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

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Baxter Healthcare Submission to NHS Chief Executive Innovation Review

Baxter welcomes the opportunity to respond to this critical review. Our portfolio of medicines and devices spans many critical therapy areas and we pride ourselves on working closely with NHS trusts to find innovation solutions to improving patient outcomes.

The importance of innovation:

Baxter strongly endorses the chapter in the review paper of the “importance of innovation” - examples we provide for this review on innovation are not just about new technologies i.e. the uptake of medicines or a device. Our examples of innovation often derive from innovative ways of working or the creation of strategic partnerships that have truly benefited patient outcomes.

Our concerns around the adoption of ‘innovation’ often lie more in the adoption and diffusion of ideas, rather than the invention of the new technology itself.

National Levers:

“Pilotitus”

Healthcare stakeholders more and more lament the spread of ‘pilotitus’. It seems that to drive innovation, the process is often slow and cumbersome because individual programmes have to be designed that are bespoke to an individual Trust, and that make diffusion and adoption incredibly difficult across England.

It is clear, that if there were a set of distinct national levers to drive change, disruptive innovation and change, could be delivered more quickly, efficiently and equally, across England.

We have 3 clear suggestions:

1. Financial Incentives: National CQUIN targets
2. National tenders that are linked to clear clinical pathways – such as NICE Quality Standards/KPI’s
3. Strategic Partnership Working

National CQUINs:

It is encouraging that in the “Call for Evidence” document, highlights

“Commissioning for Quality and Innovation (CQUIN) - To ensure innovation forms part of commissioning discussions and allow local innovation goals (agreed between commissioners and providers) to be linked to provider income.”

Whilst CQUIN’s are a useful incentive/lever to drive innovative behaviour, if the CQUIN set at regional/local Trust level, is not stretching enough, or set to meet a low commissioning standard –
national behaviour will never be changed or indeed become transformational. Nor, will behaviour be changed if CQUIN’s are paid out, when targets have not been met.

Whilst it is important for regions/local trusts to commission services that reflect the needs of their patient population, it could be argued that developing National CQUIN targets would ensure that there isn’t a ‘postcode’ lottery of care.

For example, CQUIN’s incentivising the uptake of home dialysis vary greatly across England. There are currently 23 regions/Trusts that have no CQUIN target. Trusts that do have targets vary from a 28% target to a 35% target. The NICE target is 39% for peritoneal dialysis and 10-12% for home haemodialysis.

CQUINs should also be linked back to PROMs – and there are still only a few officially listed/recognised PROMs on the DH website.

We would recommend seeing the introduction of national CQUIN’s for a range of therapies. This would incentivise national behaviour, ensure equality of access for patients, and drive better patient outcomes.

National Tenders/National guidelines/Reimbursement – a joined up strategy

Transformational change generally comes when incentives are aligned. As with our suggestion of creating national CQUINs, we believe that national tenders should also be aligned to agreed patient and or clinical pathways, national specification documents and reflected by the payment and reimbursement environment for providers.

For example, we often see clear disconnect between a NICE Quality Standard recommendation, the implementation of a national tariff (e.g. assisted peritoneal dialysis) and the publication of a national tender for a product/service.

A good example of this has been the recent National Tender for Peritoneal Dialysis. The original tender document split the tender into a number of siloed components. Through consultation, it was clear that a tender could be devised that incentivised more innovative behaviour, and a KPI scheme was devised to sit alongside the core framework document that mirrored the core national clinical specification document. There is now a framework in place whereby trusts that reach certain KPI’s receive a better pricing structure. This approach can drive transformational behaviour.

Learning from this experience, such an approach should be considered for ensuring strong uptake of Home Haemodialysis. Reimbursement needs to reflect the best clinical practice of more frequent dialysis sessions and consideration should also be given to how the cost of installation of equipment at home is going to be met to prevent this being a barrier to uptake.

Baxter continues to innovate in technology for home dialysis and is currently working in partnership with DEKA Research and Development Corporation to develop a next-generation HHD machine. This will deliver an innovative and compact design that is convenient for patients to use thus making the treatment accessible to more patients.

Baxter Healthcare Submission to DH Innovation Review, August 2011
Another example would be a national tender for IV fluids which we understand will be published in 2012. NICE are also planning on publishing a Quality Standard for IV fluids in 2012. However, the Commercial Medicines Unit do not appear to be a key stakeholder to the NICE Quality Standard which indicates that there is no joined up strategy or approach, and could therefore publish a tender that does not support the recommendations in the NICE Quality Standard.

**Regional Levers**

‘Hard wiring’ innovation into regional/local NHS trusts is increasingly difficult. The reasons for this are often simple – a hospital is unwilling to either pay for a new innovation, or is unwilling to redesign a care pathway

- a) Because they need to invest to see improved outcomes over time and Trusts do not take a long-term approach to procurement
- b) There is a clear element of ‘protectionism’ and the need for hospitals to remain competitive in their local health economy.
- c) Financial incentives mean that a hospital is often unwilling to change a care pathway, as it will lose money under the tariff system if a patient is treated in a different setting.

A good example of this is telehealth/telecare. It is clear that patients should be able to manage their care in the home/outside of hospital, and a visit to a hospital should be the final step in their care plan. However, hospitals are unwilling to allow patients home, as they often see ‘long-term’ condition patients as a good financial investment for the hospital. Without patient throughput, hospitals will lose valuable patients. Quite often, it is not the telehealth ‘kit’ that is expensive – telehealth can be achieved now through a standard mobile phone – it is the hospital’s unwillingness to lose the payment received by treating that patient. This is perverse. Penalties for readmission go some way to supporting the policy to allow patients to be treated in the home – but it often involves an arduous, time consuming business case.

Innovation payments are one way to re-address some of the perverse financial incentives, however this financial incentive is relatively unknown in the NHS, and again, is often time consuming to apply for, and wait for sign off of the payment. There needs to be more national incentives applied, to support trends at regional level – such as trying to move patients into the home.

**BAXTER HEALTHCARE EXAMPLES OF SUCCESSFUL INNOVATION PROJECTS:**

**Example 1: Baxter & Christie NHS Foundation Trust Partnership**

The Christie NHS Foundation Trust treats more than 40,000 patients a year. For the past 18 years, the Christie has been in partnership with Baxter Healthcare for the provision of chemotherapy which during 2010 saw the aseptic production of 88,000 doses for delivery to the main hospital site and a number of separate Christie community based clinics in the region. Following a review of the product and patient pathways and drug wastage in the hospital, the Trust requested a new service delivery model that would require the establishment of a Baxter managed onsite ‘delivery hub’ to
hold and release the chemotherapy dose for each patient. A newly developed service is housed in a new part of the hospital and now has all the necessary elements to provide a seamless end to end service for patients in one place. A change in practice was also required by staff in a number of departments to deliver a more efficient service. Two primary outcomes of the service redesign are reduced patient waiting times and demonstrated cost savings. The onsite ‘hub’ where chemotherapy doses were issued was also moved directly on to the ward, where the patients receive their treatment. This innovative approach was approved in the Trust due a number of factors:

1. A collaborative mind set within the Trust to work with industry and find different solutions to drug wastage and drug delivery

2. The Trust reviewed and updated internal processes and introduced standard operating procedures

3. An electronic ordering system has been established to enable the Trust to confirm with Baxter on the day, the needs of their patients.

**Example 2: Epistaxis**

Epistaxis is a relatively common problem. It is estimated that at least 60% of the population has had one episode of epistaxis in their lifetime and of these, about 6% seek medical care within a hospital. Clinical data has shown that the average length of stay in hospital for epistaxis patients is 2.53 days, consequently occupying around 5,500 bed days per year.

The vast majority of epistaxis cases are treated by A&E or ENT personnel and the standard treatment for persistent bleeding is packing with a nasal tampon. Patients requiring nasal packing are in almost all cases admitted.

We have identified opportunities in urgent care where Baxter can maximise adult patient outcomes and ensure patients return home as quickly as possible, thereby avoiding inpatient admissions. This proposal supports a change in treatment pathway by using an existing haemostat (Floseal) which can lead to a reduction in admissions, clinical advantages and better patient experience.

By adopting a new clinical pathway, the NHS in England could save 37,328 bed days, which equates to a saving of £405 per patient, and a total saving to the NHS of £7.7m per year.

University Hospital Leicester NHS Trust was the first Trust to engage in this new, innovative approach and adopt a whole new clinical pathway. By doing so, they have reduced A&E admissions, significantly improved patient outcomes, and saved £146,723. A number of hospitals in the UK are now following this new pathway, once an internal business case has been approved.

**Conclusion:**

We hope that these two examples demonstrate clear examples of innovation. One, where by adopting an open mindset to work with industry, true partnerships have transformed behaviour, improved patient outcomes, and produced significant savings. The second example is around a Trust
in the UK completely redesigning a patient pathway using an innovative product, to reduce A&E admissions, and again, significantly improve patient outcomes.

Finally, we very much welcome this deep dive into the barriers to uptake of innovation in England, and look forward to the conclusions of the review.

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