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

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Summary

To improve the adoption and diffusion of innovation, we believe there are 3 key areas for action:

1. **Raise the profile of the NHS as an innovation engine for the benefit of the health and wealth of the UK and ensure that change is sufficiently radical to make a difference.** The Government, from the Prime Minister down, in collaboration with the Department of Health and the National Commissioning Board, should talk up the opportunity of the NHS as an engine for growth. The tone and volume of communication from NHS leadership needs to be much more supportive of innovation and should empower all levels of the NHS – managers, clinicians and prescribers, with the confidence to be innovative. Making a difference will require acceptance that the way in which the local NHS judges value must be broader and include economic benefits, as well as the longer-term health advantages that new medicines and packages of care can bring.

2. **NHS commissioners should adopt and follow NICE recommendations and guidelines.** The National Commissioning Board should make it clear to Trusts/Clinical Commissioning Groups that their focus should be on delivering value through implementing NICE recommendations and guidelines to allow clinicians freedom to prescribe, rather than carrying out their own assessments and creating additional formularies and guidelines; where formularies exist, automatic access should be provided for NICE recommended medicines.

3. **Embed innovation by linking performance to metrics.** Trusts/Clinical Commissioning Groups should be accountable for improving adoption and diffusion of innovation, with objectives measured against prescribing of new medicines and undertaking research. Performance should be measured against the 90-day NICE mandatory funding requirement (if the healthcare professional wishes to prescribe a medicine) and the National Commissioning Board should set financial incentives for achieving this e.g. through QOF quality prescribing indicators.

Introduction

We welcome the opportunity set out in the NHS Chief Executive Innovation Review to increase the adoption and diffusion of innovation in the NHS. We see this as benefiting patients by receiving high quality care, the NHS by improving its ability to deliver to high standards of care, and the UK economy by driving growth to create a thriving life sciences sector. We agree with the barriers and solutions as defined by the ABPI and this paper provides additional insight from GlaxoSmithKline (GSK).

Barriers

Before highlighting the three key barriers we believe are hindering the diffusion of innovative medicines in the NHS, it is worth pointing out two broader overarching concerns
that we would welcome further discussion around, both within Government and between industry and Government.

The first is affordability, which we believe is a key underlying issue that is impacting the diffusion of innovation; in the medicines area, the Cancer Drugs Fund has improved patient access to cancer medicines which indicates that when affordability is less of a consideration for budget-holders, diffusion of innovation increases.

The second issue is generics which is problematic for two reasons. Firstly, the prices of generic medicines in the UK are amongst the lowest in Europe (IMS data, 2007); industry has long supported an efficient generics market and low prices in this essentially commodity market and driving down generic prices is a sound policy move. However, increasingly in the NICE value appraisal, these generic medicines are being compared directly to branded medicines that do not contain the same ingredient; the issue is particularly acute when bringing a new medicine to market where the standard of care is a generic, as even when innovation and added clinical benefit is proven, the low generic price can drive a very high incremental cost per QALY. An example of this is Benlysta, (belimumab) a new medicine for lupus; the current standard of care has a very low acquisition cost and therefore it is difficult to demonstrate cost-effectiveness, in terms of incremental cost per QALY, within the current NICE methodology.

The second part of the generics issue is that even if the medicine is recommended by NICE, the NHS has a keen focus on comparing the value of branded medicines with cheaper generic medicines, which can in effect be the same as therapeutic reference pricing, a practice which the Government has said it is keen to avoid.

We would welcome the opportunity for a dialogue around both of these important issues – affordability and generics, as to make progress on increasing the diffusion of innovation, both need to be tackled.

1. **Bureaucracy and duplication of decision-making**
It appears to industry that the NHS puts in place multiple structural layers of decision-making which impede access to new medicines. We tend to see value judgements being made at all levels of the system – national, regional and local and then again at the prescriber level, which can be different to NICE guidance.

This is evident in the case of Prolia (a medicine for the treatment of osteoporosis) which despite receiving positive NICE guidance in 2010, is still experiencing widespread variation in use – well beyond the 90 day requirement for PCTs to implement NICE guidance. This is largely due to significant delays in further local assessment of NICE guidance. Furthermore, in over a third of PCTs, the decision has been taken to offer Prolia only in secondary care, which is contrary to NICE guidance and creates additional cost to the NHS; this means that
patients in 64% of PCTs do not currently have access to the medicine in the way intended by NICE.

Our view is that this is a poor use of both industry and public resources, leading to cost inefficiencies, duplication and complexity in decision-making. Most important, there is potential for this to delay patient access to treatment.

2. Culture

We see two issues that we have grouped as cultural barriers to the diffusion of innovation.

Firstly, the NHS tends to be risk-averse with staff not encouraged or rewarded for experimenting and trying new things; innovation is thus not being seen as high priority and the focus of the NHS tends to be on shorter-term cost containment rather than on longer-term health outcomes.

Secondly, we believe that UK clinicians are inherently conservative in their adoption of new technologies.

The relationship between the pharmaceutical industry and the NHS may also in part be contributing to this problem. The NHS has historically been wary of industry and although many Trusts have developed good working relationships with industry, many have not. Both parties, have in recent years been working to rectify this and improve the level of understanding and trust; however we are perhaps still some way from ensuring this relationship is as effective as it could be and both industry and the NHS need to consider how to better understand each other and work in greater partnership to achieve the common goal of better diffusion of innovation to improve patient outcomes.

3. Silo budgets and perverse incentives

We believe that one of the key reasons why the use of new technologies can be resisted is due to silo budgeting in the NHS; the system has difficulty in releasing the savings they deliver, particularly if the savings are delivered in a different budget to where the cost is incurred. At national level, there is no medicines budget and in theory, savings delivered by the use of new medicines can be banked by the system overall. However, locally, most Trusts will proportion an amount of money to medicines based on previous usage as well as forecasted need. There is often a pressure to make additional savings from within this already tight allocation. In addition, if care spans primary and secondary care, we have seen examples of cost-shifting where different local organisations can be reluctant to take responsibility for funding.
Incentives in the system can also encourage behaviours that hinder the diffusion of innovation. As hospitals are paid a tariff for most of their services, this can encourage repeat visits rather than delivery of a quality outcome from fewer visits.
Actions

Action for Government

- Raise the profile of the NHS as an innovation engine for the benefit of the health and wealth of the UK and ensure that change is sufficiently radical to make a difference. The Government, from the Prime Minister down, should talk up the opportunity of the NHS as an engine for growth. The tone and volume of communication from NHS leadership needs to be much more supportive of innovation and should empower all levels of the NHS – managers, clinicians and prescribers, with the confidence to be innovative. Making a difference will require acceptance that the way in which the local NHS judges value must be broader and include economic benefits, as well as the longer-term health advantages that new medicines and packages of care can bring.

Actions for the Department of Health

- Commit to publishing data which explicitly shows the extent to which a GP practice or hospital trust is using innovative medicines. The Government committed in the Budget to publish prescribing data down to GP practice. Going further and making it clear to patients the level of access they are likely to receive to new treatments would in turn help support patient choice and decision-making of which provider to choose for treatment. It would also create visibility to the system about the differences in prescribing practice.
- Ask industry to identify and then in collaboration with the Department take action to replace perverse incentives, such as aspects of the Payment by Results tariff, with incentives that support improving patient outcomes across a holistic patient pathway (including primary, secondary and social care).
- Increase the volume of patients in clinical trials by supporting rapid implementation of the recommendations set out in the review of clinical trials governance, conducted by the Academy of Medical Sciences.

Actions at national level in the NHS

The National Commissioning Board

- Raise the profile of the NHS as an innovation engine for the benefit of the health and wealth of the UK and ensure that change is sufficiently radical to make a difference. The tone and volume of communication from the Board needs to be supportive of innovation and should empower Trusts/Clinical Commissioning Groups (CCGs) with the confidence to be innovative. Making a difference will require acceptance that the way in which the local NHS judges value must be broader and include economic benefits, as well as the longer-term health advantages that new medicines and packages of care can bring.
- Clarify accountability at national and local level for decision-making regarding value of new medicines so value assessments are made at national or local level, not both. Under the current and proposed future system of national evaluation of medicines, there should be no need for or benefit in further evaluation at local level.
• **Link performance to innovation** by recognising and incentivising strong performance against the duty to promote research and innovation e.g. giving Trusts/CCGs an ‘innovation’ score based on criteria such as prescribing new medicines/conduct of research, with an ‘innovation award’ given to high scorers; these results should be published. Performance of Trusts/CCGs should be measured against the 90-day NICE mandatory funding requirement (if the healthcare professional wishes to prescribe a medicine) and financial incentives should be set for achieving this e.g. through QOF quality prescribing indicators. PROMs could also be used to measure performance; the use of outcomes measurement will, over time, increase the ability to relate expenditure to outcomes.

• **Provide clear guidance to Trusts/CCGs on the importance of ‘I’ in QIPP** emphasising that quality and efficiency savings should be achieved through innovation e.g. use of new medicines where they achieve better outcomes across patient pathways, rather than through cost cutting measures. A specific taskforce could be set up to support diffusion of new NICE recommended medicines and clinical guidelines, by looking across treatment pathways to troubleshoot issues as well as spread best practice across other Trusts/CCGs.

**NICE**

• **Clarify guidance so it is clear how and by whom each technology appraised should be funded.** NICE guidance should be clearer about the setting in which a medicine is given, where this is of advantage to patients and will facilitate the shifting of cost to the most cost-effective location. NICE should also identify new drugs which will face challenges in implementation and provide support e.g. advice on the most appropriate service delivery options for a medicine if this would provide enhanced clinical or cost effectiveness.

**The Care Quality Commission and Monitor**

• **Ensure that providers deliver innovative care solutions which draw on NICE guidance.** As the Care Quality Commission and Monitor are together responsible for the licensing and quality evaluation of all providers of healthcare, they should audit, evaluate and make recommendations to healthcare providers to ensure that their delivery of care reflects NICE standards; as part of this, these regulators should look at how the adoption and diffusion of innovative medicines is being implemented by providers; publication of prescribing data, linked to the outcomes achieved, should help to facilitate this. Providers which meet the criteria of working with the NHS to improve diffusion of innovation should be included on the FESC recommended list.

• **Champion access to NICE recommended medicines.** In its role to promote integration, Monitor should be given a remit to deal with complaints from the industry and patients where access to NICE approved medicines is denied; for example, due to disputes between primary and secondary care in relation to funding.
Public Health England

- **Ensure that the public health strategy supports NICE guidance.** Through the production of the local Joint Strategic Needs Assessment, the commissioning and provision of services should reflect NICE standards of care, clinical guidance and high quality outcomes.

**Actions at local level in the NHS**

**Trusts/Clinical Commissioning Groups**

- **Focus on delivering value by implementing NICE recommendation and guidelines** and avoid carrying out further assessments and creating additional formularies and guidelines; where formularies exist, automatic access should be provided for NICE recommended medicines – it is then for the patient and clinician between them to decide whether a particular medicine is appropriate in that instance.

- **Link performance to innovation** through staff objectives to improve adoption and diffusion of innovation, such as prescribing of new medicines and undertaking research. Performance should be measured against the 90-day NICE mandatory funding requirement (if the healthcare professional wishes to prescribe a medicine).

- **Task the medicines management function with delivering improved outcomes** from use of medicines, such as through improved compliance and concordance and away from re-evaluating value. Medicines Managers should also ensure that they incorporate horizon scanning information to allow Trusts/CCGs to plan for the introduction of a new medicine, what it will replace and how (not if) they will fund it.

**Providers**

- **Provide innovative care solutions aligned to NICE guidance.** Care packages should be designed to look across patient pathways and incorporate new NICE approved medicines where these demonstrate improved outcomes to patients and the NHS.

- **Share and adopt best practice** to learn from each other as to what best practice looks like to enhance the patient experience e.g. lessons on how innovation has been successfully adopted and diffused by one provider could be implemented elsewhere by rotating providers to different localities.

**Actions by NHS partners**

**The Pharmaceutical Industry**

- **Focus on partnering with the NHS to deliver improved health outcomes together.** This could include industry adapting its behaviour and working practices to ensure that it provides better evidence of the benefits that usage of innovative medicines in the patient pathway will bring in terms of improved outcomes, as well as ensuring that medicines are launched with good NHS engagement within a reasonable timeframe to support the NHS to budget properly.
• **Provide education on the importance of innovation** by running learning/awareness sessions for the NHS about the industry, including how it operates and the key scientific and medical challenges it is addressing. Industry could also set up a network of good practice methodology to help disseminate best practice to the NHS on how to scale up diffusion of innovation, leveraging its experience and ability on how to network across large systems.

**Patient Groups**

• **Ensure that the participation of patients on discussions regarding the introduction of innovative medicines is encouraged**, by engaging both at national level with the NCB and at local level with Trusts/CCGs.

• **HealthWatch UK should represent patient interests in the NICE process** by assisting patients to make appeals to Monitor if they have been denied a medicine which has been recommended by NICE, making them aware of their right in the NHS Constitution to treatments recommended by NICE. HealthWatch UK should analyse if there are common trends as to why patients are being denied NICE recommended medicines and encourage the Department of Health to address these issues e.g. through national guidance.

**Academia**

• **Tackle clinical conservatism in prescribing** by increasing education of pharmacology at universities and ensuring that the role of industry is projected in a balanced way.

**Local Authorities**

• **Directors of Public Health in local Health & Wellbeing Boards should be encouraged to be more receptive to innovation** by being given a duty to promote research and innovation (as per the CCGs), when tackling the challenges highlighted in the Joint Strategic Needs Assessment; incentives should be linked to strong performance against this duty.

**Healthcare Professionals**

• **Utilise innovative prescribing data** to market their GP practice as providing innovative medicines which deliver high quality outcomes and reflect NICE standards of care.

• **Facilitate empowerment of patients** by making them aware of new NICE recommended medicines e.g. by proactively contacting patients when an appropriate new medicine has been recommended by NICE in the relevant disease area.