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

Respondent ID: 144

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**NHS Chief Executive Innovation Review**

**Memorandum submitted by Medtronic International and Medtronic Ltd**

**About Medtronic**

Medtronic is the global leader in medical technology, alleviating pain, restoring health and extending life for millions of people around the world. With deep roots in the treatment of heart disease, Medtronic now provides a wide range of products and therapies - every four seconds, somewhere in the world, another life is improved by a Medtronic product or therapy.

The company was founded in 1949 in Minneapolis, Minnesota, USA, by Earl E. Bakken and Palmer J. Hermundslie. In the UK, Medtronic has been based in Watford for over 35 years.

**Introduction**

Medtronic welcomes the opportunity to contribute to the NHS Chief Executive Innovation Review. We understand this evidence will be considered and compiled into a report by Sir David Nicholson which will be published in November 2011.

We are delighted that the ‘Plan for Growth’ recognises the importance of innovation and its potential for the NHS and the economy. We also commend the approach to this process. The breadth, range of potential stakeholders and the response period allowed indicate to us that the views of stakeholders are genuinely important. Medtronic also believes the role of the NHS Life Sciences Innovation Delivery Board is important and we welcome the fact that evidence will also inform the report this body is undertaking on life-sciences innovation.

This memorandum focuses on the innovation benefits that medical technology can offer. Medtronic believe that system changes that enable wider access patient access to new medical therapies can deliver considerable benefits to patients as well as the NHS. Our memorandum will follow closely the areas which the call for evidence stated they wished to assess – system incentives for innovation; pull from patients and NHS staff; reward for staff and organisations; experimenting more and being less risk averse; and taking a longer term view on investment.

1. **System Incentives for Innovation**

**Patient Centred Care – Tariff Reform**

1.1 There is top down pressure from the Department of Health (DoH) and politicians to move away from traditional healthcare settings and into the community – taking treatments
closer to the patients. These initiatives have been only partially successful. The potential for savings in the areas where primary care transitions in to secondary care, tertiary care and social care is considerable. Too often developments in technology are under-utilised because the benefits are realised in a different part of the system to that which made the initial investment.

1.2 The current payment system (mainly around tariff) does not incentivise commissioners and providers to look to these types of solutions. While local control is fundamental, mechanisms are needed to address the tension between annual budgeting and innovation benefits that may not support balance sheet changes in-year. The NHS needs direction and incentive changes to ensure that beneficial new treatments – many involving technologies – reach patients sooner, as happens in other OECD countries.

1.3 One such example of an innovative technology that has the potential to deliver considerable savings but for which the current tariff system is inappropriate is telehealth. A number of pilots have shown how investment in the technology and related services has led to much lower levels of admissions for patients with chronic conditions. A report from 2020 Health – ‘Healthcare without Walls’ – has estimated properly scaled up, the use of telehealth across the NHS could lead to up to £1 billion in annual savings with hundreds of thousands of patients’ lives improved significantly.

1.4 Nevertheless, to date, most NHS telehealth initiatives are no more than one-off, small-scale projects that are not well integrated into healthcare systems. The DoH has established and funded three large demonstrators – a national evaluation report is due to be published in 2011.

1.5 Other countries have developed a much more strategic approach to telehealth, leading to greater levels of adoption of managing patients with long-term conditions. They have followed more radical approaches with telehealth being part of a full service redesign or used to support preventive healthcare and self-care. In the US, telehealth is widely adopted (>130,000 systems) through several large-scale mainstream programmes. Medtronic’s CARELINK system, which allows for the remote monitoring of patients with cardiac devices, delivers benefits to over 600,000 patients and health systems around the world – but very few in the UK. A growing body of evidence shows that CARELINK reduces in-office visits, scheduled and un-scheduled, by 38%; anticipates clinically actionable events and reduces time from event to clinical decision by 79%; reduces avg. length of hospital stay (cardiovascular reasons) by 18%, with savings of US$ 1,793 per admission; and reduces overall costs by 40%.

1.6 To support this shift away from traditional healthcare settings the government must make tariff setting more flexible and look at a broader ‘pathway perspective’ when establishing a system, rather than simply paying per episode of care. One possibility could be a ‘year of care’ tariff for chronic long term conditions.

1.7 The tariff system is also heavily reliant on having large amounts of data which leads to delays in setting tariffs for new treatments and then delays in patients getting access to these treatments. A weakness of the Payment by Results system is that it relies on outdated classifications and a coding system (OPCS) that fails to recognise many new procedures. The system must include mechanisms for the rapid introduction of innovative technologies – and also recognise that the pace of change in some areas is such that
removing technologies from the exclusion list should not be an overriding objective of tariff development.

1.8 Once the National Commissioning Board is established, one of its senior clinical directors should have national advocacy and responsibility for innovation and related technologies. The Board's new duty has to 'promote innovation' can be served by including elements of NICE's obligation to monitor the implementation of their guidance. It could also include the activity and the functions of the existing NHS Technology Adoption Centre. All of these functions need to be fully integrated to support the newly established clinical commissioning groups (CCGs) with the technical aspects of implementation and the business cases that are required.

NHS Supply Chain and Procurement

1.9 The NHS fails to get full value from their current procurement practices. The current policy drive to make all decisions locally is not being seen in procurement where the current focus is on encouraging all NHS Trusts to use the central body 'NHS Supply Chain' to carry out procurement.

1.10 SMEs find it much more difficult to get their products included within the NHS Supply Chain system – they are interested in bulk orders and have a focus on 'price' rather than 'value'. A number of small British based medical technology companies who are members of the Association of British Healthcare Industries (ABHI) now trade exclusively outside of the UK because of NHS entry barriers.

1.11 Moreover, there is a growing reliance from NHS Trusts on other organisations that offer to assist with procurement. Problems arise when they sign exclusivity contracts as the procurement organisations/companies then charge fees to suppliers – many of whom were previously dealing with hospitals directly. This is stifling competition and is a further barrier to SME’s. This also restricts patient and clinician choice. Procurement organisations should be bound to offer a plurality of suppliers independent of those willing to pay a listing fee.

2. Pull from Patients and the NHS

Patient Choice

2.1 Patient choice must apply to more than the location of treatment. Modern medicine offers a range of treatments for many conditions but demand for innovation will only occur when patients are aware and fully informed about the full range of treatments available. Moreover, it is good that the Health & Social Care Bill increases the range of people who can be involved in treatment choices to include relatives and carers. If patients are to be effective advocates for innovation and new technology, it is crucial that information is presented in a manner which is easy to access by even the most vulnerable of patients.

2.2 The Board should include advice on the development of decision aids in their guidance to CCGs on patient involvement. We suggest that the Board seeks to identify and endorse organisations that can offer quality, informed advice on the full range of treatments that might be available. Such organisations might include, but not be limited to, patient groups, medical supply trade associations and individual manufacturers.
2.3 The NHS 'Atlas of Variation' has the power to be a very powerful tool for patients and professional to consult to measure the uptake of new technologies and support patient choice. The Board should use this as a benchmark in pursuit of its duty to promote innovation. This data can be the basis of information presented to local authorities and Parliament. It should be made easy to understand, perhaps broken down by clinical area, and compared against the demographic profile of the area covered by the consortia.

Patient Groups and Advocacy

2.4 CCGs consulting local Healthwatch organisations will help ensure that feedback from patients and service users are reflected in commissioning plans. However, such local activity is unlikely to have a clear view of the emergence of innovation and new treatments, nor of how local commissioners are performing against national benchmarks.

2.5 It would therefore be desirable if a Board patient-oriented function was linked closely with HealthWatch England. Many patient advocacy groups have a wealth of data and information and evidence on variation of treatment by area. Using national benchmarking this could help spread the adoption of best practice and innovation.

2.6 A good example of a patient group and technology where this would be effective would be INPUT, and patient access to insulin pumps for the treatment of diabetes. Despite the existence of NICE guidance recommending that this therapy be made much more widely available to patients, differing healthcare funding policies have led to them being much less common than in other countries and a postcode lottery in terms of who receives the device. INPUT is an independent, not-for-profit patient group run by insulin pump users and their families to raise awareness of diabetes technology – including insulin pump therapy – in the UK.

2.7 A patient group like INPUT could provide the ‘pull’ working with the DoH, the Board and local activists on ground where there is poor uptake. This would complement nicely the ‘push’ from a DoH working group chaired by Dr Rowan Hillson that is focusing specifically on improving the uptake of insulin pumps.

3. **Rewarding Best Practice**

The Quality Outcome Framework

3.1 The Quality Outcome Framework (QOF) has significant potential to deliver improvements in healthcare provision, and importantly healthcare outcomes. The ultimate aim of QOF is to promote and reward best practice. Currently QOF consists of a collection of clinical indicators, of which a proportion are procedural and another proportion are outcome based.

3.2 It is important that more of the indicators should be outcome based. This will remove the rigidity of forcing clinicians to carry out unnecessary procedures and allow them to innovate through new techniques and using new equipment improving outcome and fostering a culture of innovation throughout healthcare.

3.3 One of the indicators concerned with hypertension reward GPs when they take the blood pressure of patients and record these results in a database. While these are welcome,
QOF indicators could be improved by further targeting these at reducing blood pressure in hypertensive patients.

The Quality Innovation Productivity, Prevention (QIPP) Agenda

3.4 The QIPP programme has huge potential to be a driver for the identification of innovation and best practice that will drive higher quality and productivity in the NHS. The process should enable the establishment of new services and facilitating communication across traditional boundaries to share best practice and productivity improvements.

3.5 A key part of this programme should be looking at new care pathways. A recent Cochrane review has concluded that clinical care pathways are associated with reduced in-hospital complications and improved documentation. The majority of the 27 studies analysed reported a decreased length of stay and reduction in hospital costs when clinical pathways were used.

3.6 As well as improving outcomes and spreading best practice, QIPP has the potential to deliver significant efficiency savings as outlined in the programme’s objectives. It is crucial however, that these savings should be driven by changes in care pathways rather than by short-term procurement changes. Savings driven by short-term procurement decisions possess the danger of stifling the potential for innovation rather than enhancing it.

Multidisciplinary Working

3.7 With a greater incidence of patients presenting with long-term chronic conditions – some with more than one – there is a growing need for physicians to work within multi-disciplinary teams.

3.8 One such condition is peripheral arterial disease which leads to critical limb ischemia – which is often linked to diabetes. Evidence from a number of centres suggests improved outcomes, fewer amputations and efficiency savings are associated with physicians working within multi-disciplinary teams.

3.9 Guidance offered by the Board to clinical commission groups should include the benefits associated with working within multi-disciplinary teams.

3.10 Many medical professionals suggest that best practice is best spread through learning from other professionals. A great deal of importance is attached to continuous medical development, professional societies and medical congresses. The DoH should recognise the importance of medical congresses and scientific/health policy meetings – by sending more representatives – and the constructive role that industry plays in helping to ensure that these meetings take place.

4. Becoming less risk averse – supporting staff

Involving Clinicians in Commissioning

4.1 NHS organisations are widely seen to be risk adverse, and this can inhibit innovation. In the public sector the consequences of unsuccessful innovations can be severe attracting
media and political criticism. It could be argued that, in general, NHS staff are more motivated to avoid failure than to achieve success.

4.2 There are likely to be a number of factors that influence and encourage NHS staff to be less risk averse. NHS Institute research argued that the leadership and governance of NHS bodies were the most important factor in influencing the ‘risk appetite’ of NHS staff.

4.3 It is crucially important that the governance and leadership of new CCGs understand the importance of innovation and the threats of risk aversion. This is why Medtronic welcomes the broader involvement of clinicians in CCGs. We believe that this has the potential to equip CCGs with crucial specialist knowledge when commissioning often quite specialist services.

4.4 However, the Health & Social Care Bill going through Parliament only requires CCGs to “obtain advice” from a broad range of professionals with expertise in the “prevention, diagnosis or treatment of illness”. The duty to “obtain advice” should be strengthened with clear direction given that CCGs are required to consult with and take into account input from the clinically appropriate specialist when developing commissioning framework for a particular condition. This should be made clear in the guidance issued by the Board. Moreover, the input of secondary clinical specialists in CCG governing boards should be formalised.

Training and Technical Support

4.5 In some tenders, commissioners have in the past focussed on the initial cost of a technology without appropriately assessing other associated benefits. These include quality, technical support and training of healthcare professionals. To fully realise the benefits of certain therapies, industry plays a crucial role by providing technical support to assist with procedures and in providing training to ensure that medical technologies are used safely, effectively and efficiently. When tenders are awarded by commissioners, a greater weighting should be placed on training and technical support to ensure a “full value” approach. The Board should include this in the guidance issued to CCGs.

5. A Longer Term View on Investment

5.1 As outlined earlier in this evidence, potential for savings in the areas where primary care transitions in to secondary care, tertiary care and social care are considerable. However, these are often not realised due to short-term budgetary challenges or because the benefits are realised in a different part of the NHS.

5.2 There is often a reluctance within the NHS to spend money on high value technology due to upfront costs – despite the fact, in many cases, the technology has already been deemed cost effective by NICE. In the longer term this often means higher costs for the NHS.

5.3 One such technology are implantable cardiac defibrillators (ICDs) which prevent sudden cardiac death in patients with cardiac arrhythmia. In the UK there are 60,000 - 70,000 deaths annually but ICD implant rates are significantly below the rate recommended by NICE and 50% of that in Western Europe and 10% of that in the United States.
5.4 The main barrier to patient access is that funding in some parts of the country are focused on the initial cost of ICDs rather than their cost-effectiveness over the lifetime of the treatment. The upfront costs should be compared against the costs of long term use of drug therapy as well as the obvious benefits for patients in terms of quality of life.

5.5 Cost savings made outside the NHS should be considered when assessing a technology's value as a long-term investment. This is vital in the pursuit of joined-up government and a necessary part of the solution to budgetary pressures to be faced by the entire public sector in the coming years. One such example is how some technologies allow people to stay in or return to work. As well as allowing people to contribute economically with the attendant fiscal benefits, this lessens pressure on Incapacity Benefit.

5.6 Patient-centred forms of value should be considered as important in addition to financial value. Insulin pumps, for example, can minimise the time children who suffer from type 1 diabetes are absent from school because of their condition. This is because pumps free users from the need to frequently inject insulin, which can be particularly onerous for children. As well as the benefits associated with attendance at school and the economic success which may come later as a result, this has a very obvious patient benefit. For technologies with such profound patient benefits, different standards of cost effectiveness should be considered.

5.7 The longer term value of innovation must be properly valued by NICE if improvements are to be encouraged.

**Medtronic Recommendations**

- Tariff needs to be made more flexible so it looks at a longer term pathway – a 'year of care' tariff for long-term conditions should be considered.

- The Board should appoint a Clinical Director responsible for innovation – the broad responsibility for innovation should include NICE implementation duties and the functions of the NHS Technology Adoption Centre.

- The dominant market position of NHS Supply Chain in procuring medical devices should be broken up, and similar procurement organisations should be forced to offer a plurality of suppliers.

- Guidance issued by the Board to CCGs on the involvement of patients should include the development of decision aids working with patient groups and others

- The NHS Atlas of Variation should be used as a benchmark by the Board when exercising their duty to promote innovation.

- Through their work with Healthwatch, the Board should also work with national patient groups who have knowledge on best practice and treatment development.

- Many more QOF indicators should include rewards for improved patient outcomes.

- Savings identified by QIPP should come from changes in service delivery and care pathways rather than by procurement changes.
• Guidance from the Board to CCGs should include recommendations on multi-disciplinary teams.

• DoH officials should attend more medical congresses and scientific/health policy meetings and recognise the role played by industry and professional societies.

• The CCG duty to "obtain advice" from secondary care physicians should be strengthened with clear direction that they are required to consult with the clinically appropriate specialist when developing commissioning framework for a particular condition.

• NICE should recognise a broader definition of value which includes cost savings made outside the NHS and to wider society when assessing new technologies.

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