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

Respondent ID: 300

Organisation name: Johnson & Johnson

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Contact and organisation details

Please provide the following details:

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Summary of Johnson & Johnson proposals:

A. Quick win Actions to take

1. Clear and unequivocal leadership from the Commissioning Board, Chief Executive of the NHS, Heads of NICE and NHS Confederation promoting the merits and reasons for the NHS driving time and resources to invest in innovation for long-term effectiveness of patient outcomes as well as efficiencies of care provision.

2. Strengthen the “PbR exclusion” and “Innovation Payment” mechanisms for devices and ring-fence central funding for exclusions and innovation payments in addition to the procedural reimbursement (PbR tariffs). These mechanisms are critical to the early adoption of technologies prior to an appropriate tariff price being established and to support providers with a specialist case-mix which cannot be adequately reimbursement through national tariff.

3. Keep the mandatory funding direction for NICE-approved products and have an automatic inclusion on formulary/list for NICE-approved products/technologies.

4. The NHS Technology Adoption Centre (NTAC) receives funding to continue to promote adoption of innovation in the NHS. There is a requirement that the NHS and industry feedback experiences and data to keep NTAC advice up to date.

5. The NHS Commissioning Board should include a set of financial incentives, to promote the use of innovation and its adoption, in the Quality and Outcomes Framework (QoF), the national menu of CQUINS and NICE Quality Standards.

6. Appoint a National Director for Innovation uptake and diffusion, who will directly report to the NHS Chief Executive. We believe that industry should be involved in the interview and selection process, and propose that the recruitment scope sincerely considers a candidate with Life Sciences Industry experience.

7. Improve the transparency of decision making in the funding decisions made by PCTs and other fund-holders, particularly where treatments are classified as “Low clinical Value” or “Black Listed”. In the case that a decision not to fund a technology directly contravenes NICE guidance or guidelines on best clinical practice this should be...
open to appeal and the evidence upon which the decision was taken should be open to third party scrutiny.

8. The National Commissioning Board promotes innovation by having a budget to award financial prizes for innovation.

9. Narrow the time lag between a technology receiving its licence and an appraisal by NICE. This is especially needed for Oncology related products, and will help improve the speed of uptake and diffusion across the NHS.

B. Longer-term strategies

1. Work with NHS performance management mechanisms across all levels, to ensure that accountability for adoption of innovation is included within individuals’ job descriptions, objectives and annual appraisals.

2. A patient appeal mechanism when access to NICE-approved technologies is restricted sub-nationally. The detail of this would have to be explored further, but may involve the National Commissioning Board or Care Quality Commission.

3. The introduction of a training module on the Pharmaceutical, Medical Device and Diagnostic Industry (potentially co-authored by the NHS, ABPI, ABHI and BIVDA) on the benefits of partnership working to be introduced in the early curriculum of both clinician and managerial training. At the very least, a ‘partnership working’ course should be ran as a one day event.

4. Link the implementation of NICE Clinical Guidelines and Quality Standards to financial incentives such as CQUIN according to nationally agreed metrics.

1. Learning from elsewhere about adoption and spread

What can the NHS and NHS Commissioning Board learn from national and international best practice to accelerate the pace and scale of adoption of innovations throughout the NHS? Please include relevant examples, published papers or other evidence you have found useful.

Johnson & Johnson is the world’s largest healthcare company, and has experience of operating in over 100 different countries and healthcare systems. We cite below two concrete examples of best practice in helping spread innovation: (i) The NHS Technology Adoption Centre (NTAC) project and (ii) The Adherence Model approach developed by Dr. Werner Kissling at the Technical University in Munich, Germany.

I. NTAC. The benefits of NTAC are best shown in an example concerning Breast Cancer, which affects over 46,000 women per year in England. The NICE guidance for Early and Locally Advanced Breast Cancer (2009) advocates that minimal surgery, rather than lymph node clearance, should be performed in the first instance followed by a sentinel lymph node biopsy for assessment of lymph-node spread in early breast cancer. Therefore, each year, approximately over 10,000 women require additional surgery to treat the spread of breast cancer to the lymph nodes.

However, NTAC has helped promote the benefits of an innovative, intra-operative diagnostic test which removes the need for a second surgical procedure for 11,000 patients, as a diagnosis can be made within 30-45 minutes. If a node positive result is reported, the operation can continue and the need to wait for a post-operative result (and a possible subsequent second surgical procedure) is removed for every patient, enhancing their overall experience.
NTAC has promoted the benefit of this intra-operative diagnostic test, by informing hospitals that the intra-operative diagnosis reduces the need for a second surgical procedure for 25-30 per cent of patients; avoiding the need for 11,000 second surgeries in the NHS ever year; which is both a cost and patient experience benefit. A second advantage is that there is a reduction in overall length of stay, saving an average of 5 bed days per patient, which equates to a reduction of 24,000 bed days every year across the NHS (a saving of £4m on ward costs alone or overall financial saving of £5.01m in the NHS)\(^{ii}\).

On the basis of this example, and many others, Johnson & Johnson propose:

| Recommendation 1: That NTAC continues to promote adoption of innovation in the NHS by staying focussed on how the use of a technology helps save the NHS money and time, as well as improve the patient experience and outcome. |
| Recommendation 2: The manufacturers of the product, as well as users in the NHS, should have a continuous feedback relationship with NTAC to ensure that its advice and promotion of innovation is up to date and evidence-based. |
| Recommendation 3: That NTAC receives priority funding, because the work that it does helps ‘hard-wire’ innovation into the NHS which saves money and time. Our, anecdotal belief from discussions with NHS staff is that such an investment would pay back. |

II. The Adherence Model Approach. In order to improve the experience and outcomes for Schizophrenic patients, as well as save the health system money and time, the Adherence Model Approach, first pioneered in Germany, has produced net savings of €5000 per patient per year; with a reduction in 'hospital days' of more than 70 per cent\(^{iii}\). It is now being piloted in the NHS, via the South Essex Partnership University NHS Foundation Trust and our pharmaceutical company Janssen. The purpose of the pilot is to test the efficacy of the model in a different health economy. We encourage you to contact Andy Higby, Project Manager, andy.higby@sept.nhs.uk; Mobile Phone: 0779 4465289 as soon as possible to find out more about this innovative venture.

For context, the programme introduces a model of improving adherence to treatment that will provide significant benefits in improving healthcare for Schizophrenic patients and those with Affective Disorders. The project aims to improve the delivery of this care pathway and thereby reduce the risks associated with relapse, which is both traumatic for the patient and an extra annual cost per patient of circa £2,500 for in-patient services and more than £5,000 for total service use\(^{iv}\).

“South Essex Partnership Trust (SEPT) is excited to continue to be at the forefront of service development with this project. It will put patients first by designing highly-individualised packages around them to support their continuing recovery and improve outcomes by reducing the need for hospital stays and helping people to stay well for longer in their communities as well as reducing the pressure on families. It will improve efficiency by targeting support and assistance at a very early stage to where it can make the most difference to patient’s lives.”

Dr Patrick Geoghegan OBE; CEO of SEPT
Following the model in Munich, the programme works by having a dedicated clinical team operating within a ‘Recovery Lounge’ from which all the activities are provided. The model combines different components including an initial personalized assessment of non-adherence, provision of psychoeducation groups (Schizophrenia or Affective Disorder) for patients and for families, a telephone/text reminder service, wellbeing activities and medication clinics underpinned by a shared decision making approach. Resources used within the programme will be delivered through a digital Ipad 2 Application. As the South Essex Partnership has just started, it is not possible to provide robust evidence, but more information will be available in the coming months, and we will be delighted to keep you abreast of progress.

Here we see innovation in action because there is trust between the NHS and independent sector. Both have skills, products and expertise which improve the patient experience and outcomes, as well as save the NHS money and time.

Therefore to promote this cultural shift in the NHS, Johnson & Johnson propose:

**Recommendation 4:** The introduction of a training module on the Pharmaceutical and Medical Device and Diagnostic Industry (potentially co-authored by the NHS, ABPI, ABHI and BIVDA accordingly) on the benefits of partnership working to be introduced in the early curriculum of both clinician and managerial training. At the very least, a ‘partnership working’ course should be ran as a one day event. Industry could help resource the course, but it’s critical that all attend, for otherwise sceptics would not enrol and they are the very colleagues who would benefit most. The purpose of the course is to break down the silos between NHS and Industry which will help build trust; leading to a proliferation of authentic, transparent joint-working.

**Recommendation 5:** National leadership which calls for a stop to practices in the NHS which seek to hinder collaboration with industry by restricting access to clinicians or NHS Managers. The NHS may have annoying experiences of industry, but we believe if such ‘restrictions’ became the norm, without rationale or the opportunity for appeal, then in the long run neither party benefits, least of all patients. When restrictions do take place, there should be transparency as to why this has happened and for all parties to play their role in stopping unhelpful behaviours. In a circumstance where restrictions must be imposed around access these should be carefully considered, open to independent scrutiny and proportionate so as not to act counter to the objectives of improving patient safety and the quality of care.

### 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 successful and rapid adoption and spread of innovations throughout the NHS?

A major concern is the clear misalignment between National Policy wanting to see the NHS use and pay for innovation, and the actual behaviours of NHS Hospitals and Primary Care Trusts. These bodies are all too often seen as gate keepers slowing the uptake of new, innovative, cost-effective technologies by creating ever more complex and bureaucratic adoption processes and cost-containment initiatives. This was shown clearly by the Sir Mike Richards report. Further examples which Johnson & Johnson have experienced have also been provided in Appendix A.
Recommendation 6: Clear and unequivocal leadership from the Commissioning Board, Chief Executive of the NHS, Heads of NICE and NHS Confederation promoting the merits and reasons for the NHS taking the time and resources to invest in innovation. Johnson & Johnson recognises that this has started, but experience that the prevailing direction is still towards cost reduction, ‘making do’ with the status quo and reducing spend on drugs and other technologies. There has been strong leadership of QIPP. However, in some quarters of the NHS (but not universally) we have experienced QIPP, not as an opportunity to invest and spend in innovation in order to achieve greater efficiency, but instead as a reason to cut costs in drug therapy and technology procurement. This statement is supported by examples in Appendix A.

Recommendation 7: Keep the mandatory funding direction for NICE-approved products and further promote best clinical practice by linking the adherence to NICE Guidelines and NICE Quality Standards to additional financial incentives such as CQUIN.

Recommendation 8: The National Commissioning Board must promote innovation and have the budget to award financial prizes to promote innovation.

Recommendation 9: Promote from the top, the letter of the NHS Constitution which states the rights of patients to NICE approved products and that there should be no further qualification, reinterpretation or modification of NICE guidelines at a local level.

Recommendation 10: Appoint a National Director for Innovation uptake and diffusion, who will directly report to the NHS Chief Executive. We believe that industry should be involved in the interview and selection process, and even propose that the NHS consider employing somebody from Industry.

Recommendation 11: Work with NHS performance management mechanisms across all levels, to ensure that accountability for innovation is included within individuals’ job descriptions, objectives and annual appraisals. It is critical that responsibility for improving clinical practice, patient outcomes and uptake of innovation is the responsibility of all NHS staff including managers, clinicians and procurement by making this part of their personal objectives. It is imperative that the role of procurement and management is leveraged to act as enablers of appropriate technology uptake rather than blockers of best clinical practice.

Recommendation 12: Financial and Quality incentives. The NHS Commissioning Board should include a set of financial incentives, to promote the use of innovation, in the Quality and Outcomes Framework (QoF), the national menu of CQUINs and NICE Quality Standards. We recommend that the NHS Commissioning Board seek advice and input from reputable organisations (academic, independent and public sectors) as to how incentive systems can be used to increase the hard wiring of innovation in the NHS. This should be done hand in hand with a review of local NHS silo-budgeting as this is key to financial incentives and discussed further in question 3.

Recommendation 13: Strengthen the “PbR Exclusion” and “Innovation Payment” mechanisms for devices and ring-fence central funding for exclusions and innovation payments in addition to the procedural reimbursement (PbR tariffs). These mechanisms are critical to the early adoption of technologies prior to an appropriate tariff price being established and to support providers with a specialist case-mix which
cannot be adequately reimbursement through national tariff. Currently at a national level there is a desire to reduce the list of exclusions, whilst being reluctant to add new entries. In addition plans should be explored which reduce the time taken for new procedures to be allocated an OPCS code and matched to an appropriate HRG group. This is known to take at least 2 years and commonly 4-5 years.

**Recommendation 14:** The removal of perversely incentivised Tariffs which discriminate between the setting where care is delivered or create incentives for extra episodes of care or act counter to care pathway improvement. One such example is outpatient hysterectomy procedures which are inadequately reimbursed in the outpatient setting compared to the day-case setting so as a result the tariff is a barrier to shifting care to less acute settings which are closer to the patient. This should be accompanied by greater strategic oversight of the unintended consequences of PbR by the Department of Health. Current dialogue between the Payment by Results Team and Industry works well at an operational level but would be supplemented by regular strategic level discussions.

**Recommendation 15:** The funding direction awarded through tariff for the implementation of NICE Technology Appraisals (formerly 0.3 per cent uplift spread over all tariffs) should be available as an additional payment over and above the mandatory tariff where a NICE Technology Appraisal has been implemented in the care of a patient. Spreading this incentive across all tariffs loses the visibility of what the uplift was designated for and has not facilitated the implementation of NICE Guidance.

**Recommendation 16:** Ensure penalties are used in addition to incentives to drive change within the system. It is our belief that many of the centrally-driven top-down initiatives are most successful when there is a balance of incentives to comply and penalties for non-compliance. An example where this could have a significant impact is Healthcare Associated Infections (HCAI). For example, by making Surgical Site Infection a “Never Event” and therefore not eligible for reimbursement there would be a significant focus on avoiding such occurrences. We believe this approach has been implemented in other healthcare systems including Medicare in the USA.

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**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?

The local level NHS needs to re-engineer its mindset, funding structure and incentives if innovation uptake and spread are to improve. Why, on occasion (see page 7 and Appendix A) is QIPP being interpreted as an opportunity to restrict or stop using more innovative technologies on the grounds of cost alone? Because NHS system incentives are primarily driven by silo budgeting and not by innovation quality and value.

‘Silo-budgeting’ and ‘Service Line Reporting’ are key barriers to innovation as it encourages perverse incentives at a local level. For example, even if a technology can deliver an overall saving across a patient pathway it may not be adopted if an individual department has to increase its expenditure to deliver change. Therefore Johnson & Johnson propose:
**Recommendation 17:** The NHS reviews at a local level its silo budgeting structure. This should be done at the same time as a review of financial incentives. We encourage the local NHS to consider a longer-term and aggregate view of its budget. For example, the NHS should be allowed to carry over small deficits from one year to the next if it can be demonstrated that long-term investments in service redesign and quality improvement have been made.

**Recommendation 18:** Incentivise procurement as ‘enablers’ of best practice by facilitating the uptake of required technology rather than pushing against it. This will be achieved by revising procurement job objectives and joint objectives to focus on value not price alone.

As shown in Appendix A, there are many unfortunate examples of the local NHS finding ways to stifle the purchase of new, innovative products. A south London PCT has developed a list of surgical procedures, which it deems to be of ‘low clinical value’ and therefore optional in funding terms. This includes hip and knee operations and other NICE approved procedures. Two Trusts in the Midlands have used general statements in NICE Guidelines to block the usage of an innovative Psoriasis drug which is NICE-approved, whilst other Mental Health Trusts have arbitrarily blocked the usage of a Long Acting Injectable therapy, which is again judged by NICE to be cost and clinically-effective.

The common denominator in all our examples is the lack of transparency behind the decision making processes. There is no clinical scrutiny or accountability for these local decisions; which is especially baffling when they run contrary to the clinically published opinion of NICE. Moreover, there is no evidence that local patients have been consulted. Therefore, Johnson & Johnson proposes:

**Recommendation 19:** The automatic inclusion on formulary/list for NICE-approved products/technologies. NICE is frequently cited as having world-class science, so there is no need for multiple structural layers of assessment within the NHS at a local level. In line with the Health and Social Care Bill clinicians should be free to use innovative products, and especially those that have already been NICE approved.

**Recommendation 20:** A patient appeal mechanism when access to NICE-approved technologies is restricted sub-nationally. The detail of this would have to be explored further, but may involve the National Commissioning Board or Care Quality Commission.

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?

Industry, and Johnson & Johnson stand at the ready to work with the NHS to improve the adoption and use of innovation as a way to help the NHS save money and time, as well as improve the patient experience and outcomes.

To that end, Johnson & Johnson appreciate the collaborative and pragmatic nature of this consultation.

**Recommendation 21:** An annual report tracking the uptake of innovation in the NHS. The report would measure the number and outcomes of new approaches to health.
(e.g. the Munich Adherence Model Approach) as well as use of NICE approved technologies. Industry Trade Associations (e.g. ABHI, ABPI and BIVDA) could partner with the DH to produce the report, on the condition that objectives and resources are agreed in advance and transparent.

In respect to the NHS Partner NICE, Johnson & Johnson appreciates and respects the quality of its science and the role of NICE. However, when it comes to innovative Oncology products there is a systemic delay between the issuing of a licence and the publication of new NICE guidance and therefore adoption and use in the NHS. A compelling example is provided in Appendix A following research on 18 Single Technology Appraisals (STAs) and one Multiple Technology Appraisal (MTA) of four medicines.

The pattern of all the ongoing STAs and MTAs shows that the time between a medicine receiving a licence and the publication of its guidance ranges from a minimum of five months and a maximum of over 3 years. The mean time, derived from our Table in Appendix A, is just under 2 years (21.5 months). A good illustration of this is the ongoing appraisal of bortezomib and thalidomide for the front line treatment of multiple myeloma. Despite the licence for bortezomib being granted in September 2008, a FAD was only issued in September 2010, two years after first approval.

The Cancer Drugs Fund is helping, but Johnson and Johnson also propose that:

**Recommendation 22:** The time lag between a technology receiving a licence and a NICE appraisal is tightly closed as a priority.

In terms of Public Health, Johnson & Johnson believe that there is a role for Local Government to work with the local NHS and Directors of Public Health in addressing the most significant local public health challenges. In Scotland, there is a public health concern over the prevalence of Hepatitis C; this being compounded by its asymptomatic nature. As a result there is local political accountability (every MSP has a target for their locality) and NHS accountability as well as ring fenced funding for the patient pathway.

**Recommendation 23:** That local Public Health Budgets should be ring-fenced and spent on local NHS and local Government jointly agreed priorities.

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

Please see Appendix A for further examples of specific challenges in the uptake of medical technologies as well as some proposed solutions.
REFERENCES


iii Kissling et al. 2008 in Bäuml/Pitschel-Walz (eds). Psychoedukation, Schattauer Stuttgart, 263-269


v Kissling et al. 2008 in Bäuml/Pitschel-Walz (eds). Psychoedukation, Schattauer Stuttgart, 263-269