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

Respondent ID: 190

Organisation name: Pfizer

Type of response: Document
Executive Summary

Pfizer supports and endorses the submission made by the Association of the British Pharmaceutical Industry (ABPI) and welcomes the opportunity to comment on the NHS Chief Executive Innovation Review. We have added to the evidence within the ABPI submission and have focused on potential solutions; hence there is value in considering the two together.

The Richards International Metrics report¹ and the NHS Information Centre report² show examples of innovation not being diffused across the NHS, and highlight the significant variation that currently exists between localities.

Pfizer’s view is that there is currently a low, slow and patchy use of medicine compared to the EU average in many classes. The reason for this we believe is that the NHS is not incentivised to increase diffusion of new medicines and not held to account if it doesn’t.

Pfizer believes that the situation could be remedied through implementation of a number of key initiatives and approaches:

1. The centre needs to provide strong leadership, including a set goal for uptake.
2. Direction needs to be provided around adherence to guidelines and guidance.
3. The removal of local processes that effectively reconsider the guidance and guidelines considered as best practice, delaying or blocking the use of these medicines.
4. Incentives structures need to be in place that monitor the availability and use of innovative medicine and in turn have aligned incentives to reward performance.
5. Some measure of accountability needs to be in place where uptake goals are not met.

Introduction

The content of this submission has been aligned across the three sets of forces referenced in the ‘Call for Evidence’.

- **Top down pressures and support**
  - Adherence to NICE guidance and guidelines in a timely manner
  - Automatic inclusion on formularies for those medicines having national guidelines or guidance

- **Horizontal pressures and support**
  - Creating an aligned incentive structure in the NHS that drives appropriate uptake of innovative medicine
  - Visible leadership and communications to change behaviour throughout the system
  - Joint Working and training to support both behaviour change and capability around the uptake of innovative medicines

- **Bottom up cultures**
  - To ensure barriers to uptake are prevented and to prevent delays in the system from duplication, local decision making bodies should be removed
  - Preventing a silo mentality of the local NHS budget by driving improved outcomes as a means to financial stability
  - Removal of local bans on industry activity and support

We have also considered the local, national and international best practice to support the adoption and diffusion of innovation in the NHS, and this is outlined in section 4.

Innovation in the NHS

The ability of the NHS to drive uptake of innovative medicines will be dependent upon national direction, the leadership and communications to make it happen, incentives in place to change behaviour and monitoring to demonstrate success. In order for this to be a reality we believe the following actions are necessary:

1. Top down pressures and support

1.1 Mandatory adherence to National Clinical Guidelines and Guidance, recognised by the National Commissioning Board, should be formally in place with funding directions to implement it. This should be aligned to the current three month window.

Local compliance with NICE guidance and guidelines, the availability of funding, and the time it takes to ensure that funding is available can often present a barrier to uptake. An example of this is the review of Dementia treatments in TA111 (March 2011): a more reactive stance was taken by some PCTs when the guidance changed. So whilst not blocking the new guidance, equally it was not encouraged.

Overcoming such barriers will enable the NHS to uniformly implement, and ensure quick and consistent uptake of those medicines covered by national clinical guidelines e.g. NICE funding directions. It will be important this is measured and action taken when necessary.

Solution: The National Commissioning Board (NCB) should have a monitoring function to ensure the appropriate rate of use of new medicines across the UK. It could use the NHS Outcomes Framework and Commissioning Outcomes Framework (COF) to support the delivery of agreed targets. This will mean it can be started in 2013 and deliver ongoing results. Additionally, resource must be available to enable national clinical guidelines to be prepared in a timely manner. Absence of guidance should not be a block to uptake of innovation and this will need to be endorsed through visible national leadership.

1.2 There should be a local requirement set out by the NCB to add medicines covered by national guidance/guidelines to formularies and funds should be made available within the current three month window for prescribers to implement.

This will prevent the delay in clinicians being able to gain access to innovative medicines and ensure less variation in the NHS’ ability to secure improved patient outcomes. In some cases these delays can be extreme: it took ten years for tiotropium to be added to all formularies across England.

Solution: Communicating the need to add medicines covered by national guidance/guidelines to formularies is required and this can be delivered by the NCB to the Clinical Commissioning Groups (CCGs). Equally a ‘comply or explain’ discussion should go the other way to ensure adherence. The Care Quality Commission (CQC) as part of their validation/assessment of organisations should require evidence of this being done.

2. Horizontal pressures and support

2.1 Creating an aligned incentive structure in the NHS that drives appropriate uptake of innovative medicine through both commissioners and providers, yet overcomes current disincentives.

In order to ensure that patients benefit from innovative medicine we need to set in place a system of incentives to drive positive activity and behaviour.

Currently a number of incentives, activities and levers exist to drive down the use of newer medicines in favour of older generic medicines. Current examples of how this has played out locally are:

- Better Care Better Value indicators
- NPC QIPP indicators
- QoF prescribing indicators
- Prescribing incentive schemes
- Local prohibitive formularies
- So called “red and black lists”
- Scriptswitch
- Financial recovery plans.

Best practice uptake often requires a stratified approach (i.e. treating according to risk) and the examples above create barriers by driving a “one size fits all” attitude. Implementation of national clinical guidelines will therefore require the right incentives.
**Solution:** CQUIN, as part of the provider contract, is an example of where this could be done. Currently two approaches could be adopted; one that focuses on a clinical area and one that addresses the issue of uptake across the board. These would need to be within the nationally mandated scheme and would require a weighting that kept providers and commissioners focused on measurement and delivery. They would also need to be evolved into the emerging provider landscape of the NHS reforms. The CQUIN around innovative medicine would need to remain over the longer term to ensure the behaviour is embedded; a more clinically focused approach could be rotated sooner.

A good example of the use of CQUIN in a clinical area to the benefit of patients is Venous Thromboembolism (VTE). This has been nationally mandated since 2009/10. The main reason for this being VTE is a significant cause of mortality, long-term disability and chronic ill health and is a clinical priority for the NHS. In 2005 the Health Select Committee estimated that were around 25,000 deaths from VTE each year in hospitals in England and VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team. This goal aligns with the current national VTE prevention programme, national mandatory VTE risk assessment data collection, 2010/11 national CQUIN goal on VTE risk assessment, QIPP safe care workstream, NICE Clinical Guidance and Quality Standard, Outcomes Framework Safety Indicator, National Quality Board recommendations on VTE prevention, and VTE prevention provisions in the 2010/11 standard NHS acute contract. Other clinical areas, whilst they have innovative medicine, might not have this level of impact.

A CQUIN that drives innovative medicine would reward providers that implemented national clinical guidelines. The example below, which provides a potential framework of a CQUIN related to medicine, has been written within the South Devon Healthcare NHS Foundation Trust.

“To increase the proportion of patients being prescribed a pass through drug (as identified on the Department of Health 2011/12 High Cost Drug Exclusion list) which are supported by NICE that have a NICE TAG reference number attributed at an individual patient level and are being prescribed the drug in accordance with the guidance published.”

Whilst a version to drive the uptake of innovative medicine would require further work, this does demonstrate the opportunity to use CQUIN as an incentive to affect the use of medicine positively. The next round of CQUIN is 2012/13 and we recommend that a new national mandated CQUIN should be written by then for uptake of innovative medicine.

Whilst CQUIN is a provider mechanism, a lever to ensure commissioners behave in the same way is important. As mentioned earlier, the COF can be used to ensure CCGs support the uptake of innovative medicine through adherence to national clinical guidelines. To ensure the incentive structures are aligned it would be important to include a Quality Standard that looks at implementing national guidelines and potentially using a part of the quality premium to embed this in CCGs. Uptake of innovative medicine would then flow from the NHS Outcomes Framework all the way to the contracting done on the ground, encompassing both commissioners and providers.

### 2.2 Visible leadership and communications to change behaviour throughout system

Pfizer believes visible leadership will be crucial to make the behaviour changes required to ensure patients benefit from appropriate uptake of innovative medicine.

**Solution:** The NCB needs to take a central role in leadership of innovation. This will then need to be followed up locally through local leaders and a strong innovation culture embedded in the performance management system. Clinical senates and clinical networks should also have a role in this. How this works will need to be documented to show the robustness of performance management throughout the system. A follow up report should be written around the success of this culture change each year.

### 2.3 Joint Working and training to support both behaviour change and capability in the NHS around the uptake of innovative medicines

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Pfizer works with the local NHS to improve the capability of its people, and through this, patient benefit has been realised in a number of ways. We have developed a joint working initiative across Pfizer to collect and demonstrate the value we have brought patients with the NHS. A number of these projects (see appendix 1) have helped the NHS deliver results that they would otherwise not have achieved if they kept doing what they had always done. The diffusion of this innovation has been challenging, but is taking great strides. Through a dedicated team we have delivered skills training (including innovation skills) to 20,000 delegates from 1,000 organisations across the NHS. These are further demonstrated in appendix 1.

**Solution:** A number of organisations have a duty for innovation in the proposed NHS reform. As part of this, each organisation should develop formal links with industry to explore greater opportunity for joint working and the diffusion of this innovation locally. How well NHS organisations work with partners should be part of the performance management framework, throughout the commissioning landscape, with reference made to it in their CQC inspection and annual report.

**3. Bottom up cultures**

**3.1 Delays in the system caused by local decision making bodies should be removed.**

These, regional and local, drug and therapeutic decision making bodies create access hurdles that innovative medicines need to climb after a nationally endorsed policy has been agreed. This limits how clinicians are empowered to freely prescribe innovative medicines for eligible patients. Our analysis also suggests that potential cost savings could be secured if such bodies were removed.

The Wolfson, a regional drug and therapeutic centre, produces a series of documents called ‘Hot Topics’. One on NICE CG96 took a very negative stance against the use of pregabalin – whilst it did not actively say to ignore NICE, it pointed out a number of drawbacks and alternative information sources to back up their position. Other examples are also well presented in the ABPI submission.

**Solution:** Regional and local bodies that currently interpret national clinical guidance should either have their remit changed or have their funding moved to areas of greater value for the NHS. Value would be delivered by these organisations taking on more of an implementation role rather than one of repeat assessment.

**3.2 Preventing a silo mentality of the local NHS budget by driving improved outcomes as a means to financial stability.**

We believe that removing silos and enabling pathways to act in the best interests of patients is the best way to achieve real quality and efficiency. Prescribing innovative medicines forms a vital part of many care pathways. By empowering the NHS to think along pathways we prevent decisions being taken in isolation. A good example of this is the current attitude to the prescribing budget as a silo. Local Heads of Medicines Management are often held to a one year budget focus, and this acts as a barrier to the use of innovative medicines that will often deliver benefit over a longer period. This is well documented in both smoking cessation and statins for secondary prevention.

**Solutions:** Locality or pathway budgets need to be utilised with staff performance managed on the overall performance of that budget and its outcomes. Pathways tariffs could be used to support this, and although we do not see the tariff structure as being a key driver for the uptake of innovative medicine, we believe it has a potential use here. Programme budgeting and service line reporting need to be used to provide a better insight into pathway costs and how money can be moved from one area of the pathway to another. Patient held budgets are a further means of enabling patients to make a more informed choice around their care and where they wish to invest in their health.

**3.3 Removal of local bans on industry activity and support**

One of the barriers to joint working is the use of bans to prevent engagement with the industry. Evidence of a number of bans exist both written down in local NHS documents and anecdotally. Such an approach can serve as a block to the diffusion of innovation both through medical education which comes via industry engagement, and also a lack of opportunity for mutually beneficial joint working arrangements.
Solution: Written policies should be removed and views need to be challenged through the strong national leadership of innovation and local outreach. Evidence of joint working across different sectors should form part of the performance management in the NHS.

4. 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?

4.1 Local Best Practice

The diffusion of local best practice through joint working has been difficult as engagement locally is patchy. Greater emphasis needs to be placed on joint working as it can deliver, through both horizontal and bottom up forces, a more innovative approach or enable better access to innovative medicine. Pfizer have experience of working through local initiatives on disease pathways for mutual benefit. We have delivered projects in a number of disease areas throughout the NHS, working with SHAs, PCTs, Acute Trusts and HIECs. Examples of Pfizer’s joint working are highlighted in appendix 1.

4.2 National Best Practice

A good case study of the pace and scale of adoption is anti-TNFs. Currently it is estimated that 83% of the eligible population for treatment with anti-TNFs in Rheumatoid Arthritis are prescribed them. Whilst recognising that 17% of eligible patients are missing out on appropriate treatment the majority of patients are in receipt of the right medicine. However is has taken a decade to achieve this level of uptake due to the chronology of barriers and hurdles to be overcome. Anti-TNFs became licensed for RA in 2000 yet a NICE guideline was not present until 2002. In these two years two key issues existed; the ability of the clinician to develop a business case for funding and the service issue of enough Rheumatology nurses to support implementation. NICE guidelines helped the likelihood of success when seeking funding, but a business case was still usually required and variation in the decision occurred leading to postcode prescribing. The next decade has seen us get to a level of uptake that should have been in place much quicker. Despite this apparent success the speed to which patients can get access to anti-TNF varies, with some PCTs failing to fund the monthly outpatient visits required to move beyond DMARDs despite when necessary. This is even more important as the speed of this has being shown to improve outcomes for patients. A final point here is that despite this uptake, the treatment threshold in the UK is still lower than Europe with a DAS score of 5.1 required for treatment versus 3.1 in Europe. Although the BSR updated their guidance in 2009, NICE still remains at 5.1.

4.3 International

The critical value of an innovation is in use, and therefore it is imperative that innovations, such as medicines, are at least available for use (for uptake) as soon as they can contribute value to healthcare. To this end, the French ATU system (Temporary Authorised Use) for early access to medicines is generally recognised as an effective means of leveraging the benefit of new medicines as soon as they can bring value to patients who have limited care options otherwise.

More importantly, not only does the ATU provide early access, it also provides an example where decision-makers are happy to do something positive for innovation in the face of incomplete evidence. This is often a barrier to access in the UK, as companies are not always in a position to provide cost-effectiveness data at launch that is requested by HTA bodies such as NICE.

The ATU system is designed to maintain the clinical research programmes whilst providing much needed therapeutic alternatives in areas of unmet medical need. This system also avoids the ‘no man’s land’ where medicines can languish between regulatory approval and reimbursement decisions. This has delivered impact to French healthcare and most importantly, to the health outcomes of French patients.
APPENDIX 1

Local Best Practice

A number of joint working examples are coming to fruition and demonstrating clear robust outcomes for patients, NHS and Pfizer. Local best practice examples are shown below and more information on each case study can be available on request.

East Kent Hospitals University NHS Foundation Trust (EKHUFT) – Stroke service,
A project to improve the three combined stroke units, with specialist staff, combining the skills of neurologists and stroke physicians from across the three sites, delivering acute thrombolytic i.v. therapy all day every day, facilitated by telemedicine, with same day MRI and CEMRA support to a 7/7 TIA service.

Project outcomes

Patient
• The acute providers in East Kent now offer acute stroke units upon each site, which with horizontal telemedicine support, offer an excellent service, with improved treatment and patient outcomes.
• Mortality has been reduced for patients admitted with coded primary episodes of stroke. (Almost a 25% relative risk reduction of death compared to the national figure if admitted to EKHUFT.
• Data suggests that over 60% of patients return home post-stroke, compared to the national average of 40%.
• Length of stay data shows reductions consistent with improvements in outcomes and is now in line with national figures.

NHS
• The stroke service in East Kent has been transformed and is now the recipient of a Health Service Journal award for innovative use of telemedicine and diagnostic imaging services, improving the speed of assessment and intervention.
• Doctor Foster intelligence ranks the service No.1 nationally (December 2010).
• CQC ranked EKC PCT as being No.1 commissioners for stroke services in 2011.
• The formidable success of the telemedicine model has convinced NHS West Kent and NHS Medway to use it to replace their previous rota systems.
• The Kent and Medway Stroke Network, local providers and PCTs are now working more collaboratively and effectively together to ensure high quality services for stroke patients throughout the stroke care pathway.

Pfizer
• The project has provided another innovative example of partnership working that we can share with colleagues in Pfizer and wider NHS.
• The support we have given to the redesign of the stroke service is helping enhance service provision in an area which is of joint interest.
• We have been able to add value ‘beyond medicines’ for the benefit of both patients and the NHS.

NHS East of England
Pfizer and the NHS East of England (NHS EoE) came together to help the SHA deliver on their strategy to access hard to reach groups. Together they developed a mobile health screening unit. NHS EoE provided the staff and disposables and Pfizer provided the bus and fuel. So far 13,000 health screenings performed, forecast to deliver 25,000 in 31 weeks. In Hertfordshire in 10 days: 402 smokers set a quit date, 241 lung age checks and 52 referrals with abnormal FEV1 (approx 60% likely to have a need for medication). From an NHS perspective early treatment with appropriate medicines could lead to 91 admissions being avoided (£236k).

Together Works Better Through Innovation
We were looking for a customer orientated solution, where we could help the NHS address their need for change in delivering more care with the same or less funding. This led to an NHS workshop being commissioned and 29 senior NHS figures – arrived for a jam-packed day of innovative thinking and simple, practical techniques which prompted a truly inspirational atmosphere. The session provided customers with new skills around innovative thinking and in essence gave them a fresh set of eyes on their own business challenges. When asked to write a ‘Dear Santa - If there was one thing I could
crack, it would be...’ letter, everyone obliged. They wrote about challenging, ambitious tasks that require innovative, partnership working and from this we have now developed around 15 joint working projects, which are in place to support the delivery of better patient care for the NHS in line with the QIPP agenda.

Equip & Deliver within the West Midlands is assisting pathfinder GP Commissioning Consortia to develop commercial skills to meet the QIPP challenge. There are around 50 GP commissioning consortia in the West Midlands, 16 of which are pathfinders who are looking to develop these skills. Pfizer and the West Midlands SHA developed a partnership to support NHS leaders to develop commercial acumen and lead them through organisational and developmental change into 2013; delivering a bespoke programme for 30 NHS leaders focusing on: business acumen and clinical leadership skills. Delegates will be supported to submit applications for projects based around QIPP (long-term conditions, service redesign, medicines management and tobacco control). The benefits to the NHS include up-skilling of key leaders, implementation of policy and guidelines and improved outcomes for patients. Benefits of the programme to Pfizer include an understanding of clinical priorities and challenges facing GP consortia in the West Midlands.

Advancing Quality
Connecting parts of the NHS system together, to facilitate adoption of best practice through the Advancing Quality (AQ) mode. AQ was a success in the NW having identified 4 areas for improvement. The results in the North West include improved internal engagement of clinicians in AQ via an internal marketing campaign, better adherence to VTE guidelines, an increase in referrals to smoking cessation clinics and more accurate hospital coding to improve reimbursements.

For the patient
- Key elements of the drive for advancing quality of care are now in place; patient experience and outcomes are showing improvement.
- Specific benefits for VTE patients (better adherence to guidelines); also for patients who smoke (increasing referrals by 47% and quit rates).
- Growing awareness of benefits of AQ.

For the NHS
- Helped by combined expertise and resources, the Trust is building AQ success, improving its performance, year-on-year.
- Improved engagement with AQ has resulted in positive behaviour change. Best practice is being shared across the SHA.
- Greater adherence to policies like VTE guidelines and smoking cessation pathways are improving patient care.
- Better understanding of coding is increasing accuracy of data; this, in turn, will help improve care, outcomes and appropriate reimbursement.

For Pfizer
- Improved relationship with Aintree.
- An ability to demonstrate the value of our medicines in improving the quality of care.

The Enhanced Recovery Project
This project is working with the East Midlands HIEC. By looking at the care pathway, £2.1 million savings have been identified by reducing bed days by 1 day per patient in 4 areas of surgery. This has been done by mapping out the care pathway, identifying issues/hot spots within referral, admission, pre-op, post-op stages of the pathway and suitable solutions. This is the kind of project that could be replicated across the country, although it would depend on local priorities and objectives of HIEC being aligned.

Birmingham East and North PCT
Another example that is separate to those above is the work carried out in Birmingham East and North PCT. This has also been set up in Nottingham and the expertise used in other areas such as Oncology.

The Birmingham and Walsall OwnHealth® programme is a partnership between NHS Birmingham East and North (BEN), Pfizer Health Solutions and NHS Direct. It is the UK’s only large-scale telephone based care management service with over 10,000 patients currently enrolled. The service is provided for patients registered to practices in NHS BEN with long term conditions (including diabetes, heart failure, coronary heart disease, chronic kidney disease and chronic obstructive pulmonary disease
Many of whom live in some of the most deprived communities in the UK. Each person (member) is assigned their own Care Manager who empowers and supports them to make informed decisions about their own care and to take action to improve their health and well-being.

A recent 12 month retrospective study of the BOH programme demonstrated that participation was correlated with the following reductions in cost of care per person and time spent in hospital (when compared with the control group): \(^4\)

A recent retrospective study demonstrates that participation in OwnHealth® is associated with the reduction in the number of hospital spells across several disease areas over the course of 12 months:

- **Heart failure:** 28% reduction (p<0.001)
- **COPD:** 28% reduction (p<0.004)
- **Diabetes:** 24% reduction (p<0.001)
- **Coronary heart disease:** 12% reduction (p<0.001)

As well as showing improvements in the use of health services, participation in OwnHealth® was also correlated with reductions in the cost of care per person – when compared with the control group - with:

- **£1,031 saved for each patient with heart failure** enrolled in OwnHealth® - a saving of 39% (p<0.001)
- **£680 saved for each patient with diabetes** enrolled in OwnHealth® - a saving of 42% (p<0.001)
- **£522 saved for each patient with coronary heart disease** enrolled in OwnHealth® - a saving of 29% (p<0.001)
- **£433 saved for each patient with COPD** enrolled in OwnHealth® - a saving of 22% (p<0.379)

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\(^4\) Pfizer Ltd. Retrospective study of the impact of the OwnHealth® programme on service utilisation in Birmingham East and North PCT Data on File 110055E Feb 2011