Single Technology Appraisal

Nirmatrelvir plus ritonavir for treating COVID-19 (Partial Rapid Review of TA878) [ID6262]

Committee Papers

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

SINGLE TECHNOLOGY APPRAISAL

Nirmatrelvir plus ritonavir for treating COVID-19 (Partial Rapid Review of TA878) [ID6262]

Contents:

The following documents are made available to stakeholders:

1. **NHS England Funding Variation request**
2. **Funding Variation consultation comments from stakeholders**
3. **Further clarification from NHS England**

Any information supplied to NICE which has been marked as confidential, has been redacted. All personal information has also been redacted.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Technology Appraisal

ID6262: Nirmatrelvir plus ritonavir for treating COVID-19 (Partial Rapid Review of TA878)

All relevant health bodies must comply with technology appraisal recommendations and make a health technology available for patients within 3 months of publication of final guidance. When it considers it to be appropriate, NICE can specify a longer period of compliance.

Please see the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013, (the 'Regulations'), for more information.

This template document should be used by commissioners to submit a formal request that NICE consider a longer period of compliance. The questions and prompts are there to guide you. You do not have to answer every question. Please provide short, focused answers, giving a commissioning perspective on the issues you think NICE needs to consider.

1. Name of organisation:	NHS England
2. Your name:	John Stewart
3. Job title or position:	National Director of Specialised Commissioning, NHS England.
4. Please state the reason for applying to vary the funding period (please tick all that apply):	☒ The technology exceeds the Budget Impact Test (BIT) level of £20million in any of the first 3 years following implementation The health technology cannot be appropriately administered until: ☒ Training is put in place ☒ Certain health service infrastructure requirements including goods, materials or other facilities are put in place ☒ Other appropriate health services resources, including staff, are put in place
Additional rationale to support the funding variation request	
5. What is the duration of, and the justification for, the proposed variation? *[Include information on* *- how the request is in proportion to the size of the*	Access to nirmatrelvir plus ritonavir is already in place for around 3.9 million people who have an increased risk of progression to severe COVID-19 (as described in TA878). ID6262: Nirmatrelvir plus ritonavir for treating COVID-19 (Partial Rapid Review of TA878) recommends an expansion of the cohort beyond the high-risk group to people • aged 70 years and over • with a body mass index (BMI) of 35 kg/m2 or more

budget impact (where appropriate) *- how the request takes account of the severity and acuity of the condition to which the guidance relates]*	• with diabetes • with heart failure This expansion will more than triple the number of people eligible from 3.9 million to an estimated 15.0 million people. This equates to almost a quarter of the England population. ICBs will need time beyond the usual 90-day implementation period to put in place the necessary treatment pathways and ensure the necessary capacity, knowledge and expertise is in place to support equitable access for the expanded population. Existing ICB commissioned services will not immediately have capacity to manage the additional demand from the expanded cohort, particularly at a time when primary care is already under significant and sustained pressure to recover routine access to services. Access to COVID treatments has been transitioning from COVID medicine delivery units (CMDUs) that were established in 2021 as part of the pandemic response to more routine access and assessment arrangements. These new arrangements include GP federations operating at scale and community providers. This process is not yet complete and we expect it to continue into 2024. As Paxlovid is a complex drug with several contraindications, ICBs will have put in place additional services which provide the triage, assessment and check for drug interactions that is needed to ensure appropriate and safe prescribing. Currently, these services are scaled to meet the needs of the highest risk population only. Based on activity from 2022/23, expanding access as recommended by NICE could result in 1-2 million more people coming forward to primary care services. People with diabetes and heart failure are likely to be on several medicines, which will mean greater requirements for assessment of drug interactions to ensure safe prescribing. For example, nirmatrelvir plus ritonavir can increase bleeding risk for patients on Direct Oral Anticoagulants (DOACs) and greater caution will be required for patients on antiarrhythmic drugs. Given the significant staffing, infrastructure and resource required to scale up to provide access to all the groups in this recommendation, ICBs will need more time to determine and implement the most efficient, safe and equitable arrangements for their local populations. Therefore, NHS England is requesting, on behalf of the NHS, a one-year funding variation period. During the period of the variation, the NHS will rollout equitable access to treatment as follows: • Patients aged 85 years and above who test positive for COVID in the community. This equates to ~1.1 million more people and recognises the clinical evidence on the additional risk of severe COVID associated with ageing[1].

[1] TCRP modelling group findings: risk of severe COVID-19 outcomes – GOV.UK (www.gov.uk)

	• All eligible patients covered by the NICE recommendation who are resident in a care home (~300,000) and test positive for COVID. • All eligible patients who are covered by the NICE recommendation who are already hospitalised and who test positive for COVID. Because a positive test is a requirement for treatment with nirmatrelvir plus ritonavir, NHS England will put in place arrangements that ensure patients in the above groups can access free COVID tests. As with the current arrangements, patients in these groups will also be able to access treatment using a self-funded test. However, during the funding variation access to treatment for the full cohort of patients recommended by NICE will not be available, even if they provide their own self-funded test. This approach is fully consistent with the fundamental NHS principle that access to treatment is not based on the ability to pay. Treatment on the NHS must go hand in hand with the ability for patients to access the companion diagnostic free of charge. In the short to medium term, the only feasible approach to testing will be to extend the arrangements already in place for the highest risk cohort. Testing is currently provided by UK Health Security Agency's (UKHSA) home channel, which makes available lateral flow device (LFD) testing for the existing cohort of highest risk patients. NHS England is working with UKHSA and DHSC to agree a transfer in responsibility and funding for this testing to the NHS. From November 2023, NHS England is planning to implement a new community-based testing model. It is highly unlikely that the existing UKHSA arrangements or the new community pharmacy model would result in the cost-effective usage of Paxlovid across the entire eligible cohort when testing costs are fully factored in. The licence for Paxlovid stipulates a patient must be COVID positive and treatment must be provided in a 5-day window. In practice, this requirement means that people would need a test whenever they have flu-like symptoms, which may be many times through the year. For planning purposes, we have assumed on average that each eligible person required a box of 5 tests per year, which would mean the additional testing costs for the full expanded population could be c£150 million. However, there is uncertainty about how many people would come forward for free tests or what the ratio of tests to treatment uptake will be, which will have implications for both the financial impact and the cost-effectiveness. The take up of testing and treatment is likely to fluctuate over time depending on factors such as prevalence of both COVID and flu and severity of disease. Therefore, during the funding variation period, NHS England working in partnership with UKHSA will also consider how to put

	in place a cost-effective testing strategy that can be applied fairly and equitably to the entire eligible cohort. This will include, for example: • Exploring opportunities to reduce the acquisition costs of lateral flow device tests. • Examining alternative models for accessing tests which could improve access for patients and reduce costs. • Looking at potential trigger points for stepping up and down access to testing and treatment e.g. severity of disease, hospitalisation. These triggers might, for example, draw on the arrangements for access to antivirals for flu. • Consideration of the pipeline for new testing technologies and options e.g. multiplex testing. • Analysis of data collected on uptake of testing and treatment during the funding variation period. NHS England will also keep incidence and severity of disease under review to inform decisions about whether any further expansion of treatment and free testing should be introduced during the funding variation period. In addition, the NHS will continue to promote recruitment into the Paxlovid arm of the Panoramic clinical trial to validate the efficacy in the broader vaccinated population for the current circulating pathogens.
6. Describe any relevant provisions of any commercial arrangement reached with the company. *[Only complete where relevant.* *Include information on the amount of engagement between your organisation and the company and relevant conclusions for NICE to consider whether all reasonable opportunities for reaching a commercial agreement have been pursued]*	NHS England has engaged with the company as part of the MTA process and in relation to this Funding Variation. The updated list price for nirmatrelvir plus ritonavir is confidential until released by the company.
7. Describe the amount and phasing of funding that will be made available and how it is intended that this should be applied to patients eligible for treatment.	NHS England estimates that the costs of expanding access to people over 85 years old, people in care homes and hospitalised patients to be in the region of £20 million per annum, including both the increased administration costs and the costs of testing. These costs exclude drug costs. Based on information on prescribing from 2022/23, we estimate that 2.5% of the total population might receive treatment i.e. around 30,000 more patients, with over 100,000 coming forward for assessment. The costs of expansion include an administration cost of around £4.8 million. This cost is based on £150-200 per treatment, to

	account for the triage of patients and the additional time needed to check for any drug interactions. This cost may fall in future, but over the next 6-12 months, most system have put in place additional capacity, in part also to ensure timely access for patients. The cost of expansion also includes the costs of testing, which for 1.1 million people is estimated to be £14.4m, based on one box of tests for each eligible patient. Subject to the funding variation being accepted, further work will be needed to: - Understand with local systems how to best implement access for an expanded population. - Understand the features of an equitable, clinically and cost-effective testing strategy. This will include observed costs of testing provided and assessment of the operation of credible alternative approaches.
8. Provide detail of an assessment of the impact on patients, eligible for treatment under the guidance, but whose treatments will be delayed because of the funding variation, taking into account NHS England's and NICE's responsibilities under equalities legislation.	As set out in the Final Draft Guidance (FDG) documentation, equality issues in relation to COVID-19 antiviral treatment are complex and multifaceted. Under the variation request, access to free companion diagnostic testing will continue to be routinely provided to the highest risk cohort covered by the original recommendation in TA878, as well as hospitalised patients, people aged over 85 and those in care homes, ensuring people at highest risk of severe COVID have equitable access to testing and treatment. As with current arrangements for highest risk patients, people in these groups proposed in this variation, could potentially access assessment and treatment using a self-funded test. However, access on the basis of self-funded tests alone would not be consistent with the NHS Constitution where access to treatment is based on clinical need and not the ability to pay. NHS England also believes a testing strategy based on patients self-funding their tests would not be consistent with duties under equalities legislation. The NHS Act 2006 section 13G relates to the duty to reduce inequalities and requires that: The Board must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between patients with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.
9. Provide detail of the interim commissioning policy that would be applied to phase in funding and to manage access to the technology during the	As outlined above, during the funding variation period NHS England will set out the necessary information and policy position on access as it relates to • the highest-risk cohort and people • people aged 85 and over • hospitalised patients with COVID

extended funding variation period.	• people in care homes Our aim is to extend the testing arrangements in place for the highest risk group to the groups outlined above within 90 days of the publication of Final Guidance. Primary care services will need this time to operationally prepare the service for the phased roll out of this recommendation.

Thank you for your time. Please log in to your NICE Docs account to upload your completed submission.

National Institute for Health and Care Excellence

Health Technology Evaluation

ID6262 nirmatrelvir plus ritonavir funding variation consultation comments

Section	Stakeholder	Comments [sic]
Overall	Pfizer	We are deeply concerned about NHSE's proposal to extend the funding mandate for Paxlovid from the standard 3 months to 15 months and would urge that this proposal be rejected. Our concerns are grounded in five key areas as set out below and are fully described within our response. <u>First,</u> we do not consider that NHSE has provided adequate justification to entitle a variation to the funding period to be considered. The assertions that NHSE has put forward in support of their proposal are generalised, un-evidenced and at odds with feedback that we have obtained. As we explain in **Comment 2** below: • NHSE asserts that the recommendation will impose *"significant staffing, infrastructure and resource require[ments] to scale up to provide access to all the groups in this recommendation"* and that "*ICBs will need more time to determine and implement the most efficient, safe and equitable arrangements for their local populations."* However, integrated care board ("ICB")-commissioned pathways are already in place to support COVID-19 antiviral treatment, and we present data showing that the majority of services feel they are able to scale up these pathways to support NICE's recommendation for an expanded population. **[Comment 2, Part A]** • In relation to NHSE's suggestion that there is a need to put in place training to enable appropriate administration of the health technology, training has already been rolled out for existing prescribers and extensive guidance is available for new prescribers. **[Comment 2, Part B]** • Finally on the question whether there are resource constraints that would prevent the appropriate administration of the health technology, NHSE has ignored a critical countervailing consideration, namely, the likelihood that implementation of the recommendation would release capacity and alleviate pressure from a secondary care perspective, leading to cost savings. **[Comment 2, Part C]**

Section	Stakeholder	Comments [sic]
		Second, we consider the further justifications put forward by NHSE in support of the funding variation request, which focus on testing costs and logistics, to be misconceived and in any event wholly insufficient. As we explain in **Comment 3** below: • NHSE's comments on whether the technology would be cost-effective when testing costs are factored in are irrelevant to the question of whether the funding period should be varied, and outside NHSE's remit. The question of cost-effectiveness has already been decided by NICE in their recommendation. In any event, the costs of testing have already been factored into the appraisal process that led to the recommendation (in which NHSE was a consultee, and to which it had the opportunity to contribute); no explanation has been given by NHSE for why proposals around alternative roll-out options for testing have apparently been unexplored until now; and the basis of the testing costs calculations used by NHSE is unclear. **[Comment 3, Part A]** • NHSE's statements related to self-funding of COVID tests ignore wider practical and social considerations. **[Comment 3, Part B]** Third, several of the requirements in paragraphs 5.10.26 – 5.10.29 of the NICE Health Technology Evaluations Manual (the "Manual")[1] and the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 (the "Regulations")[2] are not met. In particular, we explain in **Comment 4** below that: • From the information that NHSE has provided as to the interim commissioning policy that would be applied, it is plain that this is not in any meaningful sense a phased allocation of funding and access. The effect of NHSE's proposals would be to prevent the vast majority of the people for whom NICE has recommended the technology – almost 10 million, who are older and clinically vulnerable – from having any access to the technology at all for a 15-month period. **[Comment 4, Part A]** • The specified period for funding is defined in the Regulations as the period "*within which*" NICE's recommendation is complied with (reg.7(2)), and relevant health bodies should "*provide funding within [that] specified period to ensure that the health technology be made available for the purposes of treatment of patients*" (reg.7(1)(b)). In other words, the specified period is a maximum and the recommendation should be implemented by the end of it. NHSE's proposal is a complete

Section	Stakeholder	Comments [sic]
		restriction in access, such that even 'system-ready' ICBs and local health authorities will be unable to implement NICE's recommendation over a 15-month period. As such, it is inconsistent with the ordinary meaning and understanding of a specified period under the Regulations. **[Comment 4, Part B]** • NHSE is required to provide an assessment of the impact on patients who are eligible for treatment under the guidance, but whose treatments will be delayed because of the funding variation. No such assessment has been provided; instead, the application form contains only a brief reiteration of the (limited) minority of the population covered by the recommendation to whom the technology may be available in the next 15 months and comments on the self-funding of testing (proposal, section 8). **[Comment 4, Part C]** • NHSE's consideration of the impact of their proposal on inequalities is cursory and incomplete. In particular, there is no explanation as to how the "complex and multifaceted" equality issues have been weighed, nor why the stated concerns around self-funding of tests are considered to outweigh the countervailing inequalities to which NHSE's proposals would give rise. **[Comment 4 Part D]** Fourth, even setting aside NHSE's failure to show that its request complies with the Manual[1] and Regulations,[2] acceding to the request would give rise to significant practical and policy concerns, which we address in **Comment 5:** • In terms of immediate considerations: **[Comment 5, Part A]** o It would result in almost 10 million vulnerable people, for whom NICE has already determined that the technology is cost-effective, being denied access to that technology over two consecutive winters, and an estimated 745 – 2,012 preventable deaths (as per **Part 5a** and **Appendix 3**). o It would be contrary to the Government's clearly expressed intentions in relation to NHS winter planning. o It would result in wastage of stock for which there has been significant pre-payment from public funds. • In terms of wider and longer-term implications **[Comment 5, Part B]**: o It would place England behind and out of step with other comparable countries and recent WHO guidance.

Section	Stakeholder	Comments [sic]
		○ Of particular concern to the industry and other stakeholders (including patient groups), it sets a worrying precedent both for future patient access in England to NICE-recommended technologies and for the NICE technology appraisals process. As we explain below, Pfizer and other stakeholders have participated in good faith in a lengthy appraisal process, [redacted] although no concerns from NHSE were raised during these discussions. Instead, NHSE has made a request at this late stage, that would in reality deny patients access to the recommended technology for at least 15 months. This is wholly unsatisfactory for patients, and we are particularly concerned that NHSE have expressed in a recent engagement that requests for funding mandate extensions are likely to become more common going forward. The healthcare system needs to be prepared to accommodate cost-effective medicines to ensure patients can access innovations without delay. Fifth and finally, as expanded on in **Comment 6** we have reservations over the procedural fairness and transparency of the process by which the consultation has come about. The Manual[1] refers (for example, section 5.10.25) to whether NHSE and NHS Improvement may "*need*" to apply to vary the funding mandate (and as noted above, the Regulations[2] suggest that the specified period for funding is the maximum within which NICE's recommendation should be implemented). Further, section 5.10.28 of the Manual requires the Guidance Executive, in reaching its decision on the variation request, to take into account (among other things) whether the request takes account of the severity and acuity of the condition to which the guidance relates. It is important to consider both whether this proposal is justified as necessary taking into account the risks of COVID-19 for the relevant population and whether it represents a funding mandate extension as per the Regulations. This variation request is, in any view, exceptional. Pfizer is aware of only two other technology appraisals where a funding mandate extension was requested by NHSE. In the first case – an appraisal of sofosbuvir[3] for treating chronic hepatitis C – the extension provided local health authorities an additional three months approximately to comply with the NICE recommendation. In the second case, a multiple technology appraisal for hybrid closed loop systems for managing blood glucose levels in type 1 diabetes,[4] NICE refer to a phased rollout, although limited detail is provided on this within FDG. In contrast, this proposal for Paxlovid is not a funding mandate extension. It would deny the vast majority of the – generally older and clinically vulnerable – people for whom NICE has already judged this

Section	Stakeholder	Comments [sic]
		technology to be cost-effective any access to it for over a year. It would take truly compelling, detailed and well-evidenced reasons for the Guidance Executive to conclude that such a request could be justified. For the reasons summarised above and explained below, we consider that there are no such reasons and cannot see how the Guidance Executive could fairly and rationally reach any other conclusion. In the circumstances, Pfizer hopes that the Guidance Executive will reconsider its decision given it states it is 'minded to agree'. Pfizer's rights of challenge are reserved.
	Long Covid Support	We are concerned about the request for such a significant extension of implementation of this technology. The extension effectively further delays access to what can be life saving interventions, despite acknowledgement of their importance in these populations.
	NHSE on behalf of ICBs	**Summary** ID6262: Nirmatrelvir plus ritonavir for treating COVID-19 (Partial Rapid Review of TA878) recommends an expansion of the cohort beyond the high-risk group to people: • aged 70 years and over • with a body mass index (BMI) of 35 kg/m2 or more • with diabetes • with heart failure. On behalf of the NHS, a one-year funding variation period is requested, and that during the period of the variation, the NHS would roll out equitable access to treatment as follows: • Patients aged 85 years and above who test positive for COVID in the community (this equates to ~1.1 million more people and recognises the clinical evidence on the additional risk of severe COVID associated with ageing). • All eligible patients covered by the NICE recommendation who are resident in a care home (~300,000) and test positive for COVID. • All eligible patients who are covered by the NICE recommendation who are already hospitalised and who test positive for COVID.

Section	Stakeholder	Comments [sic]
		Many of the ICBs noted the expansion will more than triple the eligible population from 3.9 million to an estimated 15 million. This is a significant proportion of the population and will have service implications for both primary care and secondary care. ICBs have stated that they would need time and resources to put in place treatment pathways, service capacity and increased workforce for implementation, as well as to ensure the necessary expertise is in place to support equitable access. The comments from ICBs confirmed that it will not be possible for nirmatrelvir plus ritonavir to be made available to 15 million people without significant impact on other services. Many ICBs have expressed their concerns about introducing a significant expansion while they are establishing more primary care-based access arrangements, and they transition out of the COVID medicine delivery unit (CMDU) arrangements that were established during the pandemic. The majority of ICBs are supportive of NHS England's proposed phased approach which would prioritise access to treatment during the one-year funding variation period. However, a number of ICBs raised issues over the clinical and cost-effectiveness, based on the evidence, local clinical experience and on costs of service delivery. In addition, many ICBs raised the question of how to provide greater certainty of what the proposed arrangements will be once the one-year funding variation ends.
Cohorts prioritised for funding	Cardiothoracic Transplant Patient Group	The Cardiothoracic Transplant Patient Group would strongly advocate that as an absolute minimum during the variation period access to treatment should also include people with heart failure who are on a heart transplant waiting list and / or have a long-term ventricular assistance device. This patient group is under 500 across the whole of the UK and represent the very highest risk patients with end stage heart failure. This patient group all have specialist advanced heart failure teams who would be available 24/7 to provide clinical advice and drug interaction details to the Covid 19 prescriber. Ensuring quick and optimal recovery from Covid 19 infection is vital to this patient group to support the national strategies of increasing transplant rates, improving organ utilisation and post-transplant

Section	Stakeholder	Comments [sic]
		outcomes. Relevant national strategies are Organ Donation and Transplantation: Meeting The Need (Organ Donation and Transplantation 2030 : Meeting the Need (windows.net)) and Honouring the gift of donation: utilising organs for transplant (CP 793 – Honouring the gift of donation: utilising organs for transplant – Report of the Organ Utilisation Group – February 2023 (publishing.service.gov.uk)) It would seem counterproductive to these strategies to delay implementation of proven, effective, NICE appraised treatments for Covid 19 to this small clearly defined patient population. The Cardiothoracic Transplant Patient Group believe this patient group could be included in the variation rollout without materially impacting on the reasons outlined by NHSE for the requirement to vary the funding period.
Impact on patients, eligible for treatment under the guidance, but whose treatments will be delayed because of the funding variation	Cardiothoracic Transplant Patient Group	The Cardiothoracic Transplant Patient Group are concerned that during the variation period all patients with a diagnosis of heart failure remain disadvantaged compared to some patient groups included in the McInnes list which have been shown to have lower risk of progression to severe Covid 19 compared to people with heart failure. The Cardiothoracic Transplant Patient Group believe to retain the entire existing list of the Independent Advisory Group (McInnes) patients whilst excluding newly eligible groups which have an evidence base of being at higher risk of progression to severe Covid 19 to be discriminatory.
	Lupus UK	We are concerned that this section gives no detail about the impact on patients whose treatment will be delayed by the funding variation, and instead only discusses those who would receive treatment and the impact of relying on self-funded tests only. The impact on patients who would not receive the recommended treatment is an important consideration for cost-effectiveness analyses. People with lupus who are not on immunosuppressants may qualify for treatment with Paxlovid under the new recommendations due to age or co-morbidities such as diabetes or obesity. According to a LUPUS UK survey from 2022, many people with lupus, including those who are not severely immunocompromised, are hospitalised following a COVID-19 infection because of secondary complications such as pneumonia or lupus flares. This is supported by peer reviewed research which has found COVID-19 may worsen lupus symptoms (Fernandez-Ruiz, et al., 2020: https://www.translationalres.com/article/S1931-5244(20)30302-9/fulltext) and that co-morbidities such

Section	Stakeholder	Comments [sic]
		as heart disease puts people with lupus at greater risk of severe outcomes from COVID-19 (Mehta et al., 2022: https://link.springer.com/article/10.1007/s10067-022-06227-7). According to our survey, worsened lupus symptoms from lupus flares frequently required additional treatment, such as increased corticosteroids. Additionally, approximately 43% of those who responded in our survey indicated that having COVID-19 had also disrupted their normal treatment. Some people reported that they were instructed to pause their lupus medications until recovered from COVID-19 and this risked flares of their disease: • *COVID put me into a flare that lasted for four months; limiting the amount I could do and leading to severe fatigue and constant pain in my joints."* • *"COVID triggered my lupus & polymyositis - joint/muscle pain and inability to move due to excruciating joint pain. I was then put on steroids."* • *"I had to stop immunosuppressants for 3 weeks which meant a flare of some of my lupus symptoms."* • *I had to come off drugs. It caused a lupus flare."* • *"I was unable to restart medication due to having COVID and not being able to repeat bloods or be on immunosuppressant due to infection, which resulted in joint pain and swelling."* • *"Had to stop medication and felt like I was in a flare for circa 2 months despite restarting medication."* Providing post-exposure treatment to all the expanded groups more quickly may reduce these secondary impacts and associated costs for the NHS, such as increased lupus treatment costs and increased contacts with primary and specialist care, as well as associated wider costs such as increased absence from work or impact on caregivers. These impacts are not captured within NHS England's funding variation request cost calculations nor in the impacts on patients in section 8.
	NHSE on behalf of ICBs	As set out in the Final Draft Guidance (FDG) documentation and NHS England's funding variation request, NHS England is putting in place arrangements that ensure patients in the relevant cohorts can access free COVID tests. These arrangements reflect that a positive COVID test is a requirement for treatment with nirmatrelvir plus ritonavir. Given the financial implications for the NHS and the impact on cost-effectiveness (with additional testing costs for the full expanded population which could be c£150 million), NHS England is working with UKHSA and DHSC to agree the most cost-effective model.

Section	Stakeholder	Comments [sic]
		NHS England's aim is to extend the testing arrangements in place for the highest risk group to the groups in line with the 90 day implementation period following publication of Final Guidance. On grounds of equitable access, NHS England is not proposing to provide access to treatment for the full cohort of patients recommended by NICE will not be available, even if they provide their own self-funded test, and instead only extending the current arrangements for the highest risk cohort. The majority of ICBs were pleased to see that testing is being properly considered and that NHS England will make sure that testing is freely available for patients in the proposed interim pathway.
NHSE submission section 5. Justification for the proposed variation Regarding: capacity challenges	Pfizer	In this section we outline the evidence that ICB-commissioned pathways are already in place to support COVID-19 antiviral treatment, and present data showing that the majority of services feel they are able to scale up these pathways to support NICE's recommendation for an expanded population. We also show that training has already been rolled out for existing prescribers and extensive guidance is available for new prescribers, as well as present data to support the case that Paxlovid has the potential to release capacity and alleviate pressure from a secondary care perspective, leading to cost savings. <u>Part 2A: Infrastructure & scaling of pathways</u> In December 2022, NHSE first published the 'Commissioning Framework: COVID-19 therapeutics for non-hospitalised patients',[5] (the "Framework") to assist ICBs as future commissioners of COVID-19 therapeutics "*in establishing and maintaining timely access to COVID-19 therapeutics during the remainder of 2022/23 in preparation for transition to routine provision"* (section 1) following transition from COVID Medicines Delivery Units ("CMDUs"). The Framework clearly sets out the NHSE's expectations for the establishment of services to enable access to COVID-19 treatments to a broad range of populations. The Framework further states that the preferred service delivery model should be determined by ICBs to meet the needs of their local population and that these models may be based in primary, community or secondary care models, or a hybrid of these. It clearly sets out requirements and standards that ICBs were expected to meet when determining and commissioning local delivery models for access to COVID-19 therapeutics, including ensuring equitable access to treatment and that *"sustainable and scalable services are in place ahead of transition."* (section 7.1) In addition, the Framework suggested that ICBs consider how services align or integrate with other initiatives such as those being considered under winter resilience plans.

Section	Stakeholder	Comments [sic]
		In line with this, pathways for accessing testing and community COVID-19 treatments (including Paxlovid) are already in place for the ~3.9 million eligible patients, following transition of COVID-19 treatments from CMDUs to sustainable and scalable local pathways, with ICBs assuming the responsibility for ensuring routine access to community COVID-19 treatments between 29 March and 27 June 2023.[6] Furthermore, oral antivirals, including Paxlovid, were made available for dispensing through community pharmacies from the 9 May 2023 [7] and the Directory of Services, the national NHS directory for NHS Urgent Care services, was updated to reflect changes to service arrangements from 27 June 2023 to ensure that NHS 111 and local providers are able to arrange prompt assessment or referral to a local COVID-19 treatment service where applicable.[8] Our antiviral field colleagues and medical affairs team are currently supporting and working with 67 ICB -commissioned local pathways/services across the UK, of which 60% are in primary care/hybrid models of care, 31% are acute trust-based services, 2% are community trust-based models of care, while 7% have remained 'CMDU-like' secondary care models. Within these we have observed a broad base of prescribers, with GP, pharmacist and nurse-led prescribing in primary care and hybrid models of care along with consultants, registrars and junior doctors in CMDU-like or trust-based models of care. These existing services are running effectively, and we believe they have been designed with the framework principles of sustainability and scalability at the forefront; examples of different services, with details around structure, scalability and training approaches are presented in **Appendix 1.** When meeting with Service Leads and discussing their thoughts on 'scalability' and their ability to support an expanded population they shared the following: • *"We would definitely be able to cope; we would just expand the number of clinicians in our team. We don't feel increasing the eligible cohort will have a major impact on work load" – Acute Trust-Based Service* • *"Our service upscaled and was ready to implement the new NICE guidance for the extended eligible population. Unfortunately, these plans have had to be put on hold until we receive further clarity. It took our service about a month to be ready to cover the expanded eligible population following the publication of the final NICE draft guidance." – Primary Care / Hybrid Service*

Section	Stakeholder	Comments [sic]
		• *"There's an intrinsic, what we call, agility (to our Service). So, we can pare it back, but we can escalate if required. At the moment it's a morning service, seven days a week with one clinician. When demand increases, we add another clinician to the rota. If it then escalates further, we put on an afternoon session with one clinician and then if it needs escalating again, we have two sessions a day, morning and afternoon, both with two clinicians, and so on. Because it's on a rota basis, we can pare it back, or increase"– Primary Care / Hybrid Service* • *"We have quite a robust service that has flexed already at times of high demand and we would do this again and maintain if needed" – Primary Care / Hybrid Service* To explore and consolidate the uncertainty around sustainability and scalability of existing services we conducted a brief survey among 11 healthcare professionals (HCPs) who are leaders or prescribers in an ICB-commissioned local service delivering COVID-19 oral antiviral treatments in England. Eight HCPs (73%) stated the in their clinical judgement they could adequately scale their service within 3 months (standard NICE implementation period) to meet an increase in the eligible population for an oral antiviral from 3.9 million (current high-risk population) to 15 million (over 70s, diabetes, BMI≥35, heart failure) (i.e., 3.8 fold increase in population size). Of those that would need longer, 1/3 said this could be achieved within 3 – 6 months and 1/3 within 6 – 9 months (the remaining respondents did not comment). The full results of the survey are presented in **Appendix 2.** Finally, we note that NHSE states (proposal, page 4) that "over 100,000" patients might come forward for assessment. No evidence is provided as to how this relates to the number of patients who would present to the healthcare system because of flu/or COVID-19 like symptoms. In an IPSOS study conducted by Pfizer, the proportion of patients seeking and receiving treatment is noted to be lower in countries where the population has been expanded to the full licence. It was reported to be 12.9% for these countries vs 26% in current UK eligible population reported in OpenSafely[9] and 20% for England reported by NHSE.[10] We believe this is because the current, highly clinically vulnerable patients are more focused on their health and more minded to seek treatment if they test positive for COVID. In this way,

Section	Stakeholder	Comments [sic]
		although an expansion to an eligible population of 15 million is a 3.8-fold increase in eligibility, it is unlikely to drive a 3.8 increase in patients presenting at service hubs for triage and treatment. In summary, the existence of robust, scalable and sustainable pathways for COVID-19, led by a varied prescriber-base suggest that implementation of NICE's Final Draft Guidance ("FDG") could be achieved within the standard 3 months' timeframe and certainly well before the NHSE's proposed 15 months. We refer to **Comment 1** above and **Part 4B** below, which highlight that NHSE's proposal would result is a complete restriction of access to patients before the expiry of the 15 months' period, whereby even those services that are able to scale up COVID-19 pathways to accommodate the expanded group of patients immediately or during that period would be restricted from doing so. <u>Part 2B: Training</u> Further to scaling up of the current services to ensure the necessary capacity, NHSE also highlighted the need to put in place training as a barrier to appropriate administration of the health technology. Prescribing oral antivirals across existing hubs is now standard practice, as is training prescribers to do so. Our understanding is that robust training is already in place, both centrally, such as e-Learning modules via NHSE and Teaching Hospitals[11] online training through professional bodies such as the Royal College of General Practitioners ("RCGP"),[12] guidance through the Specialist Pharmacy Service ("SPS")[13] and locally, where we have observed tutorial sessions being set up to share learning and best practice and creation of local protocols and guidance to support treatment of complex patients. There is also an abundance of publications, leaflets and tools to support DDI management,[14] and the SPS actively promotes its Medicines Advice Service for those who are prescribing COVID-19 treatments in complex clinical scenarios.[15] In the survey described above, the large majority (10/11, 91%) of HCPs stated that they had received adequate training for prescribing COVID-19 oral antivirals. Most commonly respondents referred to having received on the job / ad-hoc training (8/11, 73%), local training (6/11, 55%) and NHSE e-learning training (5/11, 45%) (see **Appendix 2**). Although we accept that any new potential prescribers within services would need to undergo training and build their experience, training materials and approaches are well established and easily accessible

Section	Stakeholder	Comments [sic]
		to support safe, effective prescribing of oral antivirals and we do not believe ICBs will need time beyond the standard 3-month implementation period to achieve this. Moreover, a training need exists regardless of the size of the eligible population. Where the population is larger it may require a greater number of colleagues to receive training; however, roll-out would not take sufficiently longer to justify a 12-month extension to the funding mandate, to the extent of prohibiting treatment with a fully funded, cost-effective medicine. Part 2C: Capacity reductions in secondary care & cost savings [redacted][1] [6] Expanding treatment access for Paxlovid to patients aged over 70 would have a greater impact on reducing hospitalisations associated with COVID-19 and capacity challenges, compared with NHSE's proposal. Our analysis suggests that NHSE's proposal to restrict access to Paxlovid over 15 months would result in an additional 2,839– 9,216 hospitalisations over the next two winters compared with NICE's broader recommendation. This is based on data from the previous winter (1 October 2022 – 31 March 2023) and assumes that all patients hospitalised and eligible would have receive access to Paxlovid. The number of hospitalisations averted has been doubled given that NHSE's proposal would result in a restriction in access over two winters. Varying assumptions were modelled related to efficacy (EPIC SR vs EPIC HR), market share and the proportion of patients in hospital for COVID, as fully described in **Appendix 3**. The additional cost savings of NICE's recommendation to expand the eligibility for Paxlovid compared with NHSE's proposal are between £30.2 and £98.1 million, compared with the cost savings associated with NHSE's proposal. We highlight the Government mandate to NHSE (15 June 2023) stating that priority 1 is to *"cut NHS waiting lists and recover performance,"* to tackle the *"backlog of elective care.*" NICE's recommendation can release capacity and alleviate pressure from a secondary care perspective, leading to substantial cost savings.[17]

Section	Stakeholder	Comments [sic]
	Blood Cancer UK	As NHS England indicates in this application, the process of transitioning COVID treatment delivery for the highest risk from COVID Medicine Delivery Units (CMDUs) to routine access via Integrated Care Boards (ICBs) 'is not yet complete and we expect it to continue into 2024'. NHS England also states that 'these services are scaled to meet the needs of the highest risk population only,' this includes people with blood cancer who are at risk of severe COVID both because of their condition and its treatments. We are concerned that many of the existing processes for the highest risk have been described as 'interim' and 'temporary' by ICBs and NHS England because they are waiting for the final NICE guidance for nirmatrelvir plus ritonavir (Paxlovid). This has had an impact on patient access to these time-sensitive treatments because permanent processes haven't been introduced into routine care. There is significant geographical variation across England in how the highest risk access COVID treatments. We have heard stories of confusion, delay and misinformation from the blood cancer community trying to access COVID treatments since the transition of delivery started. We have been reassured that these temporary processes would become routine and long-term once the Paxlovid guidance was finalised. With this requested variation to the funding requirement from 90 days to one-year, however, we are concerned that access to treatments for the highest risk will continue to be inequitable for upwards of 12 months. With COVID still circulating and new variants bringing unknown risks, continued uncertainty around COVID treatment access for the highest risk, including people with blood cancer, and for the new cohort outlined in the guidance, should be avoided. We appreciate the infrastructure, staffing, training and drug interaction challenges that need to be overcome to expand treatment access from 3.9 million to 15 million people. But the current process is struggling to serve the 3.9 million, including blood cancer patients who already have complex drug interactions that need to be considered. A one-year extension to the funding implementation period does not reflect the urgency of the situation – people with blood cancer and others at the highest risk, continue to change their behaviour and lifestyles to avoid contracting COVID-19. Post-exposure treatments like Paxlovid are an essential assurance and potentially life-saving intervention for people at the highest risk, and if a one-year extension is going to further delay easy, equitable access to these treatments for the highest risk population, then it should not be allowed.

Section	Stakeholder	Comments [sic]
		We would like to see the extension shortened and resources allocated to allow NHS England to deliver treatments to existing and newly eligible cohorts as soon as possible, no later than the end of August 2024 when COVID cases are likely to start rising again, as we saw this year.
	NHSE on behalf of ICBs	**Drug interactions** NHS England previously raised concerns that Paxlovid is a complex drug with several contraindications and ICBs will need to ensure there are additional services for appropriate and safe prescribing to meet the needs of the expanded population. Many ICBs have indicated that the people in the proposed expanded cohorts are more likely to be attributed to polypharmacy which will create the need for more extensive checks around drug interactions, and require a significant service expansion. One ICB reported that 42% of referrals in its locality are unable to have Paxlovid due to either contraindication or drug interactions, and that a high proportion of referred patients require adjustments to existing medicines if using Paxlovid. As a result, ICBs will need to put further additional services in place, to ensure the needs to the enhanced population are met. Further to the funding variation request, ICBs also asked to consider a patient decision aid to ensure the risks and benefit including the evidence base are included in any decisions around prescribing. Some ICBs also asked for greater clarity over extending the review to other treatments as the current guidance and pathway does not offer alternatives for the extended cohorts, for example patients with contraindications or drug interactions.
NHSE submission section 5. Justification for the proposed variation	Pfizer	Part 3A: testing costs Cost-effectiveness as an irrelevant consideration for the funding mandate extension request NHSE asserts on page 3 of their proposal that it is *"highly unlikely that the existing UKHSA arrangement of the new community pharmacy model would result in the cost-effective use of Paxlovid when testing costs are factored in."* The question whether the technology would be cost-effective when testing costs are factored in is irrelevant to whether the funding period should be varied. We note that in the NICE

Section	Stakeholder	Comments [sic]
Regarding: testing costs and logistics		Manual (sections 5.10.2 and 5.10.28)[1] the cost of testing is not listed as a rationale for extending the funding mandate for a new treatment. Furthermore, it is the remit of NICE, not NHSE, to assess cost-effectiveness of a new intervention considering the cost to the NHSE in its entirety. NICE's recommendation was that *"the likely cost-effectiveness estimates for these groups are also within what NICE considers an acceptable use of NHS resources" (FDG, page 3).*[18] Testing is already factored into the appraisal process That said, it is important to emphasise that the costs of testing were indeed factored into the appraisal process and contributed to a [redacted] NICE's FDG states (section 3.30)[18] "*The committee noted that using the lower administration cost, the ICER was close to its preferred threshold of £20,000 per QALY gained. The committee preferred to use this threshold because of the remaining uncertainties associated with the clinical data (see section 3.17) and the costs of testing (see section 3.26)."* NHSE was a consultee within the NICE appraisal process and had an opportunity to contribute to the discussions around testing costs. NHSE representatives attended both appraisal committee meetings related to Paxlovid use in the expanded population although no comments were inputted from NHSE on the appraisal consultation document published by NICE on 4 May; comments were only received by three PAG groups and the UKHSA. NHSE's proposal is in any event unclear in several respects NHSE refers (proposal, page 4) to *"[e]xamining alternative models for accessing tests which could improve access for patients and reduce costs"* during the funding variation period. No explanation has been given as to why proposals around alternative roll-out options for testing have apparently been ignored until now but in any event, even if these were not considered in advance, we are unclear why such consideration should require a 15-month period rather than the standard 3 months. On the testing cost estimate itself, NHSE has estimated a cost of £150 million annually (proposal, page 3), but provides limited information around the inputs/assumptions that have been used as basis for this

Section	Stakeholder	Comments [sic]
		calculation. [redacted] Further, NHSE states that each eligible patient would require a box of 5 tests per year. It would be more appropriate to base the number of funded tests required by the eligible population on the UKHSA model of provision between June and September 2023, which required eligible patients to request / order a test through a website.[19] The data relating to this 'pull -model' for accessing free/funded tests would allow a more accurate calculation of the overall number of tests required and the related costs, for the expanded population. In any event, the costs of testing for the entire eligible population recommended by NICE would still equate to £120 million annually (not the £150 million). Similarly, it is unclear, what NHSE's statement that it would cost £14.4 million to test 1.1 million patients is based on (proposal, page 5). <u>Part 3B: self-funding of tests</u> NHSE's statements as regards self-funding for COVID tests ignore wider practical and social considerations. NHSE states that *"it believes a testing strategy based on patients self-funding their tests would not be consistent with duties under equalities legislation"* referring to the NHS Act 2006 (proposal, page 5). We wholeheartedly agree that every decision must be made with a duty of reducing inequalities across patient populations. But as explored further in **Part 4D** below, there is also an inequality related to NHSE's proposal, which would result in almost 10 million people being denied a clinically effective and cost-effective treatment which is likely to otherwise be wasted. Data from 44 adults (18+) in the UK who have experienced COVID-19 in the last 24 months and have either asthma (n=13), cancer (n=1), CV disease (n=5), chronic kidney/liver/lung disease (n=1), smoker (n=14), diabetes (n=19), obesity (n=13), pregnancy (n=1), or on immunosuppressive therapy (n=2) suggests that the large majority (68%) would be willing to pay £2 for a COVID-19 test so that if they were positive they could obtain a prescription for Paxlovid (product X in the survey). This gives an indication of the willingness to self-fund a test in the population of patients covered by the Paxlovid label (the large majority of whom would be considered eligible under NICE's recommendation).
	Blood Cancer UK	By the time of writing, access to free COVID tests for those eligible for treatments has already transitioned from UK Health Security Agency to community pharmacy provision but we are yet to see how it works in practice. We are concerned to hear that this new model is not expected to be cost-

Section	Stakeholder	Comments [sic]
		effective for the expanded eligibility for Paxlovid. It is frustrating to hear that the testing strategy will need to change again, steps should be taken to make sure the highest risk populations are not confused by another new process and that the changes are adequately communicated to them by letter.
	NHSE on behalf of ICBs	**Service delivery costs** NHS England estimates that – excluding drug costs – the costs of expanding access to people over 85 years old, people in care homes and hospitalised patients to be in the region of £20 million per annum. This includes both increased administration and service delivery costs (c.£5 million, based on £150-200 per treatment) and testing costs (c.£15m, based on one box of tests for each eligible patient). The majority of ICBs agreed that the total costs must not only reflect the cost of the drug itself (which the appraisal includes) but also service costs associated with both administering the drug and testing for COVID. Their view is that the estimated cost impact could be significant and that the cost of administration and testing should be kept under review to inform future decisions on access. There is concern that providing for extra cohorts of patients will only increase the financial burden, particularly when this has not been planned for in-year and given the drug will need to be paid for locally from 2025/26. As a result, respondents are in favour of having more time to work through the expansion as a system and model local costs. **Clinical- and cost-effectiveness** A number of ICBs have raised points relating to the level of clinical- and cost-effectiveness of Paxlovid. For example, there are limitations in the evidence and a lack of direct data relating to the new cohorts, where extrapolations have been taken from previous studies that took place during a different time of the pandemic, including when people were not vaccinated, and the variants were more severe. As such, a phased approach to roll-out is considered appropriate to ensure the best use of limited NHS resources. Many of the ICBs also raised concerns about the cost effectiveness of the treatments once all the service costs were included, including the cost of testing. They questioned how it could be assured to

Section	Stakeholder	Comments [sic]
		be value for money, if cost and resource implications for the healthcare system from the delivery models for expanded cohorts have not been fully captured.
	Clinical expert	It does indicate difficulties with the affordability of the plan. It is difficult to argue with this analysis, which is the extrapolation of several assumptions. Notably it makes the assumption that all eligible individuals will come forward for treatment. In our service, only approximately 2/3rds of those currently eligible for the CMDU service (i.e. the immunocompromised and those with significant pathology that would deteriorate if they were to contract COVID) continue to maintain their COVID tests and contact us if they test positive. On the most part, these are the individuals who have contracted COVID and made an uneventful recovery. I would suggest that if we were to extend the eligibility there would be a greater proportion of adults who have experienced COVID and due to the efficacy of the vaccine and hybrid immunity, have had an uneventful disease course. I suspect that the majority of these individuals would neither test nor reach out unless COVID went through substantial changes that caused a more severe disease. I have a larger concern, however that this model has been factored entirely on the expenditure without mitigating against the cost savings of reduced hospitalisation. When I gave evidence, we discussed at length that the current metric of reducing death and ITU admissions is less appropriate now the majority of individuals are starting to seroconvert and the Omicron Variant is killing far fewer individuals (although I am currently involved in an Medical Examiner's investigation into the death of an immunocompromised person from COVID who was referred Ito CMDU n good time but due to the service being disbanded did not receive treatment, was admitted and ultimately died) . The metric we should be considering, is admission and number of bed days in hospital. Rather the metric we should be considering is hospitalisations and bed stay. People with COVID are still hospitalised for approximately twice as long as other comparable viral illnesses (influenza and RSV; 11 days vs 4.8 days). In our trust the requirement for ongoing social care is substantially higher in those with COVID delirium than in other viral illnesses. The impact this has on bed occupancy is tremendous, with an associated knock on effect on Social care utilisation. At the end of last week there were 84 medical "outliers" (i.e. medical patients outside of the usual medical bed base usually occupying surgical beds) Of these 64 were in hospital due to COVID or its sequelae - this does not

Section	Stakeholder	Comments [sic]
		include people with incidental COVID or those with nosocomial COVID. Of these 64 patients only 3 would have been eligible for antiviral treatment under the current criteria (none of whom had been referred) but 58 would have been eligible for the expanded criteria (mainly due to being over 70, but also living with obesity, diabetes or heart failure). As part of STIMULATE ICP trial we are currently exploring the healthcare utilisation of patients with acute COVID and long COVID. Compared to other diseases, we have already presented that the attributable economic costs of OVID are significantly higher than other comparable diseases. Our calculations, based on the patients we have treated and extrapolating back from the "treatment failures" rates on the relative risk reductions we would have expected, range from a conservative 798 bed days (Based on the RWE of a 50% reduction in hospitalisation) up to 1160 bed days saved if the RRR reported in EPIC-HR was achieved. This is from 1 hospital in one region of an ICB. I can fully appreciate the values demonstrated on the Budget impact test, however this should be balanced against the opportunity costs of surgical beds have medical patients in them (massively hindering the elective recovery plan), the long term consequences with regards to social care usage, and the longer term impact of COVID on vascular ageing. I don't doubt that the other elements are accurate - There will be significant training requirements, particularly as we enter winter, there will be health infrastructure requirements, however on the most part these have now bene in place for approaching 2 years, and although they are being modified this is an evolutionary process that offers the opportunity to afford updated protocols. Each of these are addressable, and if NICE were to suggest that the cost of providing the service is worth the benefit of keeping people out of hospital and allowing the resources to be used towards the elective recovery process (and hopefully fewer ambulances outside EDs) then I'm sure this training could be commissioned and the staff are already available to provide the service, given that we have been providing this service for the last 2 years. The key limitation would be access to the information and getting it to a new population (particularly those from ethnic minorities, or of lower socio-economic status who have demonstrably poorer outcomes even today from COVID).
NHSE submission section 5.	Pfizer	In this section we explain our concern that several of the requirements in sections 5.10.26 – 5.10.29 of the Manual[1] and in the Regulations[2] have not been met.

Section	Stakeholder	Comments [sic]
Justification for the proposed variation Regarding the process that has been followed		Part 4A: Phased allocation of funding and access From the information that NHSE has provided as to the interim commissioning policy that would be applied, it is plain that this is not in any meaningful sense a phased allocation of funding and access (as is required within section 5.10.29 of the Manual). NHSE's proposed interim commissioning policy, as explained on pages 2–3 of their proposal, is to make Paxlovid available to over 85s, those in care homes and patients in hospital within a 3-month period. This represents a small group, approximately 1.4 million (as indicated in NHSE's proposal, although no figure is given for people being treated in hospital), who comprise only <15% of the newly eligible population recommended for treatment by NICE. No further phasing of funding expanding the eligible population beyond this initial policy has been proposed by NICE during the 15-month period. The effect of NHSE's proposals would therefore be to prevent the vast majority of the people for whom NICE has recommended the technology – almost 10 million, who are generally older and clinically vulnerable – from having any access to the technology at all for a 15-month period. Part 4B: The requirement for a maximum timeframe over which NICE's recommendation is implemented As is explained above, the specified period for funding is defined in the Regulations[2] as the period "*within which*" NICE's recommendation is complied with (reg.7(2)). Indeed, relevant health bodies should "*provide funding within [that] specified period to ensure that the health technology be made available for the purposes of treatment of patients*" (reg.7(1)(b)), i.e., they should take steps to make recommended technologies available sooner. Thus, the specified period is a maximum and NICE's recommendation should be implemented by the end of it, not at the end of it. As we explain above, NHSE's proposal is a complete restriction in access, such that even 'system-ready' ICBs and local health authorities will be unable to implement NICE's recommendation for 15 months. It is therefore not a funding mandate extension that is consistent with the ordinary meaning and understanding of a "*specified period*" under the Regulations[2] whereby that is the period over which NICE's recommendation is implemented. The context for this complete restriction in access proposed by NHSE is (as noted in **Part 2A)**, 8/11 (73%) of HCPs stating that in their clinical judgement they could adequately scale their service within 3 months to meet NICE's increase in the eligible population. Part 4C: Assessment of patient impact

Section	Stakeholder	Comments [sic]
		The Manual refers in section 5.10.26[1] to the information that should be provided by NHSE when requesting a variation in the funding requirements and requires "*an assessment of the impact on patients who are eligible for treatment under the guidance but whose treatment will be delayed because of the funding variation."* No such assessment has been provided; instead, the application form contains only a brief reiteration of the (limited) minority of the population covered by the recommendation to whom the technology may be available in the next 15 months and comments on the self-funding of testing (section 8). There is no consideration of the remaining near-10 million people (of the population for whom NICE has recommended the treatment) who will not have access during that period or what the impact on those people will be. <u>Part 4D: Full considerations of equalities impact</u> Section 5.10.28 of the Manual[1] requires the Guidance Executive to take into account, when considering whether to vary the funding mandate period, whether "*NHS England and NHS Improvement's and NICE's duties under equalities legislation have been considered*". NHSE's consideration of the equalities impacts of its proposals (which is also set out in its response to question 8, on page 5 of the proposal) is cursory and incomplete. NHSE states that "*equality issues in relation to COVID-19 antiviral treatment are complex and multifaceted*" but does not explain what the various equality considerations are, nor how it has weighed them. In particular, as explained in **Part 3B** above, NHSE's proposal would result in almost 10 million people being denied a clinically effective and cost-effective treatment. There is no consideration by NHSE of the equality issues to which this gives rise, let alone an explanation of why its stated concerns around self-funding of tests are considered to outweigh these issues. An especially striking omission that we would highlight is that there is no consideration by NHSE of the impact of restricting access of Paxlovid to patients with diabetes, which disproportionately affects patients who are Asian (including Indian, Pakistani, Bangladeshi), Chinese, Black African and Black Caribbean ethnicities;[20] and to patients with BMI ≥35 who are typically from socioeconomically deprived populations.[21]
Other	Pfizer	<u>Part 5A: Implications for patients and policy concerns – short-term considerations</u>

Section	Stakeholder	Comments [sic]
		If NHSE's proposal to delay the funding mandate, comes into effect, it would result in almost 10 million vulnerable people for whom NICE has already determined that the technology is cost-effective, being denied access to that technology over two consecutive winters. Over the last winter period (1 October 2022 to 31 March 2023) there were 51,502 hospitalisations[22] (for COVID-19)[1] and approximately 13,520 deaths[23] (with COVID-19 on the death certificate) in England, with older and clinically vulnerable people disproportionately affected. We estimate that NHSE's proposal could result in between 745– 2,012 preventable deaths as fully described in **Appendix 3**. This is based on data on deaths with COVID-19 from the previous winter (1 October 2022 – 31 March 2023) and assumes that all eligible patients would have access to treatment. The number of preventable deaths has been doubled given that NHSE's proposal would result in a restriction in access over two winters. Given we are heading towards what is predicted to be an extremely challenging winter,[24] both for patients and the health system, we are concerned about NHSE's commitment to protect vulnerable groups over this period. In recent weeks there have been cases of critical incidents declared at hospitals related to capacity.[25,26] This decision to delay patient access to Paxlovid would also be contrary to the clearly-expressed intentions of the Government in advance of the NHS Winter Roundtable at Downing Street of 13 September 2023.[24] For example, former Health and Social Care Secretary, Steve Barclay said *"Winter is always an extremely busy period and we're working across the NHS to make services more resilient, ensuring those who most need help and support will get the care they need. I'm working closely with NHS and social care leaders to provide additional hospital capacity, protect emergency care and harness the full potential of technology to deliver the best possible service and intensify our efforts to tackle waiting lists."* Further, Prime Minister Rishi Sunak stated, *"Today we're bringing together the best minds*

[1] Office for National Statistics – https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/.
The total reported admissions to hospital with/for COVID-19 for 1 October 2022 to 31 March 2023 was sourced from– the 'Weekly Admissions and Beds' file, tab: Hosp ads & diag. This was multiplied by an estimate of the proportion of patients admitted for COVID-19 based on ONS data to give an estimate of hospitalisations for COVID-19. This proportion is calculated by dividing the 'Confirmed COVID-19 patients being treated primarily for COVID-19' by the 'Total beds occupied by confirmed COVID-19 patients' in the 'Primary Diagnosis Supplement' file.

Section	Stakeholder	Comments [sic]
		in healthcare who all have one shared aim - protecting patients and making sure they get the care they need this winter." The Department of Health & Social Care has already purchased 2.75 million doses of Paxlovid, 90% of which will expire by the time NICE's recommendation is implemented if the delay to the funding mandate is granted. The entirety of the purchased Paxlovid stock will expire by May 2025. It is deeply concerning that NHSE is proposing to allow significant quantities of a NICE-approved medicine which can help prevent hospitalisation and help save lives to go to waste, when the Government has already paid for it using public funds. <u>Part 5B: Implications for patients and policy concerns – longer-term considerations</u> NHSE's request would place England behind and out of step with other comparable countries and recent WHO guidance NHSE proposals would result in much more restrictive access to Paxlovid in England compared with comparable countries. In both France and Germany Paxlovid is available to the full labelled population (which, based on Walker *et al*. 2020[27] would be the equivalent of an eligible population of ~24.8 million patients in the UK) with no further restrictions in usage. Further, NHSE proposal is contrary to international guidance from WHO published 10 November 2023[28] stating they *"strongly recommend nirmatrelvir-ritonavir (also known by its brand name 'Paxlovid') for people at high-risk and moderate risk of hospitalization,"* based on the following definitions: High: People who are immunosuppressed remain at higher risk if they contract COVID-19, with an estimated hospitalization rate of 6%. Moderate: People over 65 years old, those with conditions like obesity, diabetes and/or chronic conditions including chronic obstructive pulmonary disease, kidney or liver disease, cancer, people with disabilities and those with comorbidities of chronic disease are at moderate risk, with an estimated hospitalization rate of 3%.

Section	Stakeholder	Comments [sic]
		NICE's recommendation for Paxlovid in an expanded population would be aligned to updated WHO guidance Opportunities to raise concerns in the appraisal process and with Pfizer directly Pfizer and other stakeholders have participated in good faith in a lengthy appraisal process – the initial MTA [TA878] and a subsequent partial review to evaluate Paxlovid for an expanded population [ID6262] has resulted in four appraisal committees over almost two years, since early 2022. As per **Part 3A**, NHSE was a consultee within the NICE appraisal process and had an opportunity to contribute to the discussions around testing costs. NHSE representatives attended both appraisal committee meetings related to Paxlovid use in the expanded population although no comments were inputted from NHSE on the appraisal consultation document published by NICE on 4 May; comments were only received by three PAG groups and the UKHSA. There has also been extensive collaboration over a [redacted] At no stage during these conversations did NHSE raise concerns related to scaling existing primary care pathways or potential testing costs with Pfizer. Implications of NHSE's funding mandate extension request We are deeply concerned about the precedent that this funding mandate extension proposal might set for future funding decisions. Of particular concern to the industry and other stakeholders (including patient groups), is the impact that this might have on future patient access in England to NICE-recommended technologies and on the NICE technology appraisals process. Companies and other stakeholders, for example clinicians and patient groups, participate in the technology appraisal process (which can be resource intensive) on the understanding that process is, as explained in the introduction to the Manual, *"designed to produce robust guidance for the NHS in an*

Section	Stakeholder	Comments [sic]
		open, transparent and timely way, with appropriate contribution from stakeholders". For the process to work as intended: • Consultees (including NHSE) will generally raise concerns promptly so that they can be addressed in the course of the appraisal process. With regards to a funding mandate variation in particular, section 5.10 of the Manual[1] emphasises that NHSE should make any application for a variation at the earliest opportunity (see for example sections 5.10.20 and 5.10.24). • Once the appraisal process has come to an end, while there is scope for an appeal, appeals will generally be brought within a limited timescale and are not opportunities to reopen the merits of NICE's recommendations: they are (in brief) limited to certain grounds (procedural unfairness, unlawfulness, and unreasonableness). • There is therefore clarity and certainty for companies and patients about what NICE has recommended and the timescales within which patients will benefit from the recommendations. In this case, NHSE has made a funding mandate extension request post-FDG (although, as set out above, it had opportunities to raise the issues it now refers to); the effect would be to deprive most of the intended population of the benefit of NICE's recommendation for 15 months; and it would seem from comments in NHSE's proposal (see the statements regarding cost-effectiveness on page 3 and *"continu[ing] to promote recruitment into the Paxlovid arm of the PANORAMIC clinical trial to validate the efficacy in the broader vaccinated population for the current circulating pathogens"* on page 4) that NHSE is reopening questions that have already been extensively appraised within the NICE technology appraisal. To agree to this request would risk undermining the technology appraisal process. [redacted] As noted under Comment 1 above, to date there has been near-universal compliance with the 3-month period set out in the Regulations.[2] If that period is extended [redacted], there may be wider negative effects, from reduced confidence as to the period within which NICE recommendations will be implemented (for example, companies may be more cautious in putting [redacted] Meanwhile, patients will no longer be assured of access to cost-effective medicines without delay.

Section	Stakeholder	Comments [sic]
	Pfizer	Finally, as indicated under **Comment 1** above, we have reservations as to the fairness and transparency of the process by which the consultation has come about. As noted under **Part 5B** above, the Manual[1] requires NHSE and NHS Improvement to make any application to vary the funding mandate period "*at the earliest opportunity, and no later than the end of the period for consideration and lodging an appeal*" (Manual, section 5.10.24) and requires NICE to present the application to the Guidance Executive "*at the earliest opportunity*" (Manual, section 5.10.27). In this case, the appeal period expired on 24 August 2023; the timeline published on the 'Project information' website suggests that the request from NHSE for a one-year extension had been made by 15 September 2023; and the consultation was published on the website on 1 November 2023 (stakeholders having been informed in accordance with section 5.10.32 of the Manual[1]). No information has been published as to when the Guidance Executive decided that it was minded to agree to the variation request, nor why.
Other	Long Covid Support	**People with Long Covid should be considered for:** **1. The new eligible population as recommended by Partial Rapid Review of TA878** **2. The phased roll out recommended by ID6262.** **Reinfection adversely affects those with a history of Long Covid. Evidence increasingly suggests people with Long Covid are immunocompromised, have a maladaptive immune response and T-cell exhaustion. The following research demonstrates a need for people with Long Covid to be considered as at-risk and therefore eligible for the technology:** i)'Long-term SARS-CoV-2-specific immune and inflammatory responses in individuals recovering from COVID-19 with and without post-acute symptoms' (Peluso et al 2021) ii)'Neuro-COVID long-haulers exhibit broad dysfunction in T cell memory generation and responses to vaccination' (Visvabharathy et al 2021)

Section	Stakeholder	Comments [sic]
		iii)'Long-term perturbation of the peripheral immune system months after SARS-CoV-2 infection' Ryan et al 2022 iv)'SARS-CoV-2-specific T cells associate with inflammation and reduced lung function in pulmonary post-acute sequalae of SARS-CoV-2' Palmer et al 2022 v)'Persistence of SARS CoV-2 S1 Protein in CD16+ Monocytes in Post-Acute Sequelae of COVID-19 (PASC) up to 15 Months Post-Infection' Patterson et al 2022 vi)'Distinguishing features of Long COVID identified through immune profiling' Klein et al 2022 vii) 'Immune signatures underlying post-acute COVID-19 lung sequelae' Cheon et al 2021 **We are concerned that the evidence for deterioration in people with Long Covid on reinfection is not being taken into account:** i) Long Covid Support Reinfection Survey 80% worsened with reinfection. Of those who had recovered or were in remission from Long Covid, reinfection caused a recurrence in 60%. ii) 'Acute and postacute sequelae associated with SARS-CoV-2 reinfection. (Al-Aly et al 2022) – "evidence shows that reinfection further increases risks of death, hospitalization and sequelae in multiple organ systems in the acute and post-acute phase". **We are concerned that the evidence for reducing the risk of Long Covid through the treatment of acute Covid with Paxlovid is not being taken into account:** 'Nirmatrelvir and the Risk of Post-Acute Sequelae of COVID-19' (Al-Aly et al 2022) – which shows that people given Paxlovid in the first five days of their infection were 26% less likely to come down with Long Covid. Paxlovid significantly reduced 10 of the 12 sequelae assessed, including cardiovascular disease, coagulation disorders, kidney problems, etc. as well as fatigue, musculoskeletal pain, and cognitive problem.

Section	Stakeholder	Comments [sic]
	Cardiothoracic Transplant Patient Group	An observational study using the OpenSAFLEY platform looked at the changes in mortality between different demographic and clinical subgroups across both pre and post vaccination Covid 19 waves, Changes in COVID-19-related mortality across key demographic and clinical subgroups: an observational cohort study using the OpenSAFELY platform on 18 million adults in England | medRxiv This study revealed that in the latest post vaccine wave analysed absolute mortality risk for people with chronic cardiac conditions (1.46) is significantly above that of people with rheumatoid arthritis or systemic lupus erythematosus (1.04). The study also demonstrated that the relative Covid 19 mortality ratio for people with chronic cardiac conditions has increased between the pre and post vaccine waves. Indicating that vaccine is less effective in this patient population and anti-viral medications are an important treatment for people with heart failure who contract Covid 19. The Cardiothoracic Transplant Patient Group believe that to delay access to Nirmatrelvir plus ritonavir for people with heart failure would actively discriminate against this patient group. The World Health Organisation (WHO) recently updated their guidelines on treatments for Covid 19, WHO updates guidelines on treatments for COVID-19. WHO strongly recommend treatment with Nirmatrelvir plus ritonavir for people in their high and moderate risk categories of hospitalisation from Covid 19. The moderate risk group includes people with chronic conditions and / or comorbidities of chronic disease. This would include people with heart failure. The Cardiothoracic Transplant Patient Group notes that the membership of the McInnes Advisory Group does not include a cardiologist. The group includes members from all clinical specialities that are listed in Box 1 but is lacking direct input from cardiology despite evidence suggesting that people

Section	Stakeholder	Comments [sic]
		with certain cardiac conditions may have similar or a greater risk of severe Covid 19 to conditions included in the recommendations The Cardiothoracic Transplant Patient Group believe that NICE and NHS England should engage with the professional heart failure community (i.e. British Society of Heart Failure) to ensure that this patient group achieve equitable and evidence based access to Nirmatrelvir plus ritonavir for treating Covid 19.
	Lupus UK	We are concerned that the funding analysis request does not adequately consider the current climate of COVID-19 prevention and treatment. The uptake of booster vaccinations has been decreasing for a variety of reasons. Many people are experiencing vaccine fatigue, in part because of the uncertainty around any potential added benefit from each dose. Some in our patient community have also reported that the vaccine triggers a flare of their lupus, and so they are balancing their COVID-19 risk with the vaccine making them unwell, and some do not want to keep having additional doses for this reason. For example, on our patient forum, there are mixed feelings towards having further vaccines. Users have said: • *"Every time I have a vaccine I experience a flare worse than the last. I won't have any more."* • *"I believe vaccination is important, but there is nothing for me against COVID-19 because I experience too many side effects to have any more of those. And we're told they don't work that well for people like us anyway, so what's the point. There's not much empathy for us as people just assume I'm an anti-vaxxer, but I'd love something that works without making me so ill!"* • *"Each vaccine induces a bad flare, but I will keep having them because I am high risk."* With an immunosuppressed cohort size for the 2023 autumn booster programme of approximately 2 million in England, the uptake numbers published by NHS England in early November 2023 puts uptake of autumn boosters among the immunosuppressed at just 14.6%. With reduced uptake of preventative vaccinations, post-exposure treatments are becoming even more important in managing the impact of COVID-19. Some of the patients who would have access to treatments delayed if this variation in funding requirement is approved do not qualify for booster vaccinations, so post-exposure treatments are their only means of preventing progression to a severe case of COVID-19 or the secondary impacts of COVID-19 such as a flare-up of their chronic health condition (as described in point 1).

Paxlovid (Nirmatrelvir plus ritonavir) for treating COVID-19: NHS England – further information to NICE in support of the Funding Variation Request

Summary

1. The NHS in England has worked at pace to establish services to support people by preventing and treating COVID-19. This has included rapid work during the pandemic to develop interim access policies for clinically effective treatments, the rollout of COVID-19 vaccinations, the rapid identification of highest risk patients[1] and the establishment of COVID-19 Medicines Delivery Units. As the NHS moves from pandemic response to living with COVID-19, NHS England has supported NICE's work to fully assess the clinical and cost effectiveness of COVID-19 treatments, as well as supporting the NHS to move from secondary care to primary care-led pathways of treatment access for those with a confirmed COVID-19 infection in the community.

2. Vaccination remains the best way to protect against COVID-19 and the winter vaccination programme opened in September 2023 provides protection against influenza and COVID-19 for eligible patients and frontline staff. In addition to vaccination, the NHS has continued to provide services to over two million people eligible for treatment. In June this year, Integrated Care Boards (ICBs) assumed responsibility for arranging routine access to COVID-19 treatments in line with the NICE guidance, at the same time that the number of eligible people increased to almost four million. NHS services are transitioning out of pandemic-specific arrangements for community access. Part of this transition has included the launch in November 2023 of a new community pharmacy service to provide access to lateral flow device (LFD) testing for patients eligible for currently recommended treatments.[2]

3. Following a partial rapid review of TA878, NICE has recommended expanding access to nirmatrelvir plus ritonavir (Paxlovid) for treating COVID-19 further still to all people over 70 and people aged 18 or over with diabetes, heart failure or BMI >35. This expansion will increase the eligible population to an estimated **15 million people**. This equates to almost a quarter of England's population. As ICBs need time beyond the usual 90-day implementation period to put in place the requisite treatment pathways and ensure the necessary capacity is in place to support equitable access for this expanded population, a funding variation request has been submitted by NHS England in line with NICE's Manual.

4. During the period of the proposed variation, the NHS will continue to rollout equitable access to treatment to the highest risk patients already eligible (3.9 million) and the additional cohort of the NICE recommended population as below:
   - Patients aged 85 years and above who test positive for COVID in the community. This equates to ~1.1 million more people and recognises the clinical evidence on the additional risk of severe COVID associated with ageing.
   - All patients covered by the NICE recommendation who are resident in a care home (~300,000) and test positive for COVID.
   - All eligible patients who are covered by the NICE recommendation who are already hospitalised and who test positive for COVID.

[1] Highest-risk patients eligible for new COVID-19 treatments: a guide for patients - GOV.UK (www.gov.uk)
[2] NHS lateral flow device tests supply service for patients potentially eligible for COVID-19 treatments (england.nhs.uk)

5. In response to NICE's Guidance Executive request for NHS England to provide further information in response to some of the stakeholder comments received as part of the consultation on the variation, including:
    - **Feeback from ICBs** – more detail on the feedback received from the NHS, including who has been consulted
    - **Equalities impact** – demonstrating the evidence-based assessment of the impact on patient groups that would not get access during the funding variation period
    - **Planning for roll out** – more detail on planned rollout following the funding variation period, including whether a shorter period is possible.

Feedback from ICBs

6. Through our work with the NHS in England, NHS England is aware that existing services will not have capacity to manage the additional demand from the entire expanded cohort at the same time that primary care is already under significant and sustained pressure to recover routine access to services.

7. As part of the consultation on the funding variation, NHS England asked all ICBs to comment on the funding variation request. Responses were received from almost a third of ICBs, 12 out of 42 ICBs (29%), covering three out of the seven regions. NHS England also engaged with all the regional Senior Responsible Officers (SROs) for COVID treatments.

8. **Eleven of the 12 ICB respondents stated that they were in favour of the funding variation**, with the other raising concerns about how to roll out across the proposed cohorts in a timely and equitable way, given the time required for implementing such a change. Local challenges in terms of cost and capacity pressures for service delivery were raised by eight ICBs, with the capacity required by both commissioners and providers, including community pharmacy (raised by five ICBs).

9. In addition, the funding variation was supported by the seven regional Senior Responsive Officers (SROs) for COVID-19 treatments, who were consulted as part of fortnightly operational calls with regional NHS England teams. The SROs were consulted ahead of the initial funding request, and their feedback reflect views from the ICBs.

10. The key points raised by individual ICBs across the country are summarised below:

- ICB 1: stated that there would be significant pressure on capacity if the cohort is widened, irrespective of the delivery model (e.g. increased referrals or prescribing / appointment pressure).
- ICB 2: stated that the NICE proposal will create more pressure on both primary care and secondary care that would be untenable during the winter period, particularly given current NHS workforce pressures without any spare capacity and staffing resource pool to enable implementation.
- ICB 3: reflected that this extension to the criteria will impact how the ICB currently supplies antivirals (eligibility triage and community pharmacy enhanced services to supply, check and, in some cases, deliver to patients) and increase workload, compounded by the fact that capacity is already stretched by referrals coming in waves. The ICB also noted that the proposed groups of patients are more likely to be attributed to polypharmacy which would create the need for more extensive checks around drug interactions. The importance of

pharmacy stock holding of medicines would need consideration during times of higher COVID prevalence.

- ICB 4: noted that the expansion significantly increases the number of eligible patients, pushing this from a niche service to widespread medicines access, and the ICB commissioned services do not currently have the capacity to implement this. The potentially enormous impact across every provider in terms of the increased capacity requirements was noted. Extra time is needed to find and utilise funding to step up a service to have greater capacity and, as such, a 90-day period to implement this wider access would be insufficient. This ICB recommended a year for phasing in the new cohorts. The ICB added that more time is also needed to train up and work with GP practices to move to access as routine medicines business as usual.
- ICB 5: stated that it would welcome the time to work through the roll out as a system, not least given the significant service, capacity and training implications.
- Regional group of ICBs: supported NHS England's funding variation request and agreed that a longer implementation period would be required. However, they highlight the importance of monitoring differences in access across populations to ensure equity of uptake, especially for under-served populations.
- Comments also included how enabling access to all eligible patients within ICBs within the full cohort will require providing access routes for harder to reach populations, such as people who are housebound and living in detained estates, not just those in community settings who are able to access mainstream primary care access points.

Equalities impact

11. NHS England has taken equalities impact into account throughout its antivirals deployment programme. While eligibility for medicines is clinically indicated based on the trial evidence and drug licence (as opposed to protected characters or inclusion groups), NHS England has further considered the equalities impacts of this funding variation request – see the table in Annex A. NHS England notes that during its appraisal , NICE considered that a recommendation more limited than the drug licence could indirectly discriminate against some groups but would be a proportionate means of achieving the legitimate aim of maximising public health. NICE came to a similar conclusion when it considered the appropriateness of making a recommendation based on age through the rapid review.

12. It is recognised that the funding variation request could impact some groups. However, NHS England considers that the proposal to continue to provide access to Paxlovid to treat mild COVID in the highest risk groups and to expand to people aged over 85 years, people in care homes and hospital inpatients over the next year is a proportionate means of:

    - protecting those at highest risk of severe COVID-19 outcomes and patients with protected characteristics who require primary care services for other health conditions. It is known from previous COVID waves that risk of hospitalisation and death are closely associate with age.
    - achieving the legitimate aim of maximising public health in the context of the availability of vaccination for the patients covered by this recommendation and of other COVID-19 treatments for hospitalised patients.
    - ensuring access is provided in an equitable way across the whole NHS and not determined either by where someone lives or their ability to pay for a COVID-19 test.
    - supporting the NHS to prepare for the implementation of NICE guidance in full as required by the legal funding requirement.

13. To mitigate some of the impacts of the funding variation request, NHS England will support ICBs in their planning of COVID-19 services, ensuring they consider the needs of their local populations when determining how services are delivered and how they raise awareness of those services. The use of the NHS England » Healthcare Inequalities Improvement Planning Matrix will be promoted. NHS England will collect information on uptake of testing and of treatment during the period of the funding variation to prepare for further rollout of NICE recommendations no later than the end of the funding variation period and sooner if practicable.

14. We understand that the manufacturer has suggested that the funding variation could result in a significant increase in hospitalisation and deaths. We agree that it is important that healthcare resources are used to avoid preventable hospitalisations and deaths. We note, however, that the data provided by the company does not consider the impact of COVID-19 vaccination or observed COVID-19 incidence or prevalence rates or the actual effectiveness of the treatment. Almost 8 million adults over the age of 65 years have already received a COVID vaccination this autumn. It is therefore misleading to imply that all patients who are covered by the NICE recommendation for Paxlovid will contract COVID-19 or will need to be hospitalised. NHS England's funding variation focuses on people aged 85 years of age and over (recognising the clinical evidence on the additional risk of severe COVID associated with ageing) and our proposal means that anyone in the recommended group who tests positive for COVID-19 and is an inpatient will be able to receive Paxlovid. Those patients who are hospitalised with severe COVID-19 will also be eligible for other COVID-19 treatments which are already recommended.

15. We understand one of the consultation responses was from the Cardiothoracic Patient Group which requested further consideration be given to including a defined group of end stage heart failure patients (those on the transplant list and / or have a long-term ventricular assistance device (LVAD)) in the phased roll out of access to Paxlovid. We have engaged with our clinical leads to understand the risks faced by this group of patients and those faced by other patients on the transplant list. We understand that most patients on the transplant waiting list are already eligible for Paxlovid through the existing TA recommendation. We will therefore include patients with end stage heart failure who are on the transplant waiting list and / or have an LVAD and patients on the organ transplant waiting list to the groups NHS England has proposed to be included in a phased roll out during the funding variation period.

16. NHS England will work with the UK Health Security Agency (UKHSA) to keep incidence and severity of disease under review to inform decisions stepping up and down access to testing and treatment.

Planning for roll out

Preparing for expanding access

17. The NHS fully understands that legally, NICE technology appraisal recommendations require the NHS to plan for implementation as soon as is practical and within the agreed mandated funding period. On approval of this funding variation request, people who test positive for COVID aged over 85, in care homes, who have end stage heart failure patients on the transplant waiting list and / or have an LVAD. and who are hospital inpatients will also

be able to receive Paxlovid within 90 days of the final guidance being published. This would increase the total number of people eligible to access the treatment to around five million.

18. The funding variation period of one year for the other recommended groups is to allow time beyond the usual 90-day implementation period to put in place the necessary treatment pathways and ensure the necessary capacity, knowledge and expertise is in place to support equitable access for the whole expanded population. The one-year variation will also enable further assessment of the new testing model.

19. To support those preparations, the following actions are underway and will continue during the variation period:

    - Introducing a new community pharmacy LFD testing access model from November 2023. This model is estimated to be around £50m a year for around four million currently eligible people.
    - Regional COVID-19 SROs will continue to support ICBs and will come together to share information and best practice as systems complete the transition from pandemic-specific COVID-19 treatment pathways to routine access in the community, including a greater role for primary care.
    - In the absence of government funded population-wide COVID-19 testing, work with the NHS in England is underway to identify options for cost effective testing models, including linking with UKHSA.
    - NHS England will continue to work with NICE and build on the information already shared through this process about the actual cost of testing. The real-world evidence of testing rates, treatment rates and services costs will be collected and shared to ensure the NHS, patients and taxpayers can have confidence that resources are being used in a clinically and cost-effective way.

20. As the feedback from ICBs has shown, it is possible that some areas may be ready sooner than others (within the next year) to expand to the full NICE recommended population. However, NHS England does not think that a phasing approach during the variation, which sees some areas providing access sooner than others, is equitable or practicable. Such an approach would mean access was based on where someone lives. Regional teams have fed back that it would lead to confusion for patients and clinicians and would likely lead to an avoidable increase in pressure on services. In addition, the NHS will need to ensure that wider access to testing is available.

Data collection

21. NHS England aims to complete data collection and initial analysis ahead of winter 2024/25 to inform planning and decisions at the end of the funding variation period – or sooner if possible. Again, NHS England would like to emphasise how we will work with UKHSA to keep incidence and severity of disease under review to inform decisions about the appropriateness of stepping up and down access to testing and treatment, including during the funding variation period.

22. The testing and treatment data NHS England will collect will reveal actual costs, and will inform decisions on how a testing strategy that supports cost-effective access to Paxlovid can be developed and implemented.

23. NICE has found Paxlovid to be clinically and cost effective at the lower end of the NICE threshold. The lower threshold provides some headroom and a guide for how any supporting testing strategy could ensure cost effective usage of Paxlovid is maintained. NHS England estimates that the testing costs would need to be around £75 million for the whole eligible 15 million population (covering tests, supply chain and logistics).

24. NHS England has the actual testing costs for 2022/23 and the year-to-date for 2023/24, but these costs are based on a different access model to the one now underway. NHS England also has an estimate the cost of the new community pharmacy model to be around £50m a year based on a population of four million, but recognises that these costs are uncertain. From January 2024, data will become available based on uptake and spending of the new testing model, which could be lower than estimated.

25. Data will also be available on the number of treatments, and NHS England will continue to work with ICBs to improve its understanding of non-testing costs as access through primary care becomes more routine and less additional commissioned support is required.

26. The aim is to collect six months of data between January to June 2024 and share this with NICE to assist with next steps in planning and decision making.

Testing models

27. The new community pharmacy model assumes all those eligible would need to keep tests at home to use for any flu-like symptoms, given the need for timely access, and assumes one box of tests per patient each year. Although this model is lower cost than the previous UKHSA model, we calculate expanding it to 15 million people could cost an additional £145 million, although recognise that cost is uncertain.

28. Alongside monitoring the actual costs of testing, NHS England will continue to keep under review alternative ways of reducing costs, including how to lower LFD acquisition costs and potential new testing options such as multiplex testing, point of care testing and accessing testing only when symptomatic.

29. NHS England remains clear that access to treatment on the NHS must go hand-in-hand with the ability for patients to access the companion diagnostic free of charge. Self-funded tests can trigger access to treatment but only when the option of obtaining a free test is available. Therefore, we do not consider that a testing model based on self-funded tests alone is appropriate or compliant with the NHS Constitution.

ANNEX A: SUMMARY OF EQUALITIES CONSIDERATIONS

Protected characteristic groups or group facing health inequalities	Equalities impact considerations
Age: older people; middle years; early years; children and young people.	Evidence from previous COVID waves indicates that risk of death and/or severe outcomes from COVID-19 increases with age. The funding variation aims to protect access for the existing highest risk patients, while expanding access to patients aged over 85 and people in care homes. Free LFD testing for highest risk groups, including people over 85, as well as people in care homes to be provided.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions	The Office for National Statistics (ONS) reports that age-related risk of death involving COVID-19 between 24 January and 20 November 2020 in England was 3.1 times greater for more-disabled men (self-reported disability status) and 3.5 times greater for more- disabled women (self-reported disability status) than non-disabled men and women (ONS 2021). Expanding to people over 85 and people in care homes may increase the proportion of people eligible. NHS England does not believe the funding variation otherwise has a disproportionate impact on people with disability.
Race and ethnicity[3]	Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (June 2020), found death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. The report highlights that health conditions that increase risk of severe infection are more common in Black and Minority Ethnic (BAME) groups. The funding variation may have a disproportionate impact on some groups, as there is a higher incidence of chronic disease and multiple long-term conditions in many BAME groups. • Type 2 diabetes is more prevalent in Asian or British Asian groups (16.1%) compared to proportion of that group in England (9.6%). • Obesity is more prevalent in Black, Black British, Caribbean or African groups (6.7%) compared to the proportion of that group in England (4.2%). • Heart failure is more prevalent in white groups (88.3%) compared to proportion of that group in England (81.0%%).
Sex: men; women	In England ~51% of the population are female and ~49% are male. The funding variation may have a small differential impact on men and women associated with specific conditions:

[3] Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. Race and ethnicity includes people from any ethnic group incl. BME communities, non-English speakers, Gypsies, Roma and Travelers, migrants etc.. who experience inequalities so includes addressing the needs of BME communities but is not limited to addressing their needs, it is equally important to recognise the needs of White groups that experience inequalities. The Equality Act 2010 also prohibits discrimination on the basis of nationality and ethnic or national origins, issues related to national origin and nationality.

	• Of patients with BMI >35, around 58% are female. • Of patients with diabetes (any type), around 56% are male. • Of patients with heart failure, around 57% are male.
People or families on a low income Self-funded tests	The funding variation ensures treatment on the NHS goes hand-in-hand with the ability for patients to access the companion diagnostic free of charge. Self-funded tests can trigger access to treatment but only when the option of obtaining a free test is available and this ensures that people on low incomes are not disadvantaged. Evidence suggests that those from lower socio-economic backgrounds are at a higher risk of death and/or severe outcomes from COVID-19 infection. The funding variation may have a disproportionate impact on people and families from lower incomes, who are more likely to have one of the conditions identified in the NICE guidance.
People living in deprived areas	Accessing COVID-19 treatment services via primary care rather than through internet/telephone services is likely to benefit this group. The mortality rates from COVID-19 in the most deprived areas were found to be more than double the least deprived areas. Prevalence of obesity and diabetes reduces is greater in the most deprived quintile. For example, around 24% of people with obesity live in the most deprived quintile in England while around 16% live in the least deprived quintile.
Other groups experiencing health inequalities (please describe) Patients living in care homes	The funding variation will have a significant positive effect on this group as access is being expanded to all patients in care homes within the broader NICE. Data from the Office for National Statistics (ONS) reports since the beginning of the COVID -19 pandemic, there were 173,974 deaths of care home residents in England and Wales, this is an increase of 19.5% compared with the five-year average (145,560 deaths); of these, 42,341 involved COVID-19 accounting for 24.3% of all deaths of care home residents (ONS 2021).
NHS England does not believe that the funding variation will result in any specific additional negative health effects on the following groups: • Gender Reassignment and/or people who identify as transgender • Marriage and Civil Partnership • Pregnancy and Maternity • Religion and belief • Sexual orientation • Looked after children and young people • Carers • Homeless people • People involved in the criminal justice system • People with addictions and/or substance misuse issues • People with poor literacy or health literacy • People living in remote, rural and island locations • Refugees, asylum seekers or those experiencing modern slavery.	