transactional suppliers. This aligns squarely with the Cancer Plan's emphasis on system-level solutions.

From publication to partnership

Credibility with clinicians matters. In 2024, HSJ Information convened a national roundtable on non-small cell lung cancer (NSCLC), bringing together chest physicians, oncology leaders and industry stakeholders. The output was a technical white paper and a publication in an indexable journal, with cross-system buy-in and clinical co-authorship.

This model does several things at once:

- Builds rapport with clinicians through serious scientific contribution
- Enables pharma to listen to frontline concerns about budgets and pathway friction
- Embeds industry as a contributor to evidence, not merely a beneficiary of it.

This is where experience pays. Reputable medical publication ensures robustness. Projects developed alongside leading NHS physicians ensure appropriate interpretation of coding, treatment patterns and system context.

The result is work that carries NHS credibility, essential in a climate wary of superficial partnership.

Bespoke insight for better launches

The oncology pipeline is rich, but launches increasingly succeed or fail on local nuance.

Using Specialised Share Data (SSD) and prescription-level insights, our consultancy team can map:

- Stakeholder segmentation across ICBs
- Current treatment patterns and uptake curves
- Inequality rates by geography
- Literature-informed ICB priorities.

For example, in a lung and bladder cancer project, clients received a tailored map of stakeholders, treatment rates and inequality metrics, alongside recommendations on how best to approach upcoming launches in specific systems.

If the South West shows slower uptake or greater travel burden, additional educational or service resource may be warranted.

If Greater Manchester demonstrates strong performance and established pathways, deployment might be recalibrated.

When you are launching, think bespoke. The aim is not generic market access theory but actionable intelligence.

Supporting cancer alliances

The Cancer Plan places Cancer Alliances at the centre of delivery.

For industry, engagement must be sophisticated, compliant and informed.

Clients need to:

- Identify key Alliance leads and programme directors
- Understand local performance against targets
- Engage in informed, supportive dialogue about pathway sustainability
- Demonstrate where industry has already strengthened resilience, for example enabling quicker patient access or earlier diagnosis in deprived populations.

There are risks in launch of course, in compliance and in terms of ROI. So HSJ Information manages outreach under full ABPI and BHBIA standards, distilling responses from oncologists, programme directors and pharmacy leaders to provide a real-time picture of the NHS cancer landscape.

In a crowded communications environment, compliant intelligence gathering is invaluable.

Technology, capacity and the future model

There is still a lot to do in the Cancer Plan and tech has been widely hedged as the saviour.

We do not know exactly how successful this will be, but there is not really a solution that does not include it.

The problem with the NHS is not clinical excellence but elastic capacity and it is only tech that can fully address this.

For example, the Cancer Plan's expansion of Community Diagnostic Centres, digital triage and risk-based screening must be matched by:

- AI-enabled imaging interpretation
- Eemote monitoring to reduce outpatient burden
- Precision medicine pathways that avoid futile treatment
- Data transparency to expose unwarranted variation.

Industry's role here extends beyond molecules.

Digital partnerships, data analytics and pathway redesign can relieve pressure on overstretched MDTs and infusion suites. Advanced medicines that reduce hospitalisation or allow ambulatory care are part of the capacity solution.

But the NHS will increasingly ask: where is the system gain? Where is the inequality reduction? Where is the evidence that this intervention improves flow?

A partnership moment

Oncology in the NHS sits at a crossroads.

The policy intent is clear: earlier diagnosis; faster treatment; fewer inequalities and smarter use of technology. The market is vibrant with innovation.

The missing piece, often, is translation, from data to dialogue, from publication to pathway, from molecule to measurable system benefit.

HSJ Information and its consultancy arm operate at that interface.

Through pathway data analysis, prescription insight, academic partnership and engagement tools, we enable companies to understand where need is greatest, where pathways falter and how to engage Cancer Alliances as allies in reform.

For an NHS seeking both capacity and improved outcomes, the opportunity is to co-produce innovation. In oncology, where weeks matter and inequalities cost lives, that partnership could define the next chapter of cancer care. ▲

Oli Hudson is Content Director at hsjinformation.co.uk

The man machine

AI is creating a new Darwinian jobs market where the super employee is king

The arrival of ChatGPT as a mass consumer tool, available to anyone with a smartphone or a PC in November 2023, heralded a new Armageddon scenario for the global employment market.

The fear that machines would replace humans within months was quickly replaced with a new narrative that, far from making millions of people redundant, AI would be a jobs creator enabling us all to be more productive.

The reality has been a strange hybrid of the two. It has also given rise to a previously unforeseen phenomenon that, while less catastrophic than the former, has the potential to destabilise companies, sectors and even entire economies – the rise of the multidisciplinary power employee.

A paradox is unfolding, particularly within knowledge-intensive sectors like life sciences, with headlines announcing tens of thousands of layoffs as companies streamline operations and embrace cost-cutting measures.

Bayer, Merck and Bristol Myers Squibb have collectively shed tens of thousands of roles. Commercial real estate firms like CBRE report that the average lab space per employee is shrinking, a tangible sign of corporate 'right-sizing'.

Yet in the same breath, hiring managers voice a persistent struggle to fill critical positions in areas like regulatory affairs, clinical operations and bioinformatics. This is not merely a hiring glitch; it is a fundamental workforce strategy problem, and at its heart is a failure to recognise how AI is redefining human capital.

By acting as a powerful co-pilot, AI tools are enabling individuals to absorb the responsibilities of two, three or even four traditional roles. However, this creation of a super-productive, multi-disciplinary workforce has a flip side.

It has the potential to trigger a seismic shift in the jobs market, making it less competitive and transparent and eroding traditional pathways that have long defined career advancement.

The rise of the multidisciplinary power employee

Employers were quick to recognise that the power of AI lies not in replacing employees but in augmenting their skills and productivity, none more so than in the life sciences sector. McKinsey Global Institute estimates that generative AI alone could generate $60–$110 billion annually for the pharma and medical-product industries.

This value is not created in a vacuum; it is realised through the dramatically enhanced output of the existing workforce.

In research and early discovery, AI tools can extract scientific knowledge from patents and publications in minutes, a task that once consumed weeks of a researcher's time.

In silico compound screening, powered by AI, can identify new drug leads in weeks instead of months, performing predictions up to 1,000 times faster than older methods, as seen with tools like Boltz-2.

This does not eliminate the researcher; it transforms him or her from a specialist in a narrow domain of biology to someone who simultaneously becomes a data analyst, computational modeller and strategic asset selector, all while applying the researcher's irreplaceable human expertise to validate and interpret the AI's output.

This pattern repeats across the corporate structure.

A clinical trial coordinator, once buried in paperwork and patient recruitment logistics, now uses AI co-pilots that can analyse trial performance data in real time, suggest interventions and auto-draft communications. Their role expands from administrator to strategic operations manager.

A regulatory affairs specialist, tasked with navigating the labyrinthine pathways of health authorities, now leverages AI engines that predict regulatory queries and help draft complex submission documents, shifting the specialist's focus from manual writing to high-level strategic oversight and ethical validation.

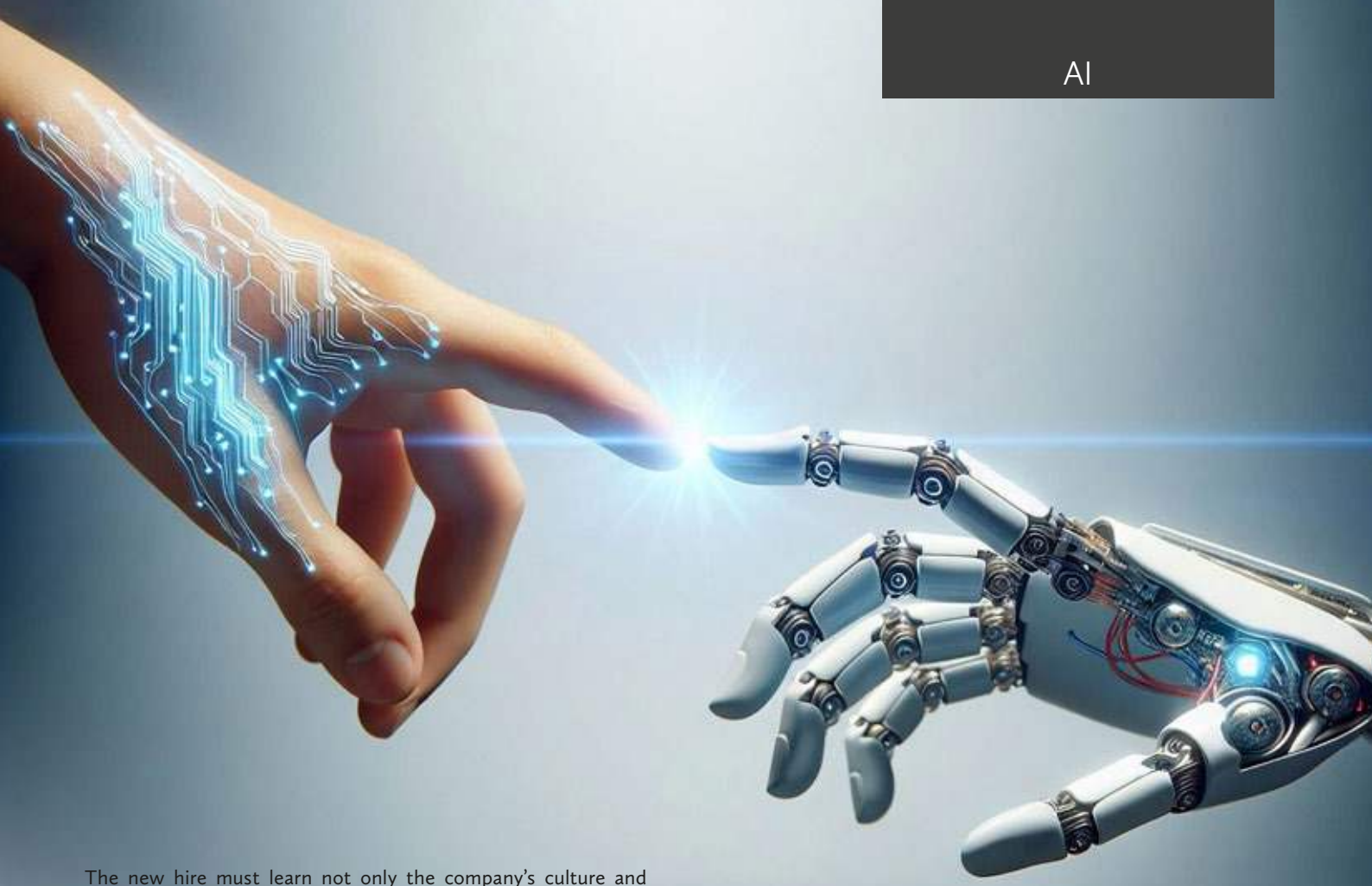
'Future work is not about humans versus machines; it is about humans, empowered by machines, achieving what was once thought impossible'

The result is the emergence of a new class of multidisciplinary power employee, able to develop a unique, integrated understanding of multiple facets of the business.

As well as being a regulatory expert, thanks to AI he or she also has a deep understanding of clinical data, commercial strategy and the underlying science. This cross-functional expertise, honed through daily interaction with augmented tools, makes the expert a repository of institutional knowledge that is incredibly difficult to replicate.

So much for the new super employees, but what happens when they leave the company because they have been offered a better job elsewhere, they have retired, are pregnant or have decided to live on a remote north Atlantic Isle raising sheep and knitting Fair Isle sweaters?

In those circumstances, the company loses not a single function but an entire nexus of interconnected capabilities. Replacing the employee is not a matter of finding another candidate with a similar job title on a CV, but someone who can potentially fill a multifaceted, AI-augmented role that has evolved organically within the company.



The new hire must learn not only the company's culture and processes but also be trained on specific AI tools.

Most challengingly, he or she must develop the same synergistic understanding of how different business functions interrelate – an understanding the employee's predecessor may have built over years of augmented work. The hole that is left is not a single vacancy; it is a crater.

The death of the CV

While AI has made individual employees significantly more valuable within a firm, it has also turned the external jobs market into a Darwinian jungle, making it less competitive and more impersonal for job seekers.

Companies seeking to hire or replace top-tier talent long ago replaced the inefficient method of posting job adverts and sifting through incoming CVs with sophisticated AI tools that scour the digital landscape for passive talent.

By analysing LinkedIn profiles, GitHub repositories, academic publications, conference presentations and project portfolios, these tools create a digital footprint map, identifying individuals with the precise, often hybrid skill sets that companies now crave.

While this digitised and automated system is ruthlessly optimised for efficiency and risk mitigation, it is poor at identifying potential and human chemistry.

Applications can often be sifted through six or seven attritional rounds before they are even considered by a human. A late developer whose CV is not stellar but who possesses unusual drive and intellectual curiosity may be discarded at round one.

A 'people person' who excels in verbal communication and team dynamics but is less adept at formulating his or her experience on paper may never get the chance to shine. The process privileges candidates who test well in isolated, automated scenarios while discarding others who could have brought invaluable human qualities to the organisation.

Augmentation, not replacement

The central lesson for employers is that their workforce no longer comprises a collection of specialised roles but a cohort of augmented, multi-skilled individuals. They must shift from simply hiring to developing a workforce strategy that includes creative internal redeployment, continuous upskilling and cross-functional mobility.

The new mandate for jobseekers is no longer to guard a single area of expertise but to adapt and integrate, becoming versatile in using AI-powered tools across multiple domains. Their greatest challenge is not to become qualified but to master the intersection of their core discipline with AI, develop hybrid skills and embrace lifelong learning to stay ahead of the curve.

The paradox of layoffs and redundancies amid talent shortages is a symptom of this transition. AI is not causing a net loss of jobs but a painful and disruptive recalibration of value.

The technology is creating a world in which the augmented employees are indispensable and where the battle for their talent is fought in the shadows of the digital footprint, while the public job market becomes an automated, impersonal filter.

Recognising this dual reality is the first step for both companies and individuals, not to survive in the employment marketplace but to thrive in a new age of human–machine collaboration.

The future of work is not about humans versus machines; it is about humans, empowered by machines, achieving what was once thought impossible. ▲

Ivor Campbell is Chief Executive of Snedden Campbell

One direction

Unlocking the next chapter for UK pharma: why the latest investment fund matters

For decades, the UK's pharmaceutical and biotech sectors have been leaders in discovery and innovation.

Yet as the cost of bringing innovation to market increases and global competition intensifies, the need for targeted investment to support breakthrough science has never been clearer.

That is why the UK government's renewal of the Biomedical Catalyst, combined with the Life Sciences Innovation Manufacturing Fund (LSIMF) and the new Life Sciences Transformational R&D Investment Fund (TRIF) pilot, is so timely.

Collectively, these funds aim to supercharge the country's R&D capabilities, focusing specifically on transformational manufacturing and high-risk, high-reward innovation projects that traditional finance often overlooks.

These funds are not just an injection of capital. They are a signal of intent for maintaining the UK's global leadership in life sciences. They highlight the importance of bold, strategic investment in ambitious ideas, supported by a strong and collaborative innovation ecosystem.

Lifeline for pharma R&D

Unlike broader innovation funds, the Biomedical Catalyst, LSIMF and TRIF target transformational projects – those with the potential to reshape markets, accelerate clinical development or create new manufacturing capabilities.

These projects often face large funding barriers due to extended timelines, high risks and uncertain payoffs, making them difficult to finance through traditional avenues like venture capital or private debt.

Public funding at this scale offers a crucial bridge between laboratory discoveries and commercial viability.

Breakthroughs such as next-generation cell and gene therapy manufacturing, AI-driven drug discovery and low-carbon vaccine platforms could all put the UK at the forefront of global life sciences.

But despite their enormous potential, these high-impact technologies frequently face an uphill battle for funding, especially in the current highly uncertain global trade environment. These funds address that market failure, ensuring that promising technologies do not stall before reaching patients.

Why this matters

The timing of this new funding is just as important as its structure.

Despite its global reputation, the UK's life sciences ecosystem is under sustained pressure. According to the Association of the British Pharmaceutical Industry, R&D investment by the UK pharma industry has underperformed since 2020 as global competition intensifies and manufacturing capabilities shift abroad.

The funds therefore represent a strategic intervention to keep cutting-edge R&D onshore and strengthen the UK's position as a life sciences leader.

At a time when the US and EU are scaling up comparable initiatives through tariffs and incentives, the UK's ability to maintain a competitive innovation environment will shape not only where research happens but where future jobs, skills and manufacturing capacity are based.

Strategic implications

From a policy perspective, the funding sends a clear message: the government is committed to supporting end-to-end R&D, from discovery through to commercialisation and manufacturing.

For pharmaceutical and biotech businesses, this creates a significant opportunity to deepen their UK footprint.

'These funds are not just an injection of capital. They are a signal of intent for maintaining the UK's global leadership in life sciences'

A major focus of the LSIMF and TRIF is strengthening domestic manufacturing resilience. The pandemic exposed the fragility of global supply chains, and the fund aims to address this by backing projects that expand the UK's capacity to produce advanced therapies, vaccines and bio-manufactured products.

Reducing reliance on overseas production remains a strategic priority for both industry and government, and this funding is intended to help firms build more secure and agile supply bases.

The fund also recognises the importance of regional innovation ecosystems. The UK's life sciences strength is not confined to the 'golden triangle'. Targeted investment in clusters across the North West, the Midlands, Scotland, Wales and Northern Ireland can unlock new capabilities and talent while supporting broader economic growth.

Learning from the past

The LSIMF and Biomedical Catalyst have helped unlock significant investment for participating businesses, but limited budgets and strict eligibility criteria meant many strong proposals went unfunded.

This new, larger fund, TRIF, expands both scope and scale but maintains intense competition. Applicants must evidence both scientific merit and national significance, alongside a clear case for how the project will improve UK health resilience, reinforce supply chains and deliver demonstrable economic outcomes.

Strong applications should highlight both scientific and societal value, providing clear evidence of job creation, skills development and long-term productivity gains. Decision-makers are ultimately looking for a strong 'multiplier effect' – evidence that every pound of public funding will unlock wider value across the life sciences sector and create spillover benefits beyond it.

For companies considering an application, preparation is everything. The most successful applicants will:

- Allow enough time to develop a coherent case that aligns with national priorities such as AI-driven drug discovery, sustainable manufacturing or advanced therapies
- Form partnerships with universities, NHS Trusts and industry partners that can strengthen both the application and project delivery
- Integrate grant and tax strategies, ensuring that funding is compliant, complementary and maximised across the R&D life cycle.

Complementing existing incentives

This fund should be seen as part of the wider landscape of UK innovation incentives.

For businesses already claiming R&D tax relief, there is a clear benefit in considering how grants and reliefs can work together.

Planning these mechanisms in tandem helps organisations avoid compliance issues and make better decisions about how to finance different stages of development.

For fast-growing biotech and pharma firms, this dual approach to accessing incentives can significantly improve research continuity and attract further private investment.

Looking ahead

The launch of TRIF, coupled with the Biomedical Catalyst and LSIMF, marks a significant moment for UK pharma and biotech.

It recognises that discovery alone is not enough. It is about building the necessary infrastructure, talent and funding mechanisms to translate that discovery into global impact.

The funds provide the early support that helps promising ideas move from concept to commercialisation. Combined with the UK's robust R&D tax relief system, they help create the conditions for sustained, innovation-led growth.

If the UK is to remain a leader in life sciences, coordinated interventions like this are essential. ▲

Karim Budabuss is Director, Grant Advisory at ForrestBrown

Serious gAIns

The intelligence revolution – navigating the future of connected engagement in life sciences

It is an incredibly exciting time to be working at the intersection of life sciences and technology. If you had asked me a few years ago where we stood with AI, I would have told you we were deep in the hype cycle.

We've all seen the flashy pilots and the bold promises that didn't quite land. But today, the atmosphere has shifted. The genie is out of the bottle, and as we move beyond mere experimentation, we are entering a phase of real, scalable utility.

At Veeva, we are seeing the emergence of Agentic AI – purpose-built, life sciences-specific intelligence that doesn't just sit on top of a system but is natively embedded into the daily workflows of field teams.

However, as we bridge the gap between hype and value, the industry faces a critical question – how do we scale these use cases to ensure we realise their absolute, undeniable potential?

The twin pillars

The path to successful AI in customer engagement is paved with two fundamental requirements: high-quality data and human trust.

In the world of retail or consumer goods, AI has it easy. There is a clear, linear outcome: a customer clicks a link; they buy a product; and the loop closes at the checkout. In pharma – particularly outside the US – the landscape is far more complex. We deal with aggregated sales data, disparate engagement touchpoints and strict regulatory boundaries.

We often say 'garbage in, garbage out' and in AI, that's an absolute law. To turbocharge AI engines, biopharma companies must invest in a common data architecture.

This means getting rigorous about how content is tagged, how data is organised and how it is accessed via direct APIs. Without a foundation of rich, clean data, even the most sophisticated AI will fail to provide the personalised engagement HCPs now expect.

Then, there is the human element: trust. If our teams don't believe in the suggestions the AI is making, they simply won't use them. I believe trust is built on three things:

1. Transparency: Can we explain why the AI recommended a specific action?

2. Integrity: Is the underlying data accurate and reliable?

3. Ethics: Are we following evolving compliance and regulatory guidelines?

The upside of getting this right is too great to ignore. We must embrace AI safely and securely, because it is the only way to deliver the speed and depth of information that modern medicine demands.

Six drivers of readiness

Transitioning to an AI-driven 'Connected Engagement' model isn't a flip of the switch moment. In my experience, there are six drivers that determine whether an organisation is actually ready to make the leap:

- Quality data availability: Do you have the right inputs, especially outcome-based data?
- Ease of collection: Is your infrastructure set up to gather data without friction?
- Data completeness: Are there blind spots in your customer view?
- User interface and experience: How do people interact with the tech? We are moving towards voice-controlled, natively embedded AI in CRM that transforms call planning from a chore into a strategy
- Scalability mindset: Are your pilots designed to be stress-tested for global rollouts, or are they just expensive science experiments?
- Political will: Does the leadership have the mindset to drive a new way of working?

> 'HCPs are under more pressure than ever; they need timely, evidence-based scientific information to make the best decisions'

Four pillars of connected Engagement

To trigger meaningful change, we have to look at the Connected Engagement model as a holistic ecosystem. At Veeva, we break this down into four essential elements that feed and reinforce one another.

1. Connected software

Gone are the days of best of breed solutions being strung together with digital duct tape. To reduce friction, companies need an integrated platform strategy. When AI is natively embedded – as we are doing with Veeva AI for CRM – it becomes a seamless assistant. For example, Voice Agent enables voice input into CRM, so field teams can capture information and follow-up actions quickly and easily, while Free Text Agent detects and flags potential issues in call notes to ensure accuracy and compliance. With more in-depth call reporting, companies gain the advantage of richer, higher quality customer insights.

2. Connected data
This is about achieving a true 360-degree view of the HCP. By using advanced analytics on a unified data set, we can close the marketing loop, understanding exactly what resonates and what doesn't. This allows for faster, more agile engagement planning.

3. Connected processes
This is where many organisations stumble. It is all too easy to focus on the shiny software and forget that old processes will stifle new tech. We need to be more adaptive. Instead of one 'e-detail' used for every customer, AI allows us to adapt the proposition in real time based on the last conversation or the specific needs of that HCP.

4. Connected Teams
Finally, we must address the people. AI-driven engagement requires new skills, new mindsets, and even new ways of measuring performance. It's a cultural shift toward 'testing, learning and failing fast'.

Empowering the HCP

Why are we doing all of this? Ultimately, it is about supporting HCP education and improving prescribing confidence. HCPs are under more pressure than ever; they need timely, evidence-based scientific information to make the best decisions for their patients.

Purpose-built AI helps bridge this gap. For instance, Veeva AI for PromoMats uses a Quick Check Agent to scan content against brand and compliance guidelines before it even hits the MLR (medical, legal, regulatory) review. This reduces errors and delays, meaning life-saving scientific information reaches the HCP, and the patient, much faster.

Furthermore, AI agents can now capture and structure insights from HCP interactions in real time via natural language processing. This allows field teams to stop worrying about data entry and start focusing on high-value, science-driven conversations.

Roadmap for the Future

We are at a tipping point. What worked in the past – the traditional, linear sales model – will not work in the future. This is perhaps the most radical period of change in the history of the life sciences industry.

For companies looking to navigate this new ecosystem, my advice is to start with a clear vision – what do your customers actually need? Don't just buy software for the sake of it. Assess your current capabilities across the four connected pillars, identify the gaps and build a roadmap.

This transformation won't happen overnight, but by focusing on 'win-win' value propositions – where the HCP gets better information and the company gets better insights – we can create a future-proof model that truly delivers for patients.

Make no mistake, the future of customer engagement is no longer a mystery; it is connected, it is intelligent and, above all, it is here. ▲

Aaron Bean is Commercial Business Consulting Lead for Europe and Asia at Veeva Systems

Heavy headlines

Could GLP-1 obesity drugs break pharma's safety infrastructure?

GLP-1 agonists like Ozempic and Wegovy are a pharma industry dream: mega-blockbuster products that are visibly transforming patient outcomes, particularly now in the context of treating obesity.

But they also present an operational nightmare for companies, as volumes of adverse events overwhelm traditional safety workflows.

Glucagon-like peptide-1 (GLP-1) receptor agonists such as Ozempic and Wegovy now account for more than 7% of all prescriptions in the US, reflecting their rapid adoption beyond diabetes care – particularly in weight management.

The success of GLP-1 agents, which has yet to peak, has created a tidal wave of new safety work for drug developers, marketing authorisation holders and industry regulators, as the products are taken up in ever higher numbers on an international scale.

Eli Lilly's GLP-1 drugs (including Mounjaro and Zepbound) reportedly generated c.$39.5 billion in revenue in the first nine months of 2025, making them among the best-selling medicines globally.

The PV strain

Traditional pharmacovigilance (PV) systems are struggling to cope with the sheer volume and complexity of adverse event reports generated by these blockbuster products.

In the case of injectables (combination products), there is the further complication of possible device failures.

These can trigger complaints that are peripheral to the medication itself, adding to the PV workload and potentially clouding drug-related safety insights.

These issues pose genuine concerns for the pharma industry, particularly as post-marketing surveillance around GLP-1 products is currently such an active area of research.

Real-world signals currently being closely monitored include those around pancreatitis and ocular safety.

The GLP-1 phenomenon highlights how quickly pharmaceutical infrastructure can become overwhelmed.

This is not a failure of diligence, or of commitment to patient safety, but rather the limitations of legacy systems and approaches to case intake and processing.

Traditional system-supported PV workflows, which involve teams being scaled up to cope with extra demand, were built around relatively predictable patterns of adverse event reporting, primarily via healthcare professionals.

They also assume clear distinctions between drug-related adverse events and device-related product complaints.

GLP-1 products have challenged these parameters. The products have been taken up quickly and widely, and real-world side effects are only now emerging.

These are being reported directly by patients, recorded by frontline care providers and pharmacists, fed back by drug sales teams, and captured as part of patient support programmes (PSPs).

Information is being captured in a multitude of ways, across an array of different channels and sources – some of which may be duplicated.

In among all of this, immediate opportunities to ask key follow-up questions may be missed.

This diversity and inconsistency in reporting is leading to delays in drawing critical insights together, with implications both for regulatory compliance (critical signals must be reported swiftly) and ultimately for patient safety.

Dual reporting challenge

On top of these issues are device considerations.

Injectable GLP-1s are combination products, administered by patients themselves without medical supervision.

During reporting potential issues, for instance via a physician, pharmacist or PSP contact, clarity around the source of the problem may be lost.

> **'Products have been taken up quickly and widely, and real-world side effects are only now emerging'**

Was it a faulty injector, or the drug itself?

While the patient may simply want to register a complaint, the pharma company needs more detail to fulfil its regulatory reporting obligations, contain risk and keep patients safe.

Any disconnect could place additional pressure on case intake and management processes, as PV teams strive to correctly capture, classify and route reports promptly, while maintaining data quality.

The limitations of manual PV processes become particularly acute at scale.

Take a single adverse event case that requires assessment and distribution to multiple regulatory bodies.

Each distribution requires careful data entry, quality checking and regulatory submission within strict timelines.

Multiply this by thousands of cases monthly, and long-standing manual approaches soon come undone. The follow-up challenge (capturing a fuller history from the patient), which has long existed, is magnified in the context of GLP-1s.

When patients first volunteer feedback about an adverse event, this is the drug company's 'golden moment' to capture all of the detail that it as well as regulators will need to properly assess and record a safety signal.

If follow-up questions aren't asked at the time (where possible), the opportunity to capture full and rich detail – which may be important for downstream analysis – risks being lost forever.

Anecdotally, pharmaceutical companies report success rates hovering at around only 10% where attempts to obtain additional information are made at a later point.

In the context of GLP-1s for weight loss, and their mass-scale take-up around the world, reliance on after-the-fact gap-filling is both impractical and risky from a safety perspective.

Canary in the coal mine

The emerging challenges with safety intake are not unique to GLP-1 products.

The trend towards combination products is accelerating across multiple therapeutic areas as companies seek to improve outcomes, enhance intellectual property and differentiate offerings.

The shift towards patient self-administration is irreversible as well.

The convenience it offers patients is too valuable, and healthcare systems under pressure increasingly support moving routine medication administration into patients' homes and daily routines.

Incremental improvements to existing processes are no longer the answer.

This is a challenge requiring a fundamental rethink of how safety data is captured at source.

The more ambitious the therapies being rolled out to patients, the more critical it is that genuine signals can be identified, qualified and circulated swiftly.

'Smart intake' approaches are gaining traction as a result.

These involve using optimised, intuitive systems that have been designed to capture safety data directly from reporters in structured formats.

This eliminates subsequent manual data entry, while also ensuring appropriate routing between adverse event and product complaint pathways (e.g. to support safety reporting for combination products).

Thanks to these efficiencies, scalability is built in.

Beyond GLP-1: a permanent shift for PV

The impact of GLP-1s on PV workloads is indicative of what is to come, as patient therapies continue to advance.

Pharma companies can no longer expect to address soaring case volumes and rising complexity by simply increasing their PV headcount.

To ensure sustainability, they will need to adopt optimised safety intake process automation, so that they can accelerate and improve routine safety data entry, while ensuring high-quality structured capture – at the point that patients or professionals are ready to report.

This will also liberate PV professionals to focus on the critical activities of scientific assessment and signal detection.

Companies that continue to rely on increased team sizes to handle peaks in case volumes risk being perpetually overwhelmed – potentially missing critical safety signals and falling foul of regulatory timelines.

In many ways, this industry's ability to keep bringing innovative therapies to patients, while maintaining robust safety surveillance, depends on the choices that companies make now. ▲

Daniel O'Keeffe is a VP at Qinesca

The long goodbye

Can the seemingly intractable problem of delayed hospital patient discharge be solved by the creation of a single responsible body?

One of the biggest challenges facing the NHS is the growing number of patients experiencing delayed discharge from hospital, meaning they are medically fit to leave but unable to do so.

The impact of delays is especially acute when waiting lists are rising, A&E departments are overstretched and the winter flu season is under way.

On top of that, because there are fewer available beds, planned procedures are also affected.

Finally, there are many risks associated with longer stays: infections; blood clots; muscle weakening and pressure sores, to name a few.

While most patients will be discharged to their home, many require more formal support, often involving resources from the social care sector.

However, within the discharge system there is friction, with the NHS often citing lack of social care capacity as the primary reason for delayed discharge, but the problems run much deeper. It is a complex, disjointed process, exacerbated by a lack of resources, poor communication, confusing financial channels and fragmented systems.

We know there are enormous pressures on the NHS, but pressures on social care services are well documented too. Growing demand, staff shortages and underinvestment have severely affected the capacity available to deliver care.

On the plus side, there is no shortage of data, analysis and proposed fixes. Everyone knows the extent of the problem, even if only through the lens of a febrile media, so why does it persist?

What can be done that has not already been tried?

Here, we break down the various components of the system to see where responsibility lies, how funding works (or does not) and examine the roles of the many players in this tangled ecosystem.

Could the answer be simplification? Creating a single body with sole responsibility for handling every aspect of the discharge process, and with a single source of funding that covers all cost areas, could bring with it the accountability that is today tellingly missing.

But first, what is the scale and nature of the problem?

Stand by your beds

According to a piece on the Nuffield Trust website from September last year, 'The total number of patients who were ready to leave hospital but were delayed has increased by 43% from an average of 8,545 patients per day in June 2021 to 9,933 patients per day in June 2025. At its peak, in January 2024, there were 14,096 patients delayed in hospital.'

The Nuffield piece goes on to note the seasonal impact: 'Every winter sees an increase in A&E admissions and a reduction of staff due to sickness absence that can hinder effective discharge processes within hospitals.'

When a patient is medically fit but cannot leave, the reasons are classified as:

- Hospital process: issues within the hospital's control, such as awaiting medications, final tests or transport
- Well-being concerns: concerns from the patient or family about safety, or delays in assessing mental capacity
- Care transfer hub process: delays in identifying the appropriate destination or funding
- Interface process: delays in coordinating care with external services such as home care or social care
- Capacity: shortages of available community or long-term care beds, or lack of staff to provide home-based support.

As noted in a May 2025 blog on The King's Fund website, other than for hospital process, all categories include delays due to both the NHS and social care. The analysis concludes that capacity delays are the most common reason for delayed discharge, and that the majority of capacity delays cannot be attributed to social care alone.

The blog noted that the Royal College of Nursing was quoted in December last year as saying that there was 'barely a spare bed' left in NHS hospitals due to a lack of capacity in social care.

Who's in (dis)charge?

There are multiple parties involved at different stages of the patient discharge process, but the NHS and social care sectors are the key players.

The NHS is vast and complex, and its multiple interactions with the social care sector are predictably Byzantine. They are two distinct systems, funded differently and often facing different demands.

Focusing on the relationship between the two bodies, and digging deeper into the systems that most directly affect patient discharge, we first find Integrated Care Systems.

ICSs and Integrated Care Boards are part of the NHS structure established by the Health and Care Act 2022. ICSs are the overall partnership, while ICBs are the statutory NHS bodies responsible for managing the budget and commissioning services.

For clarity, the body with overall responsibility for patient discharge is the ICB, of which there are currently 42 within the NHS in England.

ICBs work with local authorities to arrange community support, such as care packages, to get patients home safely and quickly.

In essence, the ICB acts as the strategic lead, ensuring the whole system works together to discharge patients safely and effectively, and preventing delays.

But it is not working, or at least not well enough, and that is partly due to a lack of proper funding, or at least inefficient use of existing funding.

According to a July 2025 blog by Dr Agnes Arnold Forster on The Health Foundation website, 'ICBs are facing cuts of 50% to their running costs.'

On a day-to-day basis, responsibility for discharging lies with a multidisciplinary team, including the consultant or clinician, the discharge coordinator or case manager, nurses, social workers and occupational therapists, and involving the patient and his or her family.

A care coordinator often acts as the main contact, bringing together health and social care professionals.

With so many bodies involved it is not surprising to find friction, communication problems and financial challenges.

Show me the money

With such a plethora of bodies involved in the discharge process, how is funding coordinated? Here are the key mechanisms.

The Better Care Fund is the main pooled fund, combining mandatory contributions from ICBs and local authorities. It is used for joint health and social care initiatives, with a significant focus on hospital discharge.

The Hospital Discharge Fund manages funds for ICBs and local authorities to pay for short-term care packages. This funding is now consolidated within the BCF.

Continuing Healthcare is for individuals with a primary health need. ICBs fund the entire health and social care costs, including personal care and accommodation in a care home, and they fund a standard weekly rate for the nursing care component for eligible residents in nursing homes, separate from personal care costs.

So, there are multiple sources of funds, coming from various places and channelled through various networks, but the management of all this adds considerable overhead and introduces complexity, which in turn creates delays.

In the face of such complexity, the obvious response is to simplify. A single body, a single source of funding and a clear mandate for delivering optimally efficient patient discharge.

The good news is that this can be achieved within the current system by improving existing mechanisms.

A new hope

Is it possible that a new service, based on an equal partnership between the NHS and the social care sector, with a direct single source of funding and a mandate to implement best practice for patient discharge, could be the answer?

The key issue is who pays for a discharge service that requires the cooperation of both health and care sector bodies.

In a report by the BBC, Kerrie Allward, who acts as a policy lead for the Association of Directors of Social Services, said: "Councils often lack the funds to invest in integrated services that would support more timely discharge."

In a report produced for the Commons Library in 2019, before the pandemic made everything worse, it was noted that, 'An increasing number of people are living longer with multiple long-term health conditions, and require support from a wide range of services at home, in the community and in hospitals.'

Meanwhile, in a report from July 2023, Age UK noted, '2.6 million people in England aged over 50 are unable to get care.'

We can fix this. The creation of a new body, a single 'health and care unified discharge programme', could take advantage of the ICBs to define and implement this new service, which would be funded directly by government.

This new service envisages the health and care sectors being equal partners in delivering a single, unified discharge programme, no longer a piecemeal, fractured association of individual services stitched together.

This unified service would bring the health and care sectors together, with a clear mandate to implement a programme that benefits the NHS, the social care sector and, most importantly, patients.

You could be forgiven for thinking this all sounds very nice in theory, but some hospitals in north west England are already demonstrating what can be achieved with such a unified approach. Patient discharge delays and hospital readmissions have been cut significantly.

In this case, the local ICB was not directly involved.

Final analysis

Making changes to a complex system is a major challenge, very often leading to unintended consequences.

The NHS is a textbook case. Governments seem unable to resist tinkering, and the results of this over the past 50 years have not been encouraging.

The problems with hospital patient discharge serve to expose and highlight structural, systemic issues within the service and the relationship it has with the social care sector.

Yet, simply by shining a light on these issues it is possible to see how existing structures, systems and processes could be used to deliver better, more efficient patient discharge.

It looks like a tangled mess – one that has emerged through continuous tinkering and interference, short-term thinking and patched up solutions – but the exceptional talents within the NHS can be harnessed to engineer a new way of working that is simpler, stripped back and lean.

The new body would be ultimately responsible for ensuring every patient is discharged in a timely manner, to an appropriate destination, with all necessary support measures in place.

This is necessarily a longer term solution; it takes time to turn a tanker. But as everyone knows, making the easy choice now only

Norman Niven is CEO at The Medication Support Company

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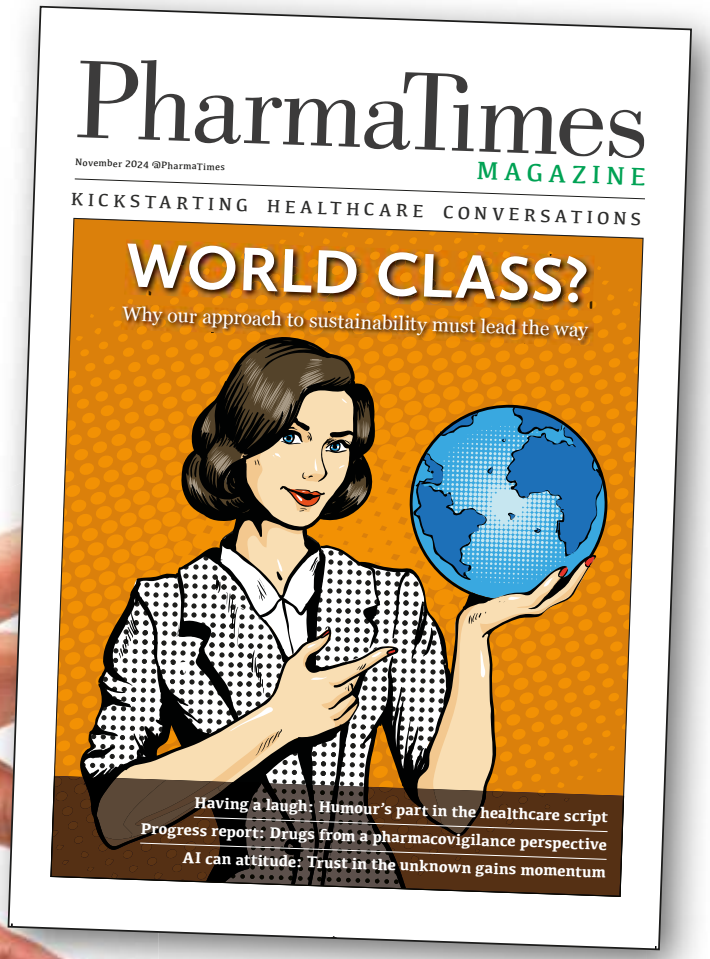

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Solve and evolve

Turning high unmet need into meaningful progress – advancing ADC strategies in rare and difficult-to-treat cancers

In oncology, some of the most pressing unmet needs lie not in the most common tumour types but in cancers that are rare, aggressive or historically underserved.

For organisations committed to transforming outcomes, solving difficult-to-treat cancers is both a moral imperative and a scientific opportunity.

Antibody-drug conjugate (ADC) platforms are central to that mission, bringing together deep expertise and innovative technology.

Addressing the gap

Across many cancers, survival remains poor, therapeutic options are limited and the urgency for new approaches is high.

In my role, I see firsthand the progress being made in the treatment of advanced solid tumours, yet patients still face limited options and significant unmet needs. This reality motivates us to think boldly and act with urgency.

In response, multiple modalities are being pursued to help redefine the standard of care, recognising the many challenges cancer patients face today.

Among these modalities, ADCs allow us to harness the precision of antibody targeting and pair it with the potency of cytotoxic payloads – creating the possibility of delivering what we describe as 'today's insights into tomorrow's breakthroughs'.

This targeted approach aims to elevate the standard of care and maximise clinical benefit while helping to mitigate the impact of traditional therapies.

Focused on the rare

One investigational ADC, ABBV-706, is directed against SEZ6, a transmembrane protein highly expressed in neuroendocrine lineage tumours such as small cell lung cancer (SCLC).

Early clinical data is encouraging. In patients with relapsed or refractory SCLC, durable responses and a manageable safety profile have been observed.

What makes this especially meaningful is that responses were seen across key subgroups, including those with brain metastases and platinum-refractory disease – areas where therapeutic options are limited and unmet need is significant.

Beyond SCLC, ABBV-706 has demonstrated notable response rates in other rare neuroendocrine tumours compared with traditional chemotherapies.

These results underscore the intent to move beyond incremental improvement and achieve meaningful change in patient outcomes.

In addition to these novel assets, a suite of ADCs in solid tumours is advancing, including a cMet-targeted ADC, ABBV-400, which has shown promise across a range of difficult-to-treat cancers.

Beyond solid tumours, there is also a commitment to advancing novel ADCs in rare haematologic cancers such as blastic plasmacytoid dendritic cell neoplasm (BPDCN).

Pivekimab sunirine (PVEK) is a CD123-targeting ADC developed for BPDCN and other CD123-positive haematologic malignancies. A Biologics License Application has recently been submitted to the US FDA for PVEK in BPDCN based on data from a global phase 1/2 study presented in 2025.

PVEK has also been granted Breakthrough Therapy designation in this indication by the US FDA, further emphasising the unmet need in BPDCN.

An evolving platform

The depth and diversity of the ADC portfolio is intentional.

At ASCO 2025, the breadth of this approach was highlighted, spanning both solid tumours and blood cancers and demonstrating the strategic reach of ongoing R&D efforts.

As part of that strategy, three key solid tumour areas are prioritised: gastrointestinal (with an emphasis on colorectal); gynaecologic (notably ovarian) and lung cancers; alongside haematologic malignancies.

The development paradigm emphasises being biomarker-driven, patient-centric and ambitious.

This includes exploring therapies in tumour types where traditional chemotherapy has had limited success and where even modest improvements may translate into major clinical impact.

Through various mechanisms, the goal is to create targeted medicines that either impede the reproduction of cancer cells or enable their elimination, ultimately replacing chemotherapy.

Rare cancers and those resistant to standard therapies, such as certain haematologic malignancies and solid tumours, pose unique challenges due to their complex biology and limited patient populations.

The ADC pipeline is designed to address these gaps by:

- Identifying actionable, tumour-specific markers that can be used to target rare cancers
- Developing next-generation linkers with improved stability and potent payloads suited to specific cancer types
- Incorporating biomarker-driven patient selection strategies to ensure and amplify clinical benefit
- Exploring novel combination approaches to overcome complex barriers, including the recent licensing of a PD-1/VEGF bispecific antibody with the intent to investigate combinations with Temab-A.

Taken together, this strategic approach enables anticipation of and response to the complex barriers that have historically limited progress in these cancers.

By integrating cutting-edge technologies, a deep understanding of cancer biology, potential best-in-class combinations and advanced research strategies, the aim is to deliver therapies that make a meaningful and lasting impact.

Looking ahead

For patients diagnosed with SCLC, BPDCN or other rare, difficult-to-treat cancers, the path ahead has too often been marked by limited options and challenging prognoses.

The ambition is to change that narrative.

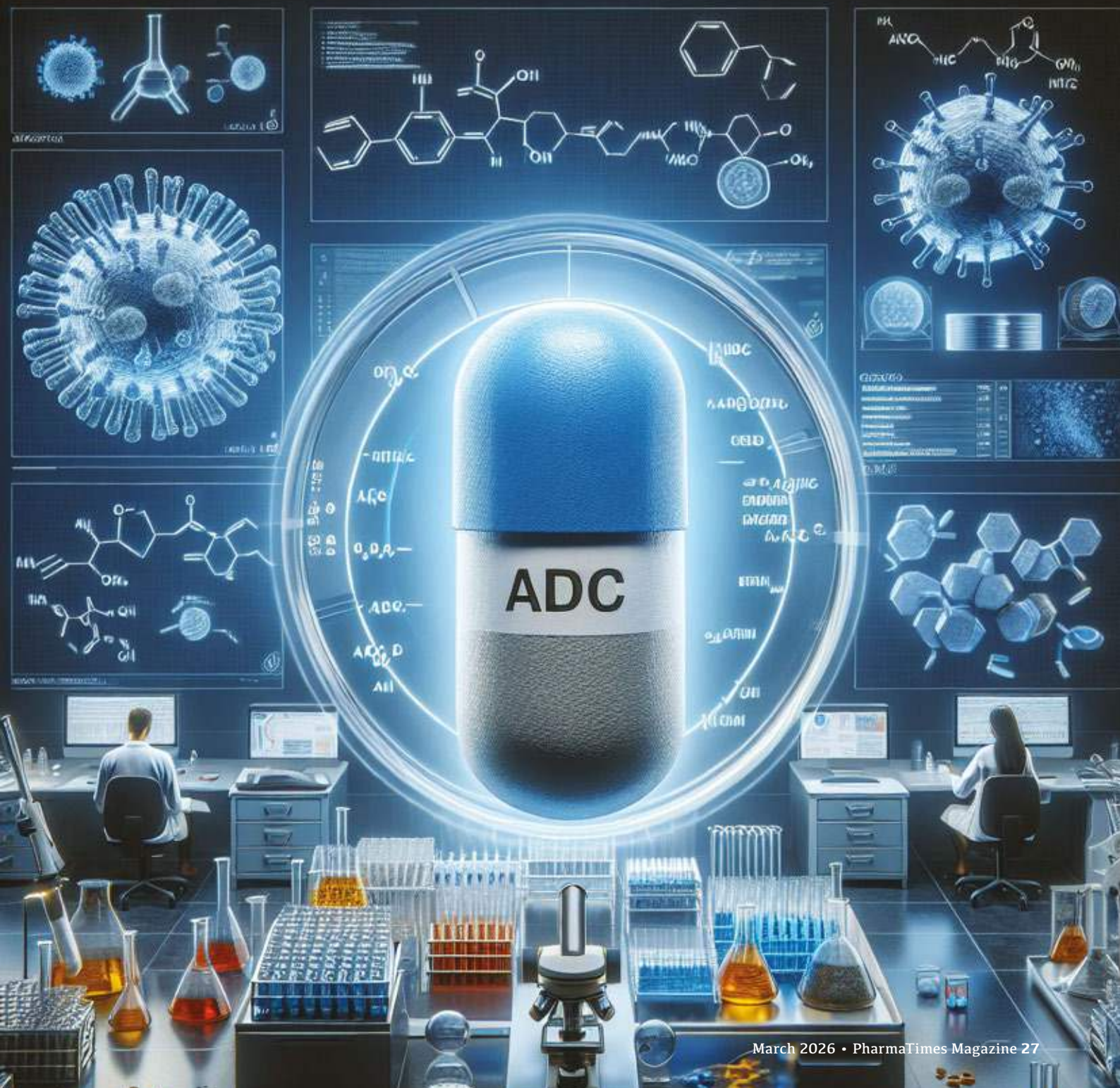
With ABBV-706, PVEK and an expanding ADC portfolio, the goal is to move towards a future in which patients receive more potent, precisely targeted therapies earlier in their treatment journey.

Through ongoing translational research, early clinical trials and collaborations with partners and patient communities, insights are continually being gathered to refine ADC design and optimise efficacy while minimising side effects.

Although many steps remain to bring these innovative treatments forward – including pivotal trials, regulatory review and eventual real-world access – the early signs are clear.

Progress is being made. And for patients and clinicians alike, that progress matters. ▲

Daejin Abidoye is Therapeutic area head, oncology, solid tumour and haematology at AbbVie



Happy talk...

The Briefing Room – what comes next for healthcare communications?

The Healthcare Communications Association (HCA) interviews senior leaders from across pharma to explore how healthcare communications must evolve in the face of growing complexity, accelerating technology and rising expectations of trust.

The pace of change in healthcare communications continues to accelerate. New technologies, shifting stakeholder expectations and increasing scrutiny of the pharmaceutical industry are reshaping not just how organisations communicate but what is expected of them.

So how should healthcare communications respond – and what will matter most in the years ahead?

We spoke to industry experts from companies including Takeda, UCB and LEO Pharma to find out.

Together, they offer a candid view of how healthcare communications is changing – from who we communicate with to how technology is used to the enduring importance of trust and value.

What emerges is not a single, linear roadmap for the future but a series of shared tensions that communicators are being asked to navigate every day.

Leaders describe a function pulled between speed and rigour, innovation and responsibility, measurement and meaning. The interviews suggest that the organisations making the most progress are those willing to acknowledge these tensions openly rather than pretending they can be solved with a single new tool or structural change.

From simple messages to complex ecosystems

One of the strongest themes running through all four conversations is just how much more complex the communications landscape has become.

For Funmi Oluwa, Senior Director and Head of Market Access and External Engagement at UCB, this shift is easy to see when she reflects on the early stages of her career.

"I started out in medical sales, promoting a brand of anti-reflux medication," she recalls. "The message was very clear, very concise – and I still remember the strapline years later. That tells you something about effective communication."

Today, however, the task is far broader.

Communications must speak not only to healthcare professionals but also to payers, policymakers, patient organisations and the wider public, often simultaneously.

"It's no longer just about communicating what a medicine does," Oluwa says. "It's also about explaining the value of the pharmaceutical industry as a whole – to governments, to healthcare systems and to society."

Eugene Osei-Bonsu, Senior Director and Marketing Strategy Lead at Takeda, agrees. He points to tighter budgets, shifting regulatory environments and rising expectations around health equity as forces reshaping how organisations think about communication.

"The difficulty is getting the message across succinctly and clearly, while really understanding your audience and what matters to them," he says. "That's always been hard but it's even harder now, because the audiences are more diverse and their needs are very different."

Matt Moore, Director of Customer Engagement at another leading pharma company, sees the same challenge.

Patients, healthcare professionals and other stakeholders no longer sit in neat, separate boxes.

"People behave like consumers," he says. "They expect the same ease of access, relevance and timeliness that they experience in other parts of their lives – even though we operate in a much more regulated environment. If they don't know something, they'll Google it. They'll look across multiple sources. So the question isn't whether one channel is better than another – it's how you get the mix of channels right and make them work together."

The promise, pressure and responsibility of technology

Across the interviews, technology is framed less as an end point and more as an accelerator.

While it has undoubtedly expanded what is possible in healthcare communications, it has also intensified expectations around speed, responsiveness and sophistication, often without reducing the underlying complexity of the environment in which teams operate.

Artificial intelligence in particular is a heavily discussed topic but it is rarely described as a simple solution.

For Oluwa, AI has already demonstrated its potential to improve education and engagement. She describes using AI-enabled holographic key opinion leaders at medical congresses, allowing delegates to interact with a realistic avatar, ask questions and receive pre-approved, accurate responses.

"It creates that person-to-person feeling," she says. "That sense of interaction really matters, because even when technology is involved, people still want to feel like they are engaging with a human being rather than a system. It's quicker, it's engaging, and people really remember it."

Moore highlights a different technological reality, explaining how many pharmaceutical companies are now rich in data but poor in insight.

As data volumes continue to grow, the risk, he suggests, is not a lack of information but a lack of focus, with teams unclear on which insights should drive action and which are simply noise.

"We've invested heavily in platforms and infrastructure," he explains. "Now the challenge is moving from being data-rich to insight-driven. Otherwise, you end up with paralysis by analysis."

But alongside the opportunity comes risk.

Osei-Bonsu describes social media as "a blessing and a curse".

"It gives us reach we could never have had before," he says. "But it also creates real risks around misinformation and misinterpretation. That's why responsible communication and strong guard rails are so important in our industry."

James Osborn, an independent consultant currently working with LEO Pharma, raises deeper ethical questions, particularly around the use of AI in patient engagement.

"We've spent years talking about the authentic patient voice," he says. "Now we're getting to a point where it's technically possible to generate a patient using AI. It might meet the communications objective, but what does that mean for authenticity? Are we at risk of undermining something we've worked very hard to build?"

Trust still sits at the centre

If technology and complexity define the external landscape, trust is what ultimately determines whether communications succeeds or fails within it.

Across all four interviews, trust emerges not as a single initiative or campaign outcome but as the cumulative result of consistent decisions about transparency, tone and intent.

For Osei-Bonsu, trust begins with clarity and precision.

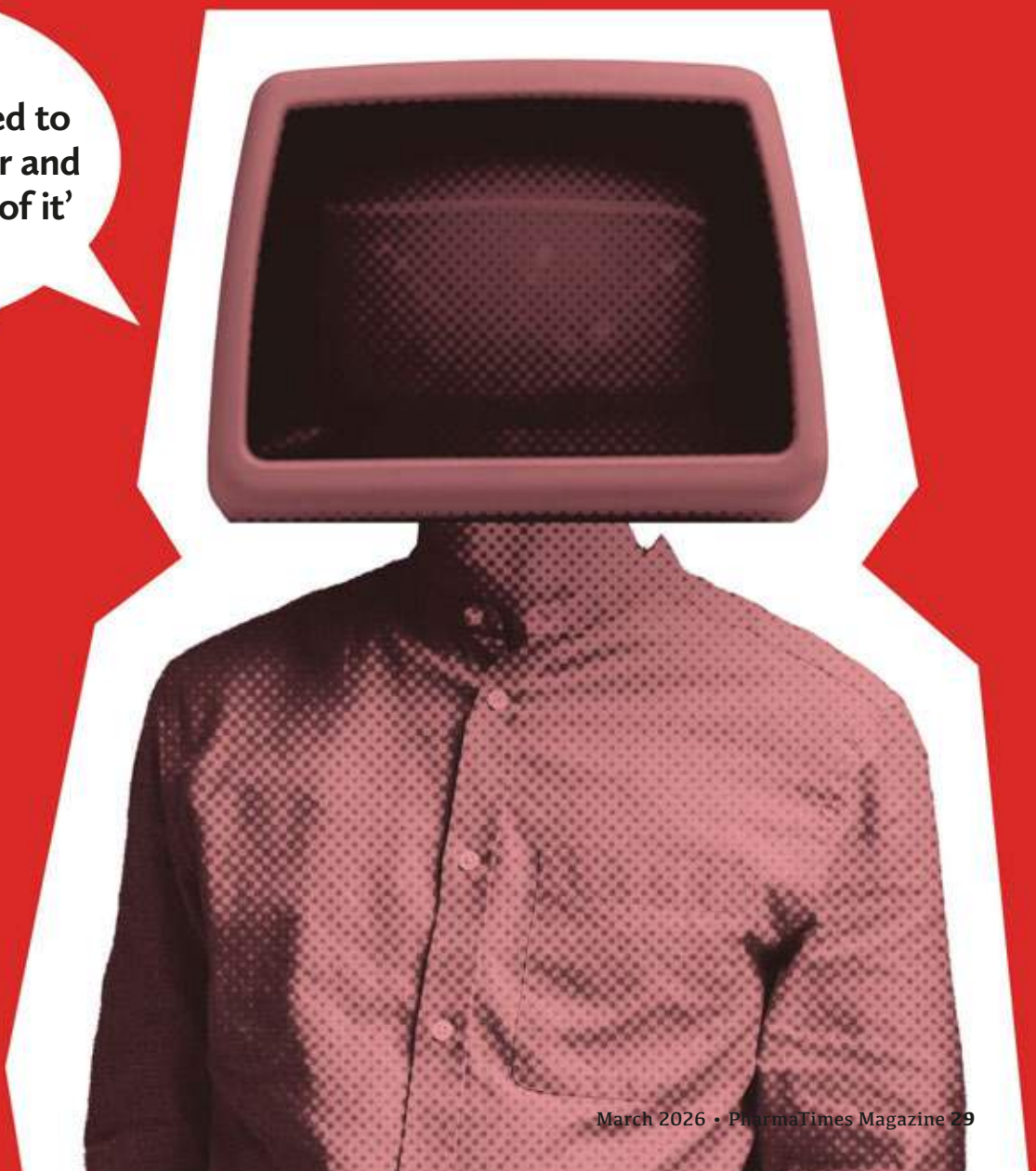
"Great healthcare communication is about being concise, factual and audience-focused," he says. "If you lose trust, it becomes very difficult to do your job effectively."

Oluwa broadens this further, pointing to the role communications plays in shaping perceptions of the pharmaceutical industry as a whole.

"There's a responsibility not just at company level, but at industry level," she says. "If people don't understand the value the industry brings, trust can quickly erode."

Osborn has seen firsthand how trust is built when communications reconnect organisations with real human experience.

'Maybe we just need to be a little bit bolder and a little bit prouder of it'



‘AI can support us, but it can’t replace judgement, experience or relationships’

“I’ve been in rooms where patient stories have been shared and you can see the impact immediately,” he says. “People’s expressions change. It reminds them why they do what they do. That kind of emotional engagement is incredibly powerful.”

This human dimension, he argues, cannot be replaced by automation.

“AI can support us, but it can’t replace judgement, experience or relationships,” Osborn says. “They are built over time, and they’re what allow communications to land in a way that feels credible rather than manufactured. Those things still matter enormously.”

Demonstrating value without losing purpose

Alongside questions of trust and technology, all four interviewees point to growing pressure on communications teams to demonstrate tangible value in an environment of constrained budgets and heightened scrutiny.

Expectations are rising at the same time as resources are being stretched, making prioritisation and clarity of purpose more important than ever.

“Budgets are tighter,” says Osei-Bonsu. “So, there’s more focus on what difference communications is really making.”

But Moore cautions against viewing value too narrowly.

“Not everything that matters is easy to measure,” he says. “Influence, understanding and long-term behaviour change don’t always show up neatly in a dashboard.”

Osborn agrees, particularly when it comes to patient engagement and corporate communications.

“Quantifying activity that’s not directly revenue-generating requires alignment with colleagues”, he says. “It’s often important to illustrate how your work is creating value for other functions, as well as the organisation overall.”

The challenge, the leaders suggest, is to balance accountability with purpose, ensuring communications supports commercial and organisational goals while remaining grounded in improving outcomes for patients and healthcare systems.

Looking ahead with confidence and clarity

Rather than calling for wholesale reinvention, the leaders consistently point to evolution by strengthening fundamentals, making more deliberate choices about where to focus effort and being clearer about where communications can have the greatest impact.

Taken together, the Briefing Room interviews present a picture of a discipline at a turning point.

Healthcare communications must now operate across more audiences, more channels and more scrutiny than ever before. Technology will continue to accelerate what is possible, but it will also demand stronger judgement and clearer ethical boundaries.

Perhaps the most striking message comes from Moore, who calls for greater confidence across the sector.

“We do a lot of good work,” he says. “Maybe we just need to be a little bit bolder and a little bit prouder of it.”

‘Great healthcare communication is about being concise, factual and audience-focused’

HCA Foresight Committee: a final reflection

As the HCA Foresight Committee reflects on these conversations, one thing becomes clear: the way the pharmaceutical industry is understood is shaped by decisions made every day, across every function.

The choices people make about what to say, how to say it and when to listen all contribute to trust.

“The interviews also suggest that progress comes not from certainty, but from a willingness to engage with complexity,” says Jo Spadaccino, member of the HCA Foresight Committee and one of the interview leads.

“That means acknowledging trade-offs, asking difficult questions and resisting the temptation to oversimplify in a landscape that rarely allows it.”

For those working across pharma today, the opportunity is to pause and reflect on the part each of us plays, in conversations with colleagues, partners, healthcare professionals and the public, and how those interactions collectively influence confidence in the industry.

Spadaccino concludes, “Because as expectations continue to rise, the most meaningful progress will come not from louder messages or the latest shiny tool, but from clearer intent, better judgement and a shared commitment to trust”. ▲

Interviews conducted by Jo Spadaccino (Stirred) and Ramota Alaran (IPSOS), members of the HCA Foresight Committee

In therapies

Ten exciting new pharmaceutical drugs emerging in 2026

After years in this game, you realise (to paraphrase) that the more things stay the same, the more they constantly change.

On this note, a wave of innovative medicines is set to reshape global healthcare in 2026, with breakthroughs spanning obesity, diabetes, oncology, neurology, rare diseases and women's health.

Drawing on industry analyses and expert forecasts, the following article explores ten of the most exciting, thrilling and mind-boggling pharmaceutical drugs expected to make a major impact this year.

The year 2026 is shaping up to be a landmark moment for the pharmaceutical industry. A convergence of scientific advances, accelerated regulatory pathways and maturing late-stage pipelines means that several high impact therapies are poised for approval or commercial launch.

Analysts predict that the top drug launches of 2026 could collectively generate tens of billions in annual revenue by the early 2030s, reflecting both their commercial potential and their transformative clinical promise.

Below is an in-depth look at ten standout medicines expected to define the therapeutic landscape in 2026 and beyond.

1. Orforglipron (Eli Lilly)

Orforglipron is widely regarded as one of the most anticipated drugs of 2026. This oral GLP-1 receptor agonist is designed for obesity and type 2 diabetes, offering a tablet-based alternative to injectable GLP-1 therapies that have dominated recent years.

Analysts project that orforglipron could achieve more than $11 billion in obesity-related sales in G7 markets by 2031, with an additional $5.2 billion from diabetes indications.

Its significance lies not only in its efficacy but also in its accessibility: an oral formulation may broaden uptake among patients reluctant to use injectables, potentially reshaping the competitive landscape.

2. Ivonescimab (Akeso/Summit Therapeutics)

Ivonescimab is a first-in-class bispecific antibody targeting both PD-1 and VEGF, offering a dual mechanism approach to cancer treatment.

Recognised as one of the drugs set to shape 2026, it stands out as the only therapy on the list originating from a Chinese company's independent R&D.

Its dual targeting design aims to enhance anti-tumour immune responses while inhibiting tumour angiogenesis, potentially improving outcomes in difficult to treat cancers. As oncology continues to shift towards precision and combination immunotherapies, ivonescimab represents a major step forward.

3. Kisunla (Eli Lilly)

Kisunla, highlighted alongside ivonescimab in FirstWord Pharma's 2026 outlook, is Eli Lilly's emerging Alzheimer's therapy.

While details in the public domain remain limited, its inclusion among the year's most influential drugs underscores the growing momentum behind disease modifying Alzheimer's treatments.

With neurodegenerative diseases representing one of the greatest unmet medical needs globally, Kisunla could contribute to a new era of earlier intervention and slowed disease progression.

4. Datroway (AstraZeneca/Daiichi Sankyo)

Another therapy spotlighted in the same industry analysis is Datroway, an antibody–drug conjugate (ADC) developed by AstraZeneca and Daiichi Sankyo.

'With obesity rates rising, the evolution of GLP 1 therapies represents one of the most impactful pharmaceutical trends of the decade'

ADCs continue to gain traction as a precision oncology modality, delivering cytotoxic agents directly to cancer cells while sparing healthy tissue. Datroway's emergence reflects the broader trend of next-generation ADCs achieving improved targeting, reduced toxicity and expanded indications.

5. Next-generation GLP-1 therapies (multiple companies)

Beyond orforglipron, several next-generation GLP-1 based therapies are expected to reach pivotal milestones in 2026. Clarivate's Drugs to Watch 2026 report highlights these agents as key drivers of future treatment paradigms for obesity and type 2 diabetes.

These therapies aim to improve metabolic outcomes, enhance weight loss, and offer more convenient dosing formats. With obesity rates rising globally, the continued evolution of GLP-1 therapies represents one of the most impactful pharmaceutical trends of the decade.

6. Targeted protein degraders for cancer

Protein degradation technologies are rapidly advancing, and Clarivate identifies targeted protein degraders as among the most promising oncology innovations expected to emerge in 2026.

Unlike traditional inhibitors, degraders eliminate disease-driving proteins entirely, offering a powerful strategy for cancers resistant to existing treatments. These therapies could open new avenues for tackling previously 'undruggable' targets, marking a significant shift in cancer drug development.

7. Precision medicines for rare diseases

Rare disease therapeutics continue to benefit from advances in genomics and molecular engineering. Clarivate's analysis highlights several precision medicines expected to launch or gain approval in 2026, each designed to address specific genetic mutations or molecular pathways.

These therapies promise earlier diagnosis, more targeted intervention and improved quality of life for patients with conditions that historically lacked effective treatments.

As regulatory agencies increasingly support accelerated pathways for rare diseases, 2026 may see a notable expansion of available options.

8. New therapies in women's health

Women's health is another area poised for meaningful progress. According to Clarivate, several innovative therapies targeting conditions such as endometriosis, menopause-related symptoms and reproductive health are expected to emerge in 2026.

This reflects a broader industry shift towards addressing long neglected areas of female health, with improved formulations, novel mechanisms and expanded access likely to benefit millions of women worldwide.

9. Late-stage neurology, immunology and cardiology therapies

PharmiWeb's analysis of anticipated 2026 drug launches highlights a diverse range of late-stage programmes across neurology, immunology and cardiology.

These include targeted biologics, next-generation cell and gene therapies, and improved small molecule agents.

Many of these therapies are expected to benefit from accelerated regulatory pathways, enabling faster patient access and potentially reshaping treatment standards in chronic and life-threatening conditions.

10. Five high-impact approvals in metabolic and allergy care

Drug Discovery News identifies five late-stage therapies expected to secure approval in 2026, spanning obesity, diabetes, hypertension and allergy care.

These therapies introduce new mechanisms of action and novel delivery formats, such as improved oral agents and long-acting injectables.

Their arrival could significantly enhance patient adherence and outcomes in some of the world's most prevalent chronic diseases.

Transformers

Taken together, these ten emerging therapies illustrate the breadth and depth of pharmaceutical innovation expected in 2026. Several themes stand out:

- Metabolic disease remains a dominant focus, with GLP-1 therapies leading the charge
- Oncology continues to evolve rapidly, driven by bispecific antibodies, ADCs and targeted protein degraders
- Neurology and rare diseases are gaining momentum, supported by precision medicine and improved trial methodologies
- Women's health is finally receiving long-overdue investment, with multiple promising therapies on the horizon
- Regulatory and technological advances are accelerating development, enabling faster translation from clinical trials to patient care.

Industry analysts estimate that the top ten drug launches of 2026 could collectively generate nearly $46 billion in annual sales by 2032, underscoring both their commercial significance and their potential to transform patient outcomes.

As these therapies progress through regulatory review and early commercial rollout, 2026 may well be remembered as a pivotal year – one that redefined treatment paradigms across multiple disease areas and set new standards across the pharmaverse. ▲

John Pinching is Editor, PharmaTimes

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■ Nucleome Therapeutics, a company tackling the molecular causes of inflammatory diseases through a breakthrough approach to 3D human genetics, has announced the appointment of **Dr Michelle Morrow** as Chief Scientific Officer (CSO).

Michelle joins Nucleome with two decades of experience in drug discovery and development and executing R&D strategy across biotech and large pharma.

Most recently she was CSO at Avacta Therapeutics, where she provided strategic leadership of discovery and preclinical research and led its oncology programme through candidate selection to IND approval.

Prior to this Michelle was SVP, Head of invoX Therapeutics Innovation, following its acquisition of F-star Therapeutics where she held positions of increasing responsibility and most recently she was SVP, Head of Research. She also held senior scientific roles at MedImmune (now AstraZeneca).

Dr Mark Bodmer, Chief Executive Officer at Nucleome Therapeutics, said: "We warmly welcome Michelle to Nucleome. She brings a wealth of experience in advancing drug discovery candidates through the clinical pathway. Her deep expertise in immunology and bispecific antibody therapeutics will be critical as Nucleome accelerates its ambition to tackle the molecular causes of inflammatory disease."

Michelle Morrow added: "Nucleome's ability to access previously untapped biology creates a powerful opportunity to deliver first-in-class immunomodulatory therapies and I am eager to work with the team to advance these programmes towards the clinic and ultimately bring meaningful impact to patients' lives."

■ VectorY Therapeutics, a leader in vectorised antibody therapies for neurodegenerative diseases, has announced the appointment of **Dr Kevin Pojasek** to its board of directors.

Kevin brings more than two decades of expertise founding, scaling and leading innovative biopharma companies, with deep experience across corporate strategy, business development, and research and development.

Kevin is currently president and chief executive officer of Enara Bio, where he has led the company since 2018 and advanced its vision to develop T-cell engager therapies against novel solid tumour targets. He is also a Venture Partner at SV Health Investors and previously served as an Entrepreneur-in-Residence at Atlas Venture.

Prior to Enara, Kevin was chief strategy and business officer at Immunocore, where he played a key role in shaping corporate and R&D strategy and led the company's business development efforts.

Earlier in his career, he co-founded Quartet Medicine while at Atlas Venture, serving as president and chief executive officer. He has held multiple executive leadership positions spanning research and development, corporate strategy and development at venture-backed biotechnology companies.

"Kevin's track record of building and guiding high-impact biotech companies makes him an exceptional addition to our board at VectorY," said Adam Rosenberg, chair of the board at VectorY. "His strategic insight and deep industry experience will be invaluable as we continue to advance patient care with new and novel approaches to address unmet treatment needs in neurodegenerative disease."

Mover of the Month

■ TECregen, a biotechnology company pioneering thymus rejuvenation, has announced the appointment of **Dr Klaas Zuideveld** as Chief Executive Officer.

Klaas will lead TECregen's strategy and execution as the company advances its thymopoietic biologics designed to rejuvenate thymic epithelial cells (TECs), restore immune function and strengthen immune resilience.

He brings more than 20 years of experience across large pharmaceutical companies and biotech, with a strong track record spanning translational strategy, clinical development and global regulatory execution.

He has contributed to multiple IND clearances and global product approvals, and has led teams through partnering, financing and value creation milestones across several therapeutic areas.

"Klaas is a highly experienced leader with a proven ability to translate innovative science into rigorous clinical development programmes," said Dr Bo Rode Hansen, chairman of TECregen. "As TECregen advances its novel approach to restoring thymic function, his leadership will be instrumental in shaping the company's development strategy and guiding its transition toward the clinic."

■ Rigel Pharmaceuticals Inc has announced that it has appointed **Michael Miller** to its board of directors.
Michael has more than four decades of experience in commercial and leadership roles in the biotechnology and pharmaceutical industries.

"Mike has a strong track record of commercial excellence, and we're delighted to have him join our board," said Raul Rodriguez, Rigel's president and CEO. "His extensive expertise in commercial execution and leadership will provide valuable insights as we execute on our transformational strategic plan, particularly our objectives of growing our current portfolio of medicines and evaluating potential in-licensing opportunities."

Michael currently serves on the board of directors at Puma Biotechnology and BioXcel Therapeutics.

He served as the Executive Vice President of US Commercial at Jazz Pharmaceuticals from April 2014 until his retirement in September 2020.

Before that, he was Senior Vice President and Chief Commercial Officer of Vivus.

Prior to that, he served as Vice President leading the HER Family Oncology franchise at Genentech.

Other roles included Senior Vice President and Chief Commercial Officer of Connetics Corporation, a specialty pharmaceutical company acquired by Stiefel Laboratories (GSK); Vice President at ALZA Corporation, a pharmaceutical company acquired by Johnson & Johnson; and various sales and marketing positions at Syntex Corporation.

■ Quotient Therapeutics, a company pioneering somatic genomics to inform breakthrough medicines, has announced that it has appointed **Susan Keefe** as Chief Financial Officer (CFO).

Susan has a 30-year tenure in finance, accounting and operations in the life sciences, most recently serving as the company's acting CFO through her role at the company's founder, Flagship Pioneering.

"Susan brings a powerful combination of strategic insight, operational rigour and experience building and scaling public and private life sciences organisations," said Rahul Kakkar MD, president and chief executive officer of Quotient. "We are thrilled to have her join Quotient as we continue to leverage somatic genomics to build our internal and partnered portfolio."

Susan added: "Somatic genomics has the potential to uncover novel biological insights that inform breakthrough therapies across a broad range of diseases. I look forward to joining the Quotient team and building a solid financial and operational foundation to support the company's long-term growth and value creation strategy."

Prior to Flagship, Susan served as the interim CFO of Benson Hill. Previously, she was CFO of GreenLight Biosciences, where she steered financial strategies for a pioneering company developing RNA-based solutions with applications in both agriculture and human health.

Before that, Susan held leadership roles in finance and administration at Danforth Advisors and Aushon Biosystems. Earlier in her career, she developed core financial acumen through roles at SeraCare Life Sciences, Procter & Gamble and PwC.

■ Sparrow Pharmaceuticals has announced the appointment of **Carlo Incerti** to its board of directors.

Carlo is a highly accomplished executive with a strong background in medicine and over 35 years of strategic experience in the biopharmaceutical industry.

"Carlo's appointment comes at a pivotal moment for Sparrow as we are looking ahead to pivotal trials of clofutriben for type 2 diabetes and seeking to expand development into other cardiometabolic indications," said Robert Jacks, Sparrow President and Chief Executive Officer.

Carlo added: "Sparrow is pioneering a new mechanism of action to tackle a common driver of metabolic dysfunction that current standard-of-care therapies do not address. By lowering intracellular cortisol specifically in patients demonstrating evidence and consequences of having elevated cortisol, HSD-1 inhibition with clofutriben could allow treatment to progress from one-size-fits-all to targeting a specific pathogenic cause of disease progression."

He currently serves as an Operating Partner at Forbion and brings over three decades of experience in the biopharmaceutical industry and most recently held the position of Senior Vice President, Chief Medical Officer and Head of Global Medical Affairs at Sanofi Genzyme.

Prior to joining industry, he was an Associate Professor of Endocrinology at the University of Modena, with a main research focus on thyroid diseases and sex hormones.

Bay-watch

Why Bayesian methods are moving into the regulatory mainstream

The FDA's recent guidance encouraging the use of Bayesian methodologies marks a clear shift in regulatory tone.

What was once viewed as specialist or experimental is now recognised as an appropriate and, in some cases, advantageous framework for modern clinical trials.

At its core, Bayesian statistics treat probability as something that can be updated as new evidence emerges. Prior knowledge, whether from earlier studies, real-world evidence or external data, is formally incorporated into the analysis and revised as fresh data is collected.

Rather than analysing results in isolation, the method reflects how evidence accumulates in development programmes.

While Bayesian theory has been established for centuries, advances in computing and simulation have made it practical at the scale and complexity required for drug development.

That shift in feasibility is now being matched by regulatory confidence.

The message is clear: regulators are increasingly open to trial designs that adapt to accumulating evidence, provided they are transparent, well justified and scientifically rigorous.

Bayesian approaches are not positioned as a replacement for established methods but as an appropriate option where trial design, data availability and risk profiles support their use.

This regulatory shift reflects a broader change already under way across development programmes.

Fixed, rigid trial designs no longer match the diversity of studies being run across life sciences. Bayesian methods formally incorporate existing evidence, including historical trials and real-world data, into the analysis.

Instead of treating evidence as a single final test, the analysis evolves alongside the data.

This represents a move away from static designs towards approaches that develop in line with the evidence. For regulators, it enables clearer reasoning about uncertainty and probability. For sponsors, it creates opportunities to design trials that are more informative and, in some cases, more efficient without compromising scientific or regulatory integrity.

Where it works

Bayesian methods are most valuable where traditional approaches struggle.

Early-phase development, rare disease research, oncology studies and medical device trials often involve small populations or ethical constraints that limit randomisation. In these settings, borrowing strength from prior data can support more confident decision-making.

Bayesian frameworks also align naturally with adaptive trial designs. Interim analyses, response-adaptive randomisation and simulation-based planning can all be implemented within a coherent Bayesian structure.

Rather than focusing solely on whether a result crosses a predefined statistical threshold, the analysis centres on more intuitive questions, such as the probability that a treatment is effective or the likelihood that one option outperforms another.

That shift in framing can make discussions clearer not just for statisticians but for clinicians, programme teams and regulators.

While the regulatory signal is encouraging, Bayesian methods require discipline.

Models must be built, validated and documented to the same standard expected of any submission-ready analysis. Assumptions and prior choices need clear justification, sensitivity analyses must be explored and results must remain fully traceable from source data through to decision.

Operational capability is equally important. Bayesian trials rely on simulation to understand operating characteristics and support adaptive decision rules. Integrating real-world data to construct external control arms adds further complexity around data provenance, bias and representativeness.

There is also a cultural challenge. Many teams are trained primarily in frequentist thinking. Upskilling statisticians, clinicians and reviewers, and providing consistent analytical frameworks, will be essential to broader adoption.

For organisations prepared to invest in the right expertise and infrastructure, Bayesian methods provide a path to learning more efficiently while maintaining the transparency and control regulators expect.

Approaches that combine simulation, traceability and governance can help teams apply these methods consistently across development programmes.

Bayesian statistics are not a shortcut. Used well, they reflect where clinical research is heading: towards trials that learn continuously; support clearer regulatory dialogue and focus on answering the questions that matter most. ▲

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