Response to NHS Chief Executive’s Open Call for Evidence and Ideas

Respondent ID: 162

Organisation name: Association of the British Pharmaceutical Industry

Type of response: Document
NHS Chief Executive
Innovation Review
Call for Evidence
Short Version 14th September 2011
Executive Summary
The Plan for Growth recognises that innovation is a key driver of long-term growth in the life sciences sector. Given that the pharmaceutical industry has invested more in Research & Development (R&D) than any other industrial sector in the UK\(^1\), the ABPI welcomes this review as a significant opportunity to align the innovative capabilities of the industry with the new focus on patient outcomes in the NHS.

There are a number of changes within the NHS currently being proposed that we believe will help create a better culture of innovation. The NHS reforms aim to improve quality of care and patient outcomes, supported by the NHS Outcomes Framework. We welcome the move to empower clinicians with freedom to prescribe, and to empower patients to make choices based on outcomes. An outcomes-focused NHS will create an environment in which clinicians and managers will need to embrace innovation and break down a siloed approach.

We are keen to see more systemic thinking that is focused on remodelling of patient pathways driven by innovation. As the aim of a care pathway is to take a holistic view across boundaries to deliver improved patient outcomes, we see use of innovative medicines as part of that holistic solution. Medicines can offer significant value to the NHS by remodelling patient pathways, improving outcomes, and releasing NHS capacity.

ABPI welcomes this review and call for evidence. We have identified some of the issues and barriers to adoption and diffusion of innovative medicines that exist in the current system and developed specific, workable solutions to address them, which are consistent with the new outcomes-based approach. In terms of harnessing the contribution of the pharmaceutical industry, we see the priority areas to address in this review as: removal of the duplication of value assessments of innovative medicines at a local level and mandatory adherence to national guidance and guidelines underpinned by performance management and metrics.

Value Assessments of Innovative Medicines: Context and Background
The prescribing of innovative medicines forms a vital part of many care pathways and has played an important role in improved outcomes. For example ‘around 4 million people are now receiving statins, saving an estimated 10,000 lives every year’\(^2\). Moreover, cancer survival rates in the UK have doubled in the past 40 years
and almost three-quarters of children with cancer are now cured of their disease, compared with around a quarter in the late 1960s.\(^3\)

However, patient access to new medicines has largely been conservative in the NHS, and evidence suggests that there exists a culture of caution towards them. While this can partly be addressed at the clinical trial stage when a medicine is licensed, there is a more deep-rooted issue.

Access to NICE-recommended medicines is enshrined in the NHS Constitution through the Secretary of State’s funding direction, and in the PPRS. Despite this, and with the UK having among the lowest-priced medicines in Europe,\(^4\) the international uptake report\(^5\) demonstrated that uptake in the UK is mediocre at best. The UK is ranked eight out of 14 countries in relation to medicines usage, and is below the average in the majority of cases, especially in newer cancers (< five years), hepatitis C and multiple sclerosis.\(^5\)

A recent analysis by IMS\(^6\) assessed the quarterly sales for 168 molecules launched in Europe (France, Germany, Italy, Spain and the UK) since the beginning of 2000. The results of the analysis indicate that:

- The UK has slow uptake of new medicines: of the 168 product launches since 2000, the UK makes up only 13.1% of the EU5 share by value (population adjusted);
- For non-appraised products, the UK has slow uptake: of the 119 product launches since 2000 not appraised by NICE, the UK makes up only 13.7% of the EU5 share by value;
- The NICE appraisal process creates a lag, during which time products are not widely adopted.

These data suggest that, when considering the early part of a medicine’s lifecycle, there is ‘slow and low’ adoption of innovative medicines compared to other countries.\(^7\) This delay in access to new medicines that have been licensed for their improved efficacy and/or tolerability ultimately puts improvement to patient outcomes at risk.

The UK typically only optimises adoption and diffusion of medicines once a product has gone generic. Simvastatin is a good example of this pattern. The UK is extremely cost-efficient when it comes to paying for medicines, as around two-thirds of all prescriptions dispensed in the UK are generic medicines.\(^8\) Due to the number of products coming off patent between 2009 and 2015, the NHS is set to save well over £3.0bn.\(^9\) The pharmaceutical industry understands and supports the value of an efficient generics market in the UK. However, the value of funding an efficient market for innovative and cost-effective branded medicines is at least as important, not least because NHS patients have a right to this through the NHS Constitution and because the generics market is dependent on it.
**Duplication of Value Assessments**

When considering patient access to new innovative medicines, there is also a disconnect between new medicines that are deemed cost-effective at a national level through NICE, and those that local health economies deem affordable. This results in further barriers to patient access and, for those treatments that are recommended by NICE, we have started to see the duplication of value assessments at a local level.

More recently, cost constraints driven under the QIPP programme are inevitably having an effect, as are restrictions on established branded products through initiatives such as Better Care, Better Value (BCBV) indicators. The national metrics report\(^\text{10}\) demonstrates that there is unwarranted variation in the adoption of innovative medicines at a regional level (e.g. for diabetes and osteoporosis), a situation which will be exacerbated by fragmentation at a local level through the introduction of Clinical Commissioning Groups (CCGs).

Our solutions address these issues by recommending the strengthening of NICE guidance and clinical guidelines, and protecting the integrity of the appraisal process and the patient rights to medicines laid down in the NHS Constitution. These solutions include the automatic inclusion on formulary of NICE-recommended medicines; mandatory adherence to national guidance and clinical guidelines; and promotion of the NHS Constitution’s patient rights to medicines through a national communication and patient appeal mechanism.

**Strengthening the Innovation Culture**

A future embracing innovation requires effective partnering between industry and healthcare professionals and payers. The ABPI has proven that industry can successfully work with the NHS, partnering in innovative projects that have resulted in direct cost-efficiencies and improved patient outcomes; we have set out examples in Appendix A. We have also taken steps to promote trust in the industry through changes to the ABPI Code of Practice. These changes, notably no longer providing branded promotional aids and declarations of aggregate payments to healthcare professionals, have also supported greater openness and transparency in the relationship between the industry and the NHS.

We believe steps should be taken at both a national and local level to scale up the level of joint working and use the expertise of the pharmaceutical industry in the redesign of patient pathways driven by the use of innovative medicines. This approach would potentially expand patient choice about where care is delivered, reduce demand on hospital resources, and provide care closer to home. We have outlined the role that industry can play in section 4.1. We also propose other solutions to strengthen the innovation culture, including the need for greater incentives and performance management.
Conclusion

To summarise, innovative medicines have been proven to save lives. As the Prime Minister recently acknowledged, if we could equal the levels of European care we would save 5,000 lives a year in cancer, 2,000 lives a year in respiratory care, and 550 lives a year in chronic liver disease and cirrhosis. Improving access to innovative care and medicines will have an important role to play in achieving this.

We welcome the opportunity to submit our evidence and solutions as part of the call for evidence. ABPI is keen to collaborate on the development of the innovation report and we are pleased to have the opportunity to elaborate on our proposals. Numerous joint working projects that we have undertaken with the NHS have brought very real benefits to patients. We are pleased that approach is being applied to this process and we look forward to establishing fully workable solutions for patients.
Summary of Solutions

Remove duplication of value assessments at a local level

Solution 1: A national communication
Solution 2: Automatic inclusion on formulary for NICE-recommended medicines
Solution 3: Mandatory adherence to NICE guidance and clinical guidelines
Solution 4: Appeal mechanism for access to innovative medicines

Strengthen the innovation culture within the NHS

Solution 5: Visible leadership and language to raise the profile of the NHS as a centre for innovation
Solution 6: Embed innovation locally
Solution 7: Training

Break down silo budgets and remove perverse incentives

Solution 8: Embed implementation of NICE guidance and clinical guidelines
Solution 9: Improved medicines expenditure planning and forecasting
Solution 10: Medicines optimisation teams
Solution 11: Ring-fenced funding for specific situations
Call for Evidence Questions

1. Learning from elsewhere about adoption and spread

What can the NHS and NHS Commissioning Board learn from local, national, and international best practice to accelerate the pace and scale of adoption of innovations in the NHS?

1.1 Local Best Practice

Summary

Industry has been successfully working in partnership across the NHS to drive best practice and identify opportunities for joint working. The success of these projects both in cost-effectiveness and patient outcomes has been recognised by the Department of Health. Many of the joint working best practice examples in Appendix A include patient pathway redesign at a local level driven by innovative medicines, reducing use of hospital resources and delivering better, more efficient patient care in the community. Industry is also developing innovative provider models available on a commercial basis. An example is shown in Appendix A.

Opportunities exist at a national level, with the introduction of innovative medicines to redesign patient pathways thus expanding patient choice about where care is delivered, reducing demand on hospital resources, and providing care closer to home. Disease area industry groups can work in partnership with the National Commissioning Board or SHA clusters and National Clinical Directors to review and redesign pathways. Potential areas to be considered for this approach are:

- **Optimising care outside of hospital in cancer**

The National Cancer Strategy highlighted the need to expand patient choice and reduce reliance on hospital-based care. Collaboration between industry and the NHS can make a real impact by moving elements of the pathway, or in some cases the whole pathway, out of the hospital setting for cohorts of patients. This provides innovation in the way care is delivered whilst achieving significant efficiency savings and a better patient experience. In the management of patients with bone metastases, subcutaneous rather than intravenous medicines for prevention of skeletal-related events can help redesign the care pathway to deliver improved patient and system outcomes. This advance helps reduce the need for costly and time-consuming iv infusions, freeing chemotherapy care capacity and nurse resources. It also supports a better experience for the patient, allowing patients to receive their medication in the community. Oral chemotherapy agents can transform patient pathways and reduce demand on hospital-based chemotherapy clinics.
• Management of atrial fibrillation (AF)

AF causes up to 25% of strokes, and it is estimated that the direct cost of AF-related stroke could reach £750m/year. AF significantly increases a patient’s risk of CV morbidity and mortality and is the leading cause of hospitalisations for arrhythmia. Studies reveal high rates of hospitalisation for AF of around 40% of patients. Newer medicines for management of AF enable patients to be treated in the community without the need for regular monitoring, reducing demand on hospital-based clinics.

• Management of rheumatoid arthritis (RA)

RA costs the NHS in England around £560 million annually in healthcare costs. Between 8% and 24% of direct RA costs are spent on drugs and monitoring and treating side-effects. However, indirect costs vastly outweigh direct costs. Total costs of RA in the UK, including indirect costs and work-related disability, are estimated at between £3.8 and £4.8 billion per year. Embedding the Treat to Target recommendations in clinical practice across the UK, with particular focus on raising awareness of the condition, early referral, and maintaining patients in remission, can reduce joint damage and reduce the cost burden of the disease.

1.2 National Best Practice

Close collaboration between the Department of Health (DH), NICE and manufacturers can ensure that treatments with clinical value are made available to patients. A case study on ranibizumab for the treatment of wet age-related macular degeneration is included in Appendix D. The manufacturer worked closely with DH and NICE to develop a patient access scheme where the cost of treatment would be shared. This resulted in NICE recommending ranibizumab for NHS use. The manufacturer also supported a disease awareness campaign on AMD and worked closely with NHS eye units, providing third party consultancy to help them redesign their service pathway.

The DH National Clinical Directors (NCDs) have been key in developing disease-specific strategies that will contribute to setting appropriate outcome measures within the NHS. Industry has worked in partnership with the NCDs through disease-based industry groups on projects that implement the national strategies.

An example of partnership working is the development of the C-PORT, a chemotherapy capacity planning tool. C-PORT has enabled chemotherapy departments to use existing resources more effectively and commissioners and providers to plan better for the future. Following Professor Sir Mike Richards’s report in 2004, C-PORT emerged as the practical solution to help plan for the challenge of increasing demand upon chemotherapy services. C-PORT is a public private
partnership (‘PPP’) involving 12 pharmaceutical industry companies from the Pharmaceutical Oncology Initiative Partnership, the Department of Health, and IT solution providers. The main uses of C-PORT, as a chemotherapy planning tool, are:

- To survey the current position in chemotherapy services;
- To model the effects of changing demand and changing capacity;
- To plan for new services and ‘new builds’ in order to meet demand.

Further information can be found at [http://www.cport.co.uk/Home.aspx](http://www.cport.co.uk/Home.aspx)

1.3 International Best Practice

The OECD survey on health technologies focused on decision-making processes and implementation methods and identified the need for early dialogue between producers and users of Health Technology Assessment (HTA) to achieve better alignment of HTA content and decision-makers’ needs. It stated that successfully implementing decisions is a key challenge for many health policy-makers. Direct healthcare programmes and the provision of information to healthcare providers were the common means by which policies were implemented, supported by education programmes and performance management. However, use of incentive funding was very limited and appears to be a gap in implementation. The survey also reviewed the barriers and facilitators to implementation. The issue of silo funding was identified as an important barrier to efficient decision-making, whilst availability of funding for implementation was seen as the biggest facilitator. Despite this example, international best practice on adoption and diffusion of innovative medicines that can be applied to the UK healthcare system is limited.

2. Actions at a national level in the NHS

**What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

2.1 Remove duplication of value assessment at a local level through national action

We have a proliferation of multiple structural layers within the NHS (PCTs, Area Prescribing Committees, Regional Technology Assessment Groups etc.), leading to inefficiencies, duplication and complexity in local decision-making. Repeated value assessments of medicines take place at a local level as formulary and funding decisions are made, despite the existence of NICE guidance; this often results in further barriers to access, such as inconsistent and restrictive guidance and the existence of red lists. Denying access to treatments that have already been found
cost-effective undermines the NICE process and the NHS Constitution, and would undermine the duty to innovate for both the National Commissioning Board (NCB) and future CCGs.

We have included detailed case studies and references in Appendix B to illustrate these barriers, and further documents are available. However, it should be noted that whilst a number of companies are in the process of bringing these issues to the attention of the local Trust, it can be difficult to obtain written evidence from NHS organisations. It should also be recognised that companies can be reluctant to pursue cases for fear of alienating the NHS organisation or individuals involved.

Appendix B also cites the introduction of two formularies (GMMMG and Northern Ireland) as examples of further duplication at a local level and outlines our concerns, particularly on the use of NICE-recommended medicines.

Increasingly, these bodies are taking on a quasi-licensing role, as witnessed by the recent decision of the North East Treatment advisory group which appraised and recommended bevacizumab for the treatment of neovascular macular degeneration, in place of the licensed and NICE-recommended treatment ranibizumab (see Appendix B). Such appraisals are undermining national regulatory processes, putting patient safety at risk, and will ultimately stifle innovation.

These sub-national groups have a valuable role to play when activities are focused on improving outcomes rather than repeated value assessments.

As a consequence of local re-assessments, unwarranted variation exists in the actual usage of NICE-recommended medicines compared to expected use.\textsuperscript{10} Wide variations in local funding and affordability further compound the problem of access. It will be important to avoid any exacerbation of this situation arising from further fragmentation of decision-making at a local level with the introduction of Clinical Commissioning Groups. We welcome the confirmation of mandatory funding following NICE approval; however, there are further steps that need to be taken.

**Solution 1: A national communication**

A national communication from DH/NHS would reinforce the commitment to the NICE approval mechanism, the mandatory funding direction for NICE-recommended medicines, the rights of patients to NICE-recommended medicines, and that there should be no further qualification, reinterpretation or modification of NICE guidance at a local level. This communication should also reinforce that unlicensed medicines should not be used where a licensed and NICE-recommended alternative exists.
**Solution 2: Automatic inclusion on formulary for NICE-recommended medicines**
A NICE-recommended medicine should be automatically included on formulary without the need for reassessment, empowering clinicians freely to prescribe innovative medicines for eligible patients. Such a mechanism would remove the need for multiple structural layers of assessment within the NHS and create a more efficient system.

**Solution 3: Mandatory adherence to NICE guidance and clinical guidelines**
The mandating of national guidance and clinical guidelines currently issued by NICE is critical and should be accompanied by national accountability and responsibility for adherence to the national guidance/guideline and monitoring of adherence. Mandatory adherence to NICE guidance and clinical guidelines should be embedded in the constitution of bodies like Monitor, CQC, and regional commissioning boards, to strengthen the effectiveness of NICE’s implementation mandate. This would also ensure that approved technologies have mandatory inclusion, without re-qualification, on local formularies (see Solution 2).

**Solution 4: Appeal mechanism for access to innovative medicines**
The NHS reforms highlight the role of the patient in healthcare management captured in the ethos ‘no decision about me, without me’, and emphasises the importance of patient empowerment and their right to choose, as well as clinical freedom to prescribe. In addition, the NHS Constitution enshrines the right to NICE-recommended medicines. The introduction of an appeal mechanism for patients, manufacturers and other interested stakeholders when access to NICE-recommended medicines is inappropriately restricted sub-nationally, would uphold this right and create a ‘pull’ from patients. Such a mechanism could empower patients to take ownership of their healthcare and engage in the decision-making process. Further work needs to be done to identify the route for the appeal mechanism. Potential options could be the NCB or CQC.

**2.2 Strengthen the innovation culture within the NHS through national action**
The clinical culture and prescribing behaviour of some clinicians in the NHS leads to slow adoption of innovative medicines compared to other countries. Suspicion of industry within the NHS creates a reluctance to work collaboratively for the benefit of patients. Innovation leadership needs to be strengthened at all levels of the NHS to support a change in culture. We recognise that longer-term solutions are required to change a culture and build trust in the industry, and we are willing to work together on these solutions. In the short term we recommend:
Solution 5: Visible leadership and language to raise the profile of the NHS as a centre for innovation

Visible leadership and consistent use of language and messages at a national level (via the NCB) cascaded throughout the NHS can change behaviour and create the culture and environment to support the diffusion and adoption of innovation. There is an opportunity for Government and NHS leadership to raise the profile of the NHS as a centre for innovation for the benefit of the health of the Nation and the UK economy. Communications need to be supportive of innovation and empower all levels of the NHS to change behaviours and instil confidence to use innovation to make a difference.

3. Actions at a local level in the NHS

What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?

3.1 Strengthen the innovation culture within the NHS through local action

While culture can be addressed at a national level, we recommend further steps are taken at a local level to embed a culture of innovation.

Solution 6: Embed Innovation locally

The Health and Social Care Bill outlines that the Clinical Commissioning Groups will have a duty both to promote the NHS Constitution and to promote innovation in the provision of health services. Similarly, the National Commissioning Board must promote innovation and will have a power to award financial prizes to promote innovation. A prize accelerating the adoption of medicines in line with national guidance and guidelines could be considered. Embedding innovation locally is likely to require a multifactorial approach. One route to achieve this would be through the performance management mechanism (or equivalent accountability framework) across all levels of the NHS, where accountability for innovation can be included within individuals’ job descriptions, objectives and work plans, supported by clear measures and incentives as outlined in Solution 8.

Solution 7: Training

Introduction of a training module on the pharmaceutical industry, the research and development process, the value of medicines, and the benefits of partnership working should be introduced in the early curriculum of clinician training. There is work on going with DH led by David Cox under the direction of Sally Davies that we fully support and with which we have been engaging. This is an effective way to break down silos between the NHS and industry, and to build trust. Initial training can
then be built upon through ongoing Continuing Professional Development and re-validation.

3.2 Break down silo budgets and remove perverse incentives
PCTs or other budget-holders tend to manage their short-term cost constraints by restricting the use of the novel, irrespective of medium- and long-term benefits. This is true even when a competent internationally-recognised body such as NICE has ruled that a medicine is cost-effective. Thus while the NHS recognises that innovation is essential to meet current and future challenges, the cost-constrained environment results in innovative medicines being viewed as ‘problems’, meaning that high barriers to initial use are set. In a cost-constrained environment, silo budgeting can discourage an integrated patient pathway approach and risk improvement to longer-term patient outcomes. **Perverse incentives at a local level and annual financial cycles can exacerbate the problem and need to be reviewed.** Case studies illustrating the challenges of silo budgeting and perverse incentives can be found in Appendix C.

A successful example of aligning lead indicators and incentives is the management of Venous Thromboembolism (VTE). VTE is a national priority disease area where outcomes and lead indicators have been identified, embedded in the system and incentives and penalties aligned to delivery. Reduced incidence of VTE is included in the outcomes framework. The Quality Standard incorporates the lead indicator of % patient risk assessed on admission to hospital. CQUIN includes 0.3% of the 1.5% CQUIN payment for reducing avoidable death, disability and chronic ill health from VTE and the penalty 1% of tariff via acute contracts is levied for failing to report monthly risk assessments. In this example, use of a national CQUIN has proven highly effective.

Another example of implementing change in the NHS through aligned incentives is arguably the QOF, as it was introduced with a package of remuneration that rewarded behaviour.

In the current climate, surety of funding for innovative medicines becomes increasingly important. Overall, the industry and the NHS need to adopt differentiated strategies to approaching funding surety, to reflect the challenges of affordability. We have outlined our current thinking below and would like to work with the DH Innovation Review team to develop this further, build the evidence and co-create a solution.
Principles

1. **Increase transparency for products that reduce system cost**

For products that reduce system costs and will therefore respond to the pure economic incentives of the NHS, the DH/NHS should promote awareness of the new technology and allow the market to drive the appropriate behaviours.

2. **Improve implementation and adoption for products deemed clinically cost-effective**

For products that are deemed nationally clinically and cost-effective (once QA / ‘quality adjusted’) but which nevertheless have incremental cash cost to the system, strengthening of NICE’s role in implementation performance management should be considered, to counteract the normal economic behaviours that would impair innovation adoption. This is discussed in more detail below.

3. **Ring-fenced funding for specific situations**

For specific situations, ring-fencing will be the most appropriate funding response. Key areas include products where there is a widespread public interest (e.g. vaccines, epidemics, HIV), or where products are not deemed cost-effective under whatever formula, but where patient access is nevertheless deemed desirable (e.g. orphan drugs, which are currently assessed by the standard HTA process despite the hurdles of this process being too high). Consideration should also be given to pump-priming funds where there are considerable upfront transition/infrastructure costs that could block adoption (e.g. diagnostics), and ultimately deny significant patient benefit.

**Solution 8: Embed implementation of NICE guidance and clinical guidelines**

For products that are deemed clinically and cost-effective, a strengthened implementation role for NICE should be introduced to achieve consistent implementation of NICE guidance. The current ‘implementation template’ approach that accompanies NICE guidance for new technology should be upgraded into a full implementation management capability. In practice this would mean that guidance for a new technology would be complemented by a more extensive implementation package, including localised budget impact assessment, recommended funding levels, specific recommendations of pathway redesign to optimise end-to-end funding, in-pathway disinvestment (where appropriate), and recommended changes to incentives and metrics to enable adoption (e.g. PbR, QOF, CQUIN). Adoption and diffusion of innovative medicines should also be included in provider contracts supported by appropriate performance management.
Solution 9: Improved medicines expenditure planning and forecasting

Improved medicines expenditure planning and forecasting should be introduced in the NHS, building on current horizon-scanning processes (UK Pharmascan). The forecasting effort would have a short- to mid-term focus (i.e. 1 to 3 years) and should specifically consider policy directions that have a significant impact on medicines usage, underlying demand trends, new innovation, patent expiries, QIPP initiatives, and cross-pathway disinvestment opportunities. The expectation is that improved forecasting will allow budget-holders to plan and make adequate provision for innovation in the mid-term. The process could be jointly owned between finance, public health and commissioners.

Solution 10: Medicines optimisation teams

Medicines optimisation teams in Clinical Commissioning Groups (CCGs) should focus on consistent implementation of NICE Quality Standards, use of NICE-recommended medicines as part of a care pathway to improve outcomes in eligible patients, improving patient adherence, reducing wastage, and reducing unwarranted regional variation. Clear measures and incentives should be built in at CCG level to support consistent implementation of care.

Solution 11: Ring-fenced funding for specific situations

For specific situations, ring-fencing will be the most appropriate funding response. Key areas include products where there is a widespread public interest (e.g. vaccines, epidemics, HIV), or where products are not deemed cost-effective under whatever formula, for a number of reasons including patient need or severity of disease (e.g. orphan drugs). For the funding to work effectively, a robust process and governance needs to be in place. While ensuring patient access to beneficial innovations it will be essential to find workable solutions through which treatments can be accessed even if they are not initially deemed cost-effective.

4. Actions by NHS Partners

What specific actions do you believe others such as industry, academia, patient groups or local authorities could take to accelerate adoption and spread, and what might encourage them to do so?

4.1 Actions by industry

Whilst we have included solutions for the NHS in our submission, we believe there are actions that all stakeholders in industry can take to contribute to the acceleration of adoption and diffusion of innovation to improve patient outcomes. We have
outlined our early thinking below and look forward to further dialogue to develop these and other proposals over the coming months.

4.1.1 Industry works in partnership with National Commissioning Board (NCB) to redesign patient pathways incorporating innovation
Disease area industry groups should work in partnership with the NCB or SHA clusters, and National Clinical Directors (NCDs), in areas of national priority (and high cost) to review and redesign patient pathways for the potential to incorporate benefits offered by innovative medicines and reference NICE guidance. Efficiency savings can be reinvested to improve quality of care locally. Potential areas are: optimising care outside of hospital in cancer, management of atrial fibrillation, and management of rheumatoid arthritis. The resulting best practice pathways could be incorporated in the commissioning framework, and implementation supported by aligned incentives and/or penalties, e.g. Best Practice PbR tariff and CQUIN.

4.1.2 Improving patient adherence and reducing wastage
The report published on 7 July 2011 by the DH entitled *Making the best use of medicines* estimates the avoidable cost of waste medicines in England to be up to £150 million, and points out that there also a cost to patients in improved health outcomes forgone, if medicines are not used to best effect. Industry is keen to work with the NHS to support research in the best ways of improving compliance, share examples of pilot approaches to improving adherence which member companies are currently implementing, and discuss how we can tackle this issue at a national level.

4.1.3 Training and education
Industry can provide significant input and value through the education and training of healthcare professionals and medical students in the value of engaging with industry and the role industry plays in the life sciences sector. Training sessions could include the industry research and development process and the value it delivers to the UK and to patients and the importance of adoption and diffusion of innovation.

4.1.4 Facilitating a new Business to Business relationship between industry and the NHS to deliver improved patient outcomes
Current relationships with industry can be thought of by either side as risk transfer. Industry would be keen to discuss options for development of a Business to Business relationship on the basis of genuine risk share.

Industry has demonstrated that it can work effectively in partnership with the NHS through joint working projects, and deliver successful patient outcomes. Section 4.1.1 builds upon this partnership approach.
There should be a review of the ABPI Code of Practice to enable appropriate governance of any future Business to Business relationship and further facilitate meaningful joint working partnerships.

4.1.5 Improving advanced notification of new medicines
Building on UK Pharmascan, the newly-populated register for new medicines, an opportunity exists for industry to extend further the data provided to include budget impact assessment, in order to enable the NHS better to plan and budget accordingly for new medicines.

4.1.6 Strategic partnership with NHS Confederation
ABPI is working in partnership with the NHS Confederation to develop a strategic initiative to accelerate joint working by identifying areas of greatest need, setting up joint working pilots, and sharing of best practice.

4.1.7 Sharing of data
In line with the current transparency agenda and sharing of data, industry has data on local prescribing patterns and trends which could be tailored and shared with local CCGs through a more formalised arrangement to enable better management of patient populations.

4.1.8 NHS Global
There are a number of initiatives underway that showcase internationally the successful work that has been undertaken in the NHS. The Innovation Expo and NHS Global are two examples of how the UK can spread best practice and promote the NHS brand. Industry would be interested in exploring ways in which it can promote the mechanisms and experiences that come from this review, and support the NHS in disseminating these messages internationally.

5. Any other comments
Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?

Scope of innovation
It is important that the report focuses on the widest possible definition of innovation. Innovation is multidimensional and continuous; it can vary in degree on each dimension. Most pharmaceutical innovation is not a single enormous step or breakthrough innovation, but a series of smaller but still valuable steps leading to a significant improvement. Each step contributes value through a variety of benefits,
whether these are improved patient outcomes, cost savings elsewhere in the NHS, enabling redesign and innovation within the patient pathway, convenience for patients, or wider societal benefits. Many of these benefits only become apparent after medicine’s use in real world settings. Indeed a report published by SECOR in May 2011, *How Next Happens – Building our Economy through Incremental Innovation*, confirms that most progress and productivity is made through incremental innovation.

Innovation tends to be evolutionary not revolutionary. Innovation builds on the platform created by previous therapies. For example combination therapies, which rely on the experience gained from use of existing medicines, are becoming increasingly common (e.g. those for HIV or colorectal cancer).

**References**

3. CRUK July 2011: CancerStats, Key Facts, All Cancers Combined.
6. IMS Health MIDAS data.
12. The OECD Health Project 2005 - Health Technology and Decision-making. Chapter 4 - Decision-making and implementation: an analysis of survey results.