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

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Response of the British In Vitro Diagnostics Association

Executive summary

The in vitro diagnostics (IVD) industry has been a leader in healthcare innovation in recent years and is committed to developing more efficient, effective and accurate diagnostics tests that deliver significant benefits to patients and to the NHS.

The patient benefits of IVD tests include quicker and more accurate testing and an increased chance of improved outcomes, together with a better experience of care. For the NHS, IVDs allow the health service to target treatment better and more effectively, adapting patient pathways and enabling earlier intervention - ultimately using resources in a more efficient way.

As an industry we have already demonstrated success in supporting the uptake of innovative technologies through training and support to NHS organisations. This risk-sharing approach is standard practice within the IVD sector, and demonstrates the support our industry continues to show for the adoption of innovation.

We have identified the following broad issues where change is required to help this process:

- Adoption mechanisms
- Financial incentives
- Quality incentives
- Spread of best practice
- Staff/c Clinical buy-in
- Care pathway redesign
- Collection and spread of evidence
- Risk-sharing

Based on our analysis of these issues and the challenges and barriers facing the spread of change in the NHS, we have set out four priority sets of solutions to support innovation in the NHS:

- There should be stronger national and regional support for change in the NHS
- Financial incentives should be reviewed to drive innovation
- There should be greater accountability for meeting outcomes and quality through innovation
- Evidence on the adoption signals that work must be gathered and shared

These solutions and the mechanisms to deliver them are set out in Section 5 Making it happen. We believe that these solutions and the points raised in our submission provide the opportunity to ensure the rapid and appropriate spread of new technologies, in turn providing improved patient outcomes and efficiency savings for the NHS.

BIVDA looks forward to working with the Innovation Review team to substantiate our recommended solutions in more detail and examine the evidence base needed to support change. Our submission is supported by a number of examples of innovative diagnostic tests that have been developed for use on the NHS.
1. Introduction

The British In Vitro Diagnostics Association (BIVDA) welcomes the opportunity to respond to the NHS Chief Executive Innovation Review and to submit evidence and ideas concerning the adoption and diffusion of innovation and change in the NHS. BIVDA and its members look forward to working with the review team to substantiate and examine, in more detail, the steps need to support the solutions set out in our submission.

BIVDA is the national trade association for companies with major involvement and interest in the IVD industry. IVD tests are used for:

- Early detection or diagnosis of disease
- Screening for disease pre-disposition
- Monitoring of treatment and disease management

BIVDA represents manufacturers and distributors who are active in the UK – in total over 95% of the industry with more than 100 member companies. Members include UK subsidiaries of multinationals, small and medium sized companies and a number of start-up companies who supply diagnostic tools to the NHS for a range of disease areas, including diabetes and cancer.

2. The opportunities for a changing NHS

The IVD industry has been a leader in healthcare innovation in recent years and is committed to developing more efficient, effective and accurate diagnostics tests that deliver significant benefits to patients and to the NHS. 70% of all clinical decisions are based on the results of laboratory or point of care tests using IVD products.

The benefits to patients of IVD tests include quicker and more accurate testing and an increased chance of improved outcomes, together with a better experience of care. The benefits for the NHS include the ability to target treatment better and more effectively, adapting patient pathways and enabling earlier intervention - ultimately using resources in a more efficient way.

### Case study 1: IVD test to discriminate between Inflammatory Bowel Disease and Irritable Bowel Syndrome

- Patients who present with symptoms of possible bowel disease are often required to undergo further examination to obtain a diagnosis, usually involving an invasive and unpleasant test such as a colonoscopy or small bowel radiology

- A quick and simple diagnostic test can be performed on a stool sample to differentiate between organic intestinal diseases such as Inflammatory Bowel Disease (IBD) and functional bowel diseases such as Irritable Bowel Syndrome (IBS), enabling a swift diagnosis and allowing the correct treatment to be initiated

- The benefits of this test to the NHS are simple, non-invasive and low cost. It is ideal for serial monitoring of disease activity and treatment success. It also allows disclosure of treatment failure, allowing patients to avoid prolonged courses of steroid drugs when these are not proving effective. For patients, the test allows for quick diagnosis and screening, thereby avoiding unnecessary referrals and anxiety
BIVDA believes that there is scope to achieve further efficiency savings and improved patient outcomes with the better application of innovative diagnostic technologies and increased focus on spreading good practice of existing diagnostic technologies.

3. How innovation in diagnostics can be supported in the new NHS

BIVDA recognises that the NHS is evolving towards a system where decisions that will affect the diffusion and adoption of innovative technologies are taken at an increasingly devolved and localised level, and our members are adapting their businesses accordingly. Diffusion and adoption of innovation, and spread of change, are affected by a number of factors in a rapidly changing NHS including: new structures and organisations; the culture within organisations and among different types of professionals; and incentives in the system. These must be considered holistically in this review to ensure that innovation in diagnostics is supported in order to drive continued improvement in patient outcomes.

The IVD industry recognises that it has a role to play in working with NHS organisations and other academic and research organisations to build awareness of innovative technologies and share good practice where there is a demonstrable benefit in terms of patient outcomes and efficiencies. BIVDA welcomes the emergence of clinical commissioning groups, supported by clinical networks and senates, as bodies which will increase decision making at local level and potentially act as partners to help spread knowledge of examples of successful local projects in diagnostics and therefore aid diffusion across the NHS.

The challenge will be in translating the changes in the new health system to support adoption of new technologies across the whole of the NHS. BIVDA believes that there will continue to be a need for direction and support from the centre to communicate awareness and understanding of the benefits of innovative technologies which could support consistent and more rapid decision making at local level. This direction could be from the NHS Commissioning Board at both national and regional levels.

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Case study 2: HER2 identification in breast cancer treatment – driving personalised care and avoiding unnecessary costs

- Around 20% of women with breast cancer are positive when tested for the HER2 gene, which is associated with aggressive cancer cell growth. Herceptin is a treatment designed specifically to target the HER2 protein

- Before beginning treatment, patients are required to be tested for their HER2 status. Clinical trials have shown that HER2 positive individuals receiving Herceptin as a treatment experience substantial improvements in survival and quality of life compared to treatment with conventional chemotherapy alone

- The highly targeted nature of the treatment means that response rates are good, and wastage is minimised. HER2-normal tumours will not derive any benefit from Herceptin. It is therefore vitally important that patients who are positive for the protein are identified accurately to ensure that they will benefit from the treatment, and that those who are negative do not receive the treatment unnecessarily
The cost benefits for using diagnostics are very clear, as the annual cost for a patient on Herceptin is estimated at £20,000 per year while the costs of the test is about £225, and the initial screen using immunohistochemistry is much less than this.

The identification of HER2 is a practical example of how diagnostics can be used to guide targeted treatments to deliver personalised healthcare, improve patient outcomes and avoid unnecessary costs.

4. The changes needed to support innovation

The development of new and existing innovative diagnostic tests will require support. We have identified the following themes where change is required to help this process:

- **Adoption mechanisms**: There are multiple points for entry of innovation (i.e. different pathways and processes). The fact that there are different routes for adoption means that the system is sometimes complex and difficult to navigate, with inconsistency between processes in terms of timescale, documentation and decision making. This can hamper the industry from introducing innovative solutions to the NHS as quickly as possible.

  In addition, existing organisations such as the NHS Technology Adoption Centre (NTAC), which have the responsibility to improve uptake of innovative technologies, lack the powers and means of ensuring that such technologies which are proven to have clinical benefits are put to use widely. In some cases, such as with NTAC, this is because of a lack of funding.

  **Solution**: As stated above we see a continued role for mechanisms at national level to support adoption, but these will require committed funding to ensure that they can work effectively. We are aware that there are question marks about the future of NTAC as an organisation but BIVDA is supportive of the role that it plays and sees a continued valuable role for its methodologies.

- **Financial incentives**: There has been a longstanding failure within the NHS to recognise the benefits that IVD tests can have in predicting and preventing diseases and thereby helping to save money in the future. NHS budgets have traditionally been allocated on a departmental basis which has resulted in a failure to make long-term decisions on the overall benefits of expenditure on a particular technology in respect of a patient pathway, particularly in relation to long-term conditions such as diabetes. Such ‘silo-budgeting’ is a key barrier to innovation as it encourages perverse incentives at a local level. For example, even if a technology can deliver an overall saving across a patient pathway it may not be adopted if an individual department has to increase its expenditure to deliver change.

  **Solution**: The key issue to effect change and enable these benefits to be achieved is for there to be appropriate financial incentives in the NHS that encourage recognition of the longer-term value of innovative diagnostic technology. This could involve redesigning tariffs in accordance with a care pathway to ensure that the value of effective diagnostic tests at the appropriate stage is rewarded. This could also involve looking at other comparable healthcare systems which use financial mechanisms such as reimbursement schemes for IVDs to examine how these support increased uptake.
• **Quality incentives:** Incentives such as the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) payments are increasingly important levers in the evolving NHS in rewarding providers for quality care.

**Solution:** To ensure that such mechanisms support diffusion of innovation they will need to be reviewed to ensure that they encourage and reward a longer-term and more holistic approach to planning across a care pathway.

• **Spread of best practice:** There is frequently a lack of awareness among professionals of the availability of and latest developments in IVD testing technologies. There is an absence of clear mechanisms for updating healthcare professionals on new developments that will enable them to use innovative technologies to improve patient outcomes. The onus has traditionally been on industry to inform and educate professionals and approach commissioners. In some cases our members often find that the barrier to adoption of a particular technology within the NHS is less a question of ‘why?’ but rather a case of ‘how’?

**Solution:** The support needed to address this could be in the form of strengthening the dissemination of existing or new national guidance including that developed by the National Institute for Health and Clinical Excellence (NICE), horizon scanning for potential opportunities or barriers to adoption and giving an impetus to unblocking such barriers. The NHS Commissioning Board at national and at regional ‘hub’ level will play a vital role in this process.

• **Staff/clinical buy-in:** It will also be important to disseminate best practice and make evidence more readily available in order to convince staff of the value of using innovative IVD technologies in particular care pathways and create the necessary cultural change.

**Solution:** There is a need to demonstrate how such technologies can help trusts and their staff to meet particular outcomes set under the new NHS Outcomes Framework. In this regard there will be an important role for the new national leads of the five domains of the NHS Outcomes Framework in promoting and spreading innovation to help meet the indicators for which they will be responsible.

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**Case study 3: Supporting patients to better manage their health and clinical needs through diagnostics**

- Patient surveys show that 55% of patients with Atrial Fibrillation would monitor their own international normalized ratio (INR) levels in the community, if they had the choice

- However, a lack of awareness and cultural leadership amongst healthcare professionals has been a barrier to more widespread adoption of Patient Self Testing (PST) and Patient Self-Management (PSM) of their INR levels

- Despite evidence demonstrating improved patient outcome and patient experience, rollout of PST and PSM remains limited across the NHS compared with other European countries. For example, while there are 140,000 patients on PSM in Germany, there are only 17,000 patients practicing PST/PSM in the UK
• **Care pathway redesign:** Adoption of innovative technology can sometimes be hampered by how the different care pathways relate to each other and how they interact. Even if there is a clear recognition from clinical staff of the value of innovations to the patient and to the NHS, the administrative and financial systems provide major blocks as they may not relate to the reality of a particular care pathway.

**Solution:** The solution will be for the NHS Commissioning Board, healthcare professionals and industry to work together in partnership to look at particular care pathways and redesign them in such a way that enables uptake of clinically effective technologies with funding mechanisms aligned to support this. BIVDA is already working with other industry partners and the Department of Health to assess how this can be achieved in diabetes care.

• **Collection and spread of evidence:** There is currently little evidence on how innovative technologies are being mainstreamed effectively in the NHS.

**Solution:** In the same way that best practice needs to be spread to build awareness, mechanisms need to be put in place to ensure that appropriate evidence to support the use of IVDs is gathered and disseminated to show how it can improve health outcomes.

• **Risk-sharing:** Annual budget planning in the NHS is not conducive to long-term investment and this can hamper the adoption of innovative technologies. In some cases, the adoption of new technologies may require significant up-front capital investment which industry is expected to fund.

**Solution:** Industry is committed to exploring innovative and flexible financial mechanisms where the financial burden is shared. Examples of current practice are set out in Section 6.

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**Case study 4: enabling more targeted treatment for patients with non-small cell lung cancer**

- Of the approximately 40,000 new cases of lung cancer diagnosed every year in the UK, around 80% are non-small cell lung cancer

- It has been demonstrated in clinical studies that genetic mutations in individual tumours can cause variations in the response of tumours to certain therapies. Therefore understanding the genetic profile of a patient’s tumour can allow better therapeutic targeting

- One of BIVDA’s members has developed a specific test designed to detect the presence of mutations in the EGFR gene which can affect a patient’s response to the non-small cell lung cancer therapy

- By preselecting patients likely to respond to a therapy and eliminating non-responders, healthcare providers can make considerable cost savings by knowing in advance which therapies will prove to be ineffective rather than using a traditional trial and error method
5. Making it happen

Based on our analysis of the challenges and barriers facing the spread of change in the NHS, we have set out four sets of priority recommendations to support innovation in the NHS:

- There should be stronger national and regional support for change in the NHS
- Financial incentives should be reviewed to drive innovation
- There should be greater accountability for meeting outcomes and quality through innovation
- Evidence on the adoption signals that work must be gathered and shared

We believe that these provide the opportunity to ensure the rapid and appropriate spread of new technologies, providing improved patient outcomes and efficiency savings for the NHS.

**Priority one: Providing national and regional support for change in the NHS**

- NTAC has helped to improve uptake, developing models to guide and support NHS organisations through the adoption process
- NTAC’s methodology should continue to be used to provide guidance on the uptake of new and existing technologies
- Industry should cooperate with organisations using NTAC-type methodology to ensure that guidance is fully evidence-based
- The Department of Health should absorb the principles and operations of NTAC within the new NHS commissioning structures – in particular, the NHS Commissioning Board and its regional bodies
- NHS Commissioning Board hubs should use methodology developed by NTAC to identify areas of potential pathway change. This could include recommending that tariffs are revised to reflect the change in clinical pathways
- NHS Commissioning Board hubs should have responsibility for providing advice to clinical commissioning groups and NHS trusts on the introduction and spread of new technologies
- Hubs should have a dedicated technology planning group to ensure roll out in their region

**Priority two: Driving innovation through financial incentives**

- The Department of Health should seek to review financial incentives to ensure they adequately support change in the NHS
- The development of CQUIN indicators offers an opportunity to incentivise uptake of innovative technologies and spread of change
- As part of the national menu of CQUINs, the NHS Commissioning Board should develop a range of indicators designed to encourage the spread of innovation which commissioners can choose to incorporate into agreements with providers
- As part of the diagnostic appraisal process, NICE should identify suitable CQUIN indicators which could be used by commissioners to incentivise the uptake of relevant innovations
• Providers should be required to demonstrate how the use of medical technologies will contribute to achievement of their selected CQUINs. This could form part of their quality account.

• Departments that achieve the CQUINs should see the financial benefit and be allowed to invest this in further improvements. CQUINs should therefore be developed at the service line level so as to create a stronger link between incentives and specific service change.

• Providers should be required to show how their CQUINs will encourage pathway redesign.

• Providers should include CQUINs which encourage the effective use of in vitro diagnostics, for example:
  o provider can demonstrate that 80% of IVD tests were conducted using a CE-marked test
  o provider can demonstrate that 80% of patients for whom a test was applicable received it.

Priority three: Meeting outcomes and quality through innovation

• In the reformed NHS, the NHS Commissioning Board and local clinical commissioning groups will be held to account on the outcomes they deliver within the NHS Outcomes Framework. There should therefore be a focus on how innovation and change can deliver improved outcomes.

• The domain directors within the NHS Commissioning Board will be accountable for delivering improvements in the outcomes within their domain.

• The national leads of the domains should be responsible for promoting and spreading innovation to help meet the indicators for which they will be responsible. These leads should also work with the regional commissioning hubs to ensure positive examples of innovation are being devolved and spread locally for the benefit of patients.

• Quality accounts should be used to measure and publish the spread of innovation and change at individual NHS trusts. This will allow for benchmarking of individual trusts, highlighting the need for improvement in some areas.

• All providers should set out in their quality account what steps they are taking to encourage the uptake of new technologies, including specific examples.

• All providers should set out what proportion of pathology tests were carried out using a CE-marked test.

Priority four: Gathering evidence on the adoption signals that work

• There is currently little evidence on the effective spread of innovation in the NHS. The Department of Health should commission a study on the diffusion of new technologies in the NHS. The study should look at technologies that have had different adoption signals, for example:
  o A diagnostic test that has been linked to a medicine in a technology appraisal
  o A diagnostic test that has been approved through the Diagnostic Approval Pathway
  o A diagnostic test that was encouraged by NTAC
  o A diagnostic test where none of the above has occurred

• Industry can contribute to the study, providing case studies and analysis where appropriate.

• Following the study, an expert group should be convened to consider the signals to adoption that do and do not work, making recommendations for changes to these signals where appropriate.
6. The IVD industry’s support for uptake of innovative technologies in the NHS

The in vitro diagnostics industry has a history of supporting the uptake of innovative technologies by the NHS through the provision of labour-saving equipment free of charge and education and training for patients and clinical staff. This risk-sharing approach is standard practice within the IVD sector, and demonstrates the support our industry continues to show for the adoption of innovation.

Around 1990, instrumentation started to become available that reduced labour costs by automating the bench work in laboratories. The first obstacle that occurred was that pathology departments, their funding allocated by annual fixed budgets, did not have the money to finance capital purchases of equipment, which at first cost less than £100,000.

**Case study 5: Use of the d-dimer test for patients with preventable venous thromboembolism**

- An estimated 25,000 people die from preventable venous thromboembolism (VTE) in hospital each year – mostly affecting older people, but also children and babies

- Effective diagnosis of VTE, in primary care, can lead to improved mortality rates by ruling out a significant proportion of low risk patients

- A D-Dimer test is a good example of a point of care blood test that can be carried out in primary care and used to rule out VTE. The sample required is from a simple finger prick and a result is given within 8 minutes – thereby avoiding unnecessary hospital attendance

- Significant savings can be achieved in the NHS by accurately diagnosing VTE in a primary care setting. The D-Dimer diagnostic test cost approximately £10, compared to referral costs to secondary care for non-elective spell for VTE of around £1,941

Over the past 20 years the sophistication of this instrumentation has developed enormously – as has technology in all sectors. But because the ability to reduce manual input to the tests has increased, it also means the cost and number of technological elements have increased accordingly. To address this issue, the IVD sector has had to use imaginative financing. The most usual model sees the instrumentation placed free of charge for an agreed contracted time, while the customer laboratory pays for the reagent throughput, usually for all the testing done in the blood sciences laboratories.

There are now fully automated systems available which – for large throughput labs – reduce the operating hands-on time to simply loading blood tubes at one end and ensuring the consumables are kept stocked in the onboard storage. Most instruments will provide alerts if stocks are running low. When a need for repair is imminent, many instruments will also directly alert the company, which can then liaise with the laboratory to schedule a service visit to effect a repair at a time convenient to the laboratory. A similar system allows the use of reagents to be monitored, which means delivery is triggered as required; minimising the need for the pathology department to manage stock levels.
Of course, there are also more simple systems in place that give pathology the flexibility to run specialist tests, and which do not require the financial support that the ‘bread and butter’ workload in blood sciences demands.

We set out below a series of examples demonstrating how the IVD industry is already engaged in supporting the uptake of innovation in the NHS.

- **Support in diabetes care**: The IVD sector provides services that are essential to the delivery of high quality patient care for diabetes. For example, hardware for blood glucose monitoring is provided free of charge by the suppliers of chemical reagents. Educational support is offered to patients, such as: brochures and pamphlets on diabetes testing and management in 15 different languages; software support leaflets; internet sites developed specifically for children; videos and DVDs in six different languages; and diaries to record blood glucose levels. Companies provide telephone customer care helplines staffed by professionals, including 24 hours a day services, freephone services and Asian language services.

  Other diabetes care support provided by industry includes:
  - Training for nurses on blood glucose monitoring etc
  - CD Rom-based learning programme for healthcare professionals
  - Literature and brochures for healthcare professionals involved in diabetes care
  - Study days for diabetes practice nurses
  - Helpline support for diabetes practice nurses
  - Provision of software audit tools for hospitals
  - External quality assurance schemes to assure the quality of the tests performed in point of care testing

  In 2006, it was determined that the aggregated value of service suppliers provided to supplement and support the provision of diabetes testing strips amounted to over £16 million.

- **Training support for clinical staff**: Miniaturisation of laboratory instruments and simplification of their use has allowed industry to provide equipment that can be used at the point of care, e.g. in ICU to measure and monitor blood gas levels. Due to the high level of staff turnover in these clinical areas, industry often supports regular training programmes, rather than one-off training at initial installation.

- **Educational support for pathology**: It has become standard practice in the sector to run regular training courses and user group meetings to provide additional training to laboratory staff, as well as wider educational information in their specialty using external speakers and lecturers. User group meetings in particular – perhaps due to the geographical size of the UK – mean that this is an unusual practice even compared to other western European countries.

- **Managed Equipment Service Contracts**: Many pathology departments, and indeed geographical areas, now operate under Managed Equipment Service (MES). This means one company takes on the management of procuring and supporting all pathology needs for a hospital or hospital group for the contracted period (normally not less than seven years’). The advantage to the NHS is that the procurement eliminates management time in raising and managing invoicing, and other similar requirements, once the initial contract is in
place. The company takes on the risk of the service provision and the Trust can reclaim the VAT for the whole of the pathology expenditure. The pathology manager effectively deals with one supplier instead of a multitude of them.

7. **BIVDA’s response to questions set in the call for evidence**

This submission sets out some of the measures BIVDA are looking to be put forward to help drive the spread of innovation in the NHS. Below we have addressed these recommendations to the questions set out in the consultation.

**What can the NHS and NHS Commissioning Board learn from local, national and international best practice to accelerate the pace and scale of adoption of innovations in the NHS?**

- As set out in our submission, BIVDA has recognised the value of NTAC in improving the uptake of new and existing technologies. However, despite some initial success, the lack of resource and significant powers has meant such bodies have not always been effective in diffusing such technologies

- That is why BIVDA is calling on NTAC to work with the NHS Commissioning Board to ensure that its principles and operations are effectively incorporated into the new NHS structures to ensure best practice examples can be learnt from

- It will also be important for NTAC to work with the NHS Commissioning Board in developing pathway redesign to best meet clinical need and to drive innovation

**Case study 6: Breast Lymph Node (BLN) Assay® - for breast cancer**

This was the first IVD to go through the NTAC process

- **A reduction in acute hospital admissions.** Intra-operative diagnosis reduces the need for a second surgical procedure for 25-30% of patients. NTAC shows that the use of this diagnostic test has the potential to avoid 11,000 second surgeries in the NHS every year

- **Reduction in overall length of stay.** Avoiding a second surgical procedure would save an average of 5 bed days per patient, which equates to reduction of 24,000 bed days every year across the NHS. This equates to a potential saving of £4m on ward costs alone

- **Improved efficiency for the NHS.** A reduction in patient length of stay will improve efficiency and improve patient care pathways. This shows that overall financial savings of £5.01m could be realised in the NHS every year by introducing this technique

**What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

- The emerging NHS Commissioning Board provides a good opportunity for the NHS to support the spread of innovation at a national level. BIVDA welcomes the renewed focus on delivering improvements in outcomes as set out in the NHS Outcomes Framework and the decision to establish the Board to reflect the five domains of the Outcomes Framework
• BIVDA believes the national leads for these five domains should be responsible for promoting and spreading innovation and work with their regional counterparts to ensure this is devolved locally

• Despite a focus on driving innovation, there continues to be a lack of evidence and arrangements in place to measure the effective spread of change in the NHS. BIVDA, therefore, is calling on the Department of Health to work with industry and others to commission a study on the diffusion of technology, including diagnostics, in the NHS

• Once complete, the Department of Health should establish an expert group to consider the study and make a series of recommendations

**What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

• The regional NHS Commissioning Board hubs should work with local clinical commissioning groups in identifying areas of potential pathway change, and specifically look at where innovation through the uptake of technology can look to drive improvements in clinical outcomes

• BIVDA supports the use of quality accounts in the NHS to help patients, commissioners and others in holding providers accountable on the services they provide. However, we also believe these should be used to measure the spread of innovation and change at a NHS trust level

• This data should be made publically available and include specific details and examples of how they are supporting the spread of technology to help improve clinical outcomes. Specifically, BIVDA is calling for providers to set out what proportion of pathology tests were carried out using a CE-marked test

• As part of the quality accounts programme, the Department of Health and NHS Commissioning Board should encourage providers to demonstrate how they are spreading innovation through the use of specific CQUINs. In our submission above, BIVDA has set out, in general terms, what we would imagine such CQUINs looking like

**What specific actions do you believe others, such as industry, academia, patient groups or local authorities, could take to accelerate adoption and spread, and what might encourage them to do so?**

• BIVDA members have extensive experience working with local NHS organisations, patient groups and other parts of industry in helping to drive clinical outcomes through the uptake of diagnostic tests. BIVDA is committed to working at national and local level with these organisations to share best practice and help improve diffusion of technologies across the NHS

• We are keen to work with the Department of Health in helping to deliver on the recommendations we have set out above and, in particular, in building the evidence base for how we can help drive uptake of diagnostic tests
Contact details

For further information about this submission, please contact Doris-Ann Williams MBE, Chief Executive of BIVDA at doris-ann@bivda.com or 020 7957 4633

\[1\] BIVDA Technology Brief No. 5
www.bivda.co.uk/LinkClick.aspx?fileticket=NOI7DN83NFQ%3d&tabid=1195&language=en-GB

\[2\] BIVDA Technology Brief No. 4
www.bivda.co.uk/LinkClick.aspx?fileticket=LLvEwtBy61M%3d&tabid=1195&language=en-GB

\[3\] NHS Technology Assessment Centre, How to why to guides, Breast Lymph Node Assay