Factors affecting innovative prescribing in the UK

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In Autumn 2023

KPMG and the ABPI convened a roundtable discussion, bringing together medical leaders and experts from across the healthcare system and pharmaceutical industry, to discuss the key factors impacting clinical decision making when prescribing new medicines.

Previous work has shown that despite NICE approving innovative medicines for use, there is sometimes significant variation in their uptake **– resulting in unequal health outcomes across England**[i].

We convened colleagues on this topic to explore barriers to uptake and contribute to the conversation about the role the individual clinician plays in improving accessibility of innovative medicines - which have the potential to transform patients' lives, and bring wider benefits to the UK economy and society as a whole[ii]. This is particularly important because it is well known that in some areas, **clinicians are at the forefront** of driving improvements in access to innovative medicines for their patients and improving outcomes.

This article details some possible factors regarding where innovative prescribing is less commonplace, according to event attendees. There are, of course, a wide range of influencing factors which might contribute to a clinician's likelihood of prescribing new or innovative medicines, and therefore affect clinical decision making.

Much of the conversation with attendees referred to 'cultural' factors which contribute to the attitudes that some clinicians may have about newer medicines, and the willingness to use these in their practice.

Although in this article we touch on some systemic factors, it is some of the more cultural influences which we want to return to in a future roundtable event this year.

Culture – 'Clinical Conservatism'

There was consensus amongst attendees that some clinicians in the UK are more inclined to have an embedded scepticism of medical products that are newly approved. This was described partly as the natural and reasonable consequence of some healthcare professionals simply being quite removed from the detail of newer medicines – i.e. unless they were involved in a clinical trial or an industry partnership they are not privy to information and evidence on outcomes first hand. Clearly, by the very definition of 'newness', clinicians may display an ambivalence to a treatment until much later when the treatment is the status quo or standard of care for certain therapy areas.

By others, it was described as a more deliberate attitude of caution towards the perceived 'hype' which accompanies newer medicines being developed and approved by pharmaceutical companies and regulators respectively.

A very British phenomenon

The cautious approach to new products described, fits with a wider narrative which was present throughout the roundtable discussion – the presentation of the UK as a whole having a 'safety-first' and cautious tendency.

How then, does the UK compare to other countries culturally? Well, this is something which needs more investigation. What we can make assumptions from is: firstly the fact that in terms of the risk to a prescriber - the generalist role of a GP in the UK differs from overseas, where we see a less generalist and more specialist approach.

Similarly, one notable area highlighted in terms of job roles and professional boundaries in the UK was that we have a higher proportion of non-medical prescribers (who are aware of their professional boundaries). Again, there is an argument that this adherence to a 'sphere of confidence' drives conservatism.

Areas of innovation

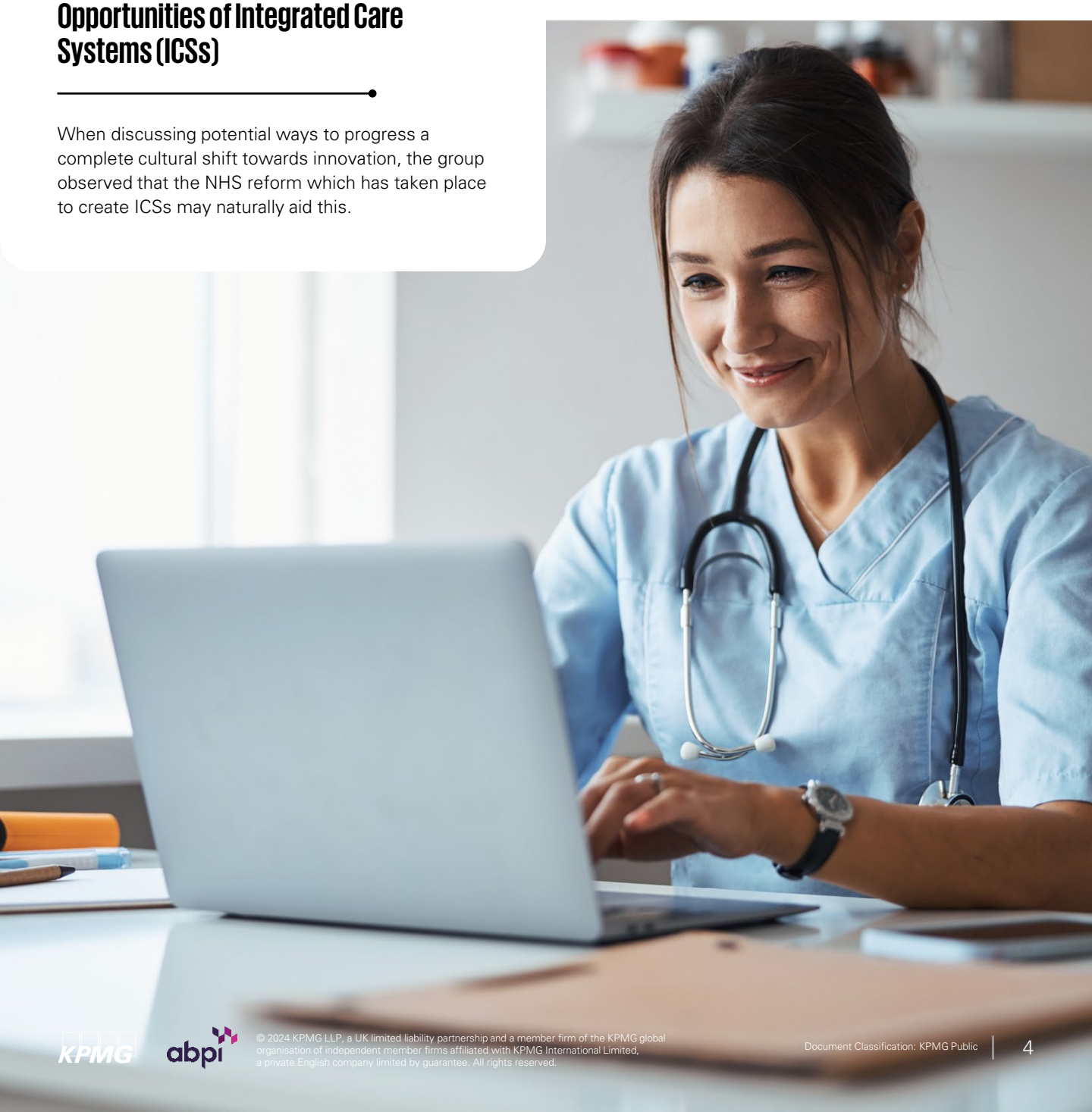
This aversion to risk was seen as varying across different clinical settings – for example primary care prescribers, as time-pressed generalists, being more cautious than more specialist secondary or tertiary care clinicians. Notably, attendees were able to identify many pockets of therapy areas with innovation often very present and driving accelerated outcomes where there are significant gaps in care that need to be filled. This is especially true when gaps are identified and tackled through a joint partnership between industry and the NHS.

As an example, NHS Confederation and the ABPI have reported on innovation and medicines optimisation in post-myocardial infarction via multidisciplinary clinics to treat diabetes. Collaboration between cardiology and pharmacy (consultant cardiology pharmacist-led clinic in parallel with a consultant cardiologist) at Leeds teaching hospital has optimised and reduced the cardiovascular risk factors amongst patients with Type 2 diabetes and cardiovascular disease. This collaboration with Boehringer Ingelheim saw multiple medicine classes optimised - beta blockers, ACEI/ARBs, lipid lowering therapy, SGLT2i. antianginal agents, antiplatelet therapies.

Opportunities of Integrated Care Systems (ICSs)

When discussing potential ways to progress a complete cultural shift towards innovation, the group observed that the NHS reform which has taken place to create ICSs may naturally aid this.

As the ICS model places an emphasis on preventative treatment of the population, there is a chance that 'clinically conservative' professionals, may (with more emphasis being put on population health) become encouraged to implement guidelines for newer medicines which help to achieve local systemic aims and priorities – e.g. lipid management. Furthermore, the ICS model drives alignment between primary care and secondary care, potentially creating professional environments in which innovation can be fostered through shared learning.



Culture – role of the pharmaceutical industry

It is perhaps unsurprising that in a room which included medical leaders from the industry, the role of pharmaceutical companies was affiliated with how individual clinicians perceive and therefore engage around the introduction of new medicines.

It is likely that industry intensity in engaging healthcare professionals' factors into how new medicines are prescribed, despite the fact that this frequency of proactive engagement is limited in some circumstances by the ABPI Code. There is one obvious argument that the purpose of engagement is intended to result in an increase in understanding of the benefits of a product, and therefore more confidence to use something novel.

There is another argument which could be made, which is - if there is indeed a cultural cautiousness towards innovative medicines, then the same low confidence will be applied to research and evidence about a medicine from a pharmaceutical company or a regulator, potentially even if it shows clear evidence of superiority compared with standard of care, from an efficacy and/or safety perspective. Therefore, the impact of pharmaceutical intervention, engagement and education has the potential to be limited.

Reputation counts

It is worth noting here then, the recent **ABPI IPSOS** research into how the industry is perceived by healthcare professionals to understand how many people fall into either camp described. The research shows that companies in the UK enjoy a stronger reputation amongst healthcare professionals: only a relatively small proportion distrust or are critical of the sector, although the majority view is still one of neutrality. Only one in three have a 'high degree' of trust in the industry, so there is room for improvement.

A shared vision to cultural barriers

A recent publication by the ABPI and NHS Confederation, 'Partnering with Purpose', notes the hesitancy that can exist towards working with industry, which 'coupled with scepticism towards industry motives, can discourage innovation and new practice'[iii].

The report notes that a 'shared vision' would go some way to reduce these cultural barriers

articulating a common set of values and purpose – as well as increase understanding of the ABPI Code of Practice so that medical leaders understand how partnerships are governed.

In overcoming these barriers and realising the potential value of public-private partnerships; innovation, service delivery, and outcomes will be improved. What is needed is joint efforts to strengthen trust and nurture a pro-innovation culture across the NHS and industry[iv].

The report highlights that ICSs present a real opportunity to drive accountability and uptake of new and innovative treatments and technologies and consequently to reduce health inequalities and support broader social and economic development and concludes that there is a strong appetite for partnership working, particularly if clear guardrails and assurance can be put in place.

The report highlights the industry's role and the support available in fostering more trusting relationships with clinicians to increase innovative partnerships.

Regulation and Guidelines – innovation in practice

Clinical autonomy

Another aspect of the healthcare system which received attention from roundtable attendees, was the implementation of national guidelines concerning the use of medicines. There were some ways in which guidelines were described as potentially helpful levers to increase uptake of medicines if they were implemented in a particular way. There was other sentiment that guidelines can sometimes eradicate the clinical autonomy which may lead to more innovative prescribing.

On the latter, a term which summarises the dynamic between guidelines and the individual prescribers according to those present was 'cognitive dissonance'. That is to say that depending on an individual's expertise, and indeed the kind of treatment being prescribed, there can sometimes be some tension between an individual's personal experience, and what the guidelines impose. Clinical freedom and autonomy are becoming increasingly important to prescribers – the key question when it comes to prescribing is around whether prescribers were willing to let go of this autonomy to follow guideline recommendations or if there was a push to standardisation.

There are already some studies into the impact of guidelines affecting uptake of certain classes of medicine which shows some variability in guidance translating through to higher rates of uptake. Arguably, the impact of guidelines is possibly one of the largest influences impacting clinicians' decision to prescribe or not – so it is important to further explore and understand some of the factors which impact how guidance affects prescribing.

Looking at guidelines as a useful tool which should be utilised better, one of the suggestions made at the joint ABPI/KPMG roundtable was that it is not atypical for clinicians to express apathy towards guidelines if they have not been involved much in their production. There was some shared sentiment that clinicians will often feel like national guidelines and directives can feel 'top-down' without the right support to understand their context and how best to implement them in real world settings. Indeed, attendees suggested that as with any behaviour changing aim, the mere act of publishing guidelines may not result in their objectives being achieved, especially if what they are replacing isn't seen as 'broken'.

Viewing this again through a lens of the individual perspective, we're reminded that some individuals may need extra incentives to change their habits – if there is a 'win' for the individual in increasing the uptake of innovative medicines in their behaviour, i.e. it frees up their time and affects them personally, then this should be made clearer as a potential benefit.

There were some other reasons given as to why publishing guidelines to improve uptake may not always be the silver bullet it seems on its own. Practically, for example, there is the time it takes for national guidelines to update, accompanied with the time it takes for a) the administration to take place in the system to implement the use of a new medicine in a clinical pathway; and b) the time it takes for cohorts of prescribers to understand and interpret new guidelines before implementing them routinely.

This is particularly an issue given the current capacity pressures that clinicians are under. Headspace and bandwidth is needed to understand and familiarise with new guidance, as well as make service/pathway redesigns that may be needed to accommodate a new treatment.

Here then, we learn that system partners need to do a better job at demonstrating to individual clinicians, the potential positive benefit of prescribing newer medicines on their time and service in the longer term.

Further, additional various local guidelines and responsibilities (say for instance as part of budgetary control) were described as a barrier and run contrary to the purpose of bodies such as NICE - where their recommendations should be implemented as mandated in the statutory timelines, without any further cost/benefit calculations, decisions, or bureaucracy at a local level.

An example to demonstrate this point was diabetes and continuous glucose monitoring (CGM). Despite NICE recommendations for CGM for adults and children living with Type 1 diabetes and for patients with Type 2 diabetes on multiple daily insulin therapy, there is variability on formulary recommendations and uptake of CGM across the ICBs. Many reasons have been cited for this variability in uptake – for example, ICBs may state their own eligibility criteria that may differ from NICE or guidelines may not be systematically applied by prescribers and specialists.

Financial Influences

Cost consciousness

Not unexpectedly, different financial factors were raised as impacting on clinicians prescription decision making.

It was noted that the national fiscal environment is likely to add to a conservative mindset for a clinician as the assumption will be that high innovation equals high cost. Indeed, restricted budgets may make it harder to take risk on innovative medicines. The group were keen to understand if greater onus is being placed on clinicians to routinely opt for the more cost-effective treatments, particularly in a healthcare system with finite resources.

In fact, clinicians should not be overly worried about this as there are already schemes, assessments, and regulatory processes to ensure cost-effectiveness such as the government's Statutory Scheme, industry's Voluntary Scheme, and NICE cost-effectiveness assessments.

Rewarding good clinical practice

The Quality and Outcomes Framework details what financial rewards are voluntarily available to GP providers, for using particular interventions which fit good practice according to the NHS. There was some consensus around the table that although QOF is an effective incentive tool in primary care, given the financial power it wields, the way to financially encourage innovative prescribing is for ICBs to be able to prove the model of 'invest to save' through longer term-funding solutions.

Next article date

Further roundtables will be held by the ABPI and KPMG to 'deep-dive' in to certain areas, which we look forward to sharing the results of later in 2024.

I. NHS Confederation, ABPI (2023), Transforming lives, improving health outcomes: tackling the true cost of variation in uptake of innovative medicines, available at: **https://www.nhsconfed.org/publications/transforming-lives-improving-outcomes**

II. Transforming lives, raising productivity: Is the UK missing out on the full potential of innovation medicines? Available at: **www.abpi.org.uk/media/5frnryxy/transforming-lives-raising-productivity-v4-may.pdf**

III. NHS Confederation, ABPI (2023), Partnering with Purpose: How integrated care systems and industry can work better together, available at: **https://www.nhsconfed.org/system/files/2023-11/Partnering-with-purpose-ICS-industry-FNL-2023.pdf**

IV. NHS Confederation, ABPI (2023), Partnering with Purpose: How integrated care systems and industry can work better together, available at: **https://www.nhsconfed.org/system/files/2023-11/Partnering-with-purpose-ICS-industry-FNL-2023.pdf** p. 31

V. Office of Health Economics, London, UK and Centre for Health Economics, The University of York, York, UK, Factors affecting the uptake of new medicines in secondary care – a literature review, Journal of Clinical Pharmacy and Therapeutics (2008) 33, 339–348

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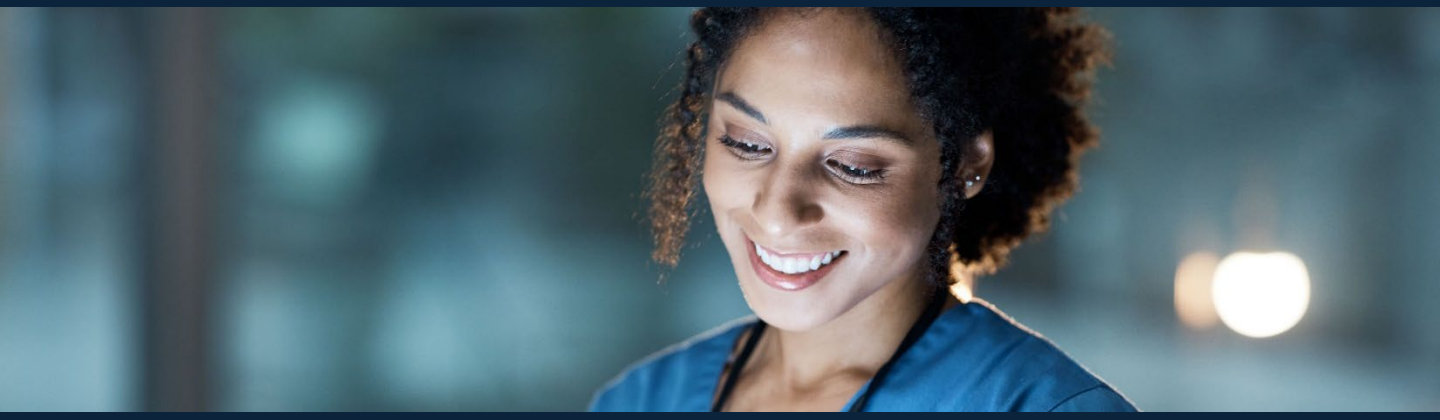

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