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

Respondent ID: 222

Organisation name: Boston Scientific

Type of response: Document
NHS Chief Executive Innovation Report

Survey for ideas to increase the spread of innovation

Introduction

The survey below is taken from the Department of Health call for ideas and evidence on how the adoption and spread of innovation can be accelerated throughout the NHS (see attached introduction letter). The responses to this survey will shape a report to the NHS Chief Executive on innovation in the NHS to be published in November 2011.

This initiative was announced in the Plan for Growth and is being led by Sir Ian Carruthers, Chair of the NHS Life Sciences Innovation Delivery Board and Chief Executive of NHS South West.

ABHI has been invited to input to this report. We would like to hear your views, your ideas and your recommendations. This could include actions for government, the Department of Health, industry, the National Commissioning Board, the NHS, and other sectors.
The survey

The closing date for your responses back to ABHI is close of business Friday 12th August. Our intent is to review responses with the Public Affairs Policy Group the following week and compile and submit an industry response.

Responding to this survey does not preclude you from responding directly to DH. In responding, you might wish to think about the questions below.

1. Contact and organisation details

Please provide the following details:

<table>
<thead>
<tr>
<th>Name of Organisation:</th>
<th>Boston Scientific</th>
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<tbody>
<tr>
<td>Name of Chief contact:</td>
<td>Mark McIntyre</td>
</tr>
<tr>
<td>Contact details (email &amp; phone):</td>
<td><a href="mailto:mark.mcintyre@bsci.com">mark.mcintyre@bsci.com</a>; 0044 7717 300167</td>
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NB – Boston Scientific fully supports the submission from ABHI. The following comments are additions to the ABHI submission.

2. Learning from elsewhere about adoption and spread

What can the NHS and NHS Commissioning Board learn from national and international best practice to accelerate the pace and scale of adoption of innovations throughout the NHS? Please include relevant examples, published papers or other evidence you have found useful.

   a. We are aware of some links between UK-based managers and organisations like Kaiser Permanente. To augment this kind of exchange industry could offer exemplar providers of specific clinical services based in Continental Europe to allow for exchange of best practice that is not only focussed on NHS. **How would this work?** ABHI set up an email address ‘International Good Practice’. NHS colleagues use this to request information on specific therapy/service areas e.g. Primary Angioplasty; Day Case Knee Replacement etc. Companies with a presence in those areas can then respond suggesting hospitals/manager/clinicians with an expertise in the chosen subject and make the necessary introductions.

   b. A number of commercial procurement organisations employ ‘innovation pathfinders’ whose role is to seek new products/ways of doing things within organisations and drive implementation. It would make sense for some of the many people involved in procurement in the NHS to focus more on this type of approach rather than shaving prices on products/services that may no longer be fit for purpose. **How would this work?** Workstream for executive of the Supply Association to contact Chartered Institute of Purchasing and Supply and find successful examples of ‘innovation pathfinders’, which companies they are in, how they operate and how they are measured/rewarded. Large Trusts/Hubs to adopt similar approach.

   a. Greater collaboration on business case development across sectors, as part of primary, secondary and social health integration – move the focus into whole-system benefit and how benefits will be realised. **How would this work?** Each PCT cluster/CCG to have Business Case review team drawn from primary, secondary and social care. Purpose – to rapidly review business cases where the value is derived from across sectors rather than necessarily one Directorate. This could lead to a
joined up approach for investment/disinvestment and make adoption of innovative techniques/technologies part of contract negotiations between providers/CCGs

c. Recognise and embed proven change management principles as part of the ‘Nicholson Challenge’ – major companies/organisations are in a pretty permanent state of flux and have adopted various methodologies for managing that process. How would this work? Jim Easton/Sir Ian Carruthers to review main methodologies e.g. Tipping Point, Kotter etc. Choose one and take a 2-3 year view of implementation. Stick with it and use it as a vehicle to implement new cultural norms around innovation uptake.

Payment by Results – HRG tariff

The new role of the Commissioning Board in the tariff development should include the coding role currently held by Connecting for Health, the HRG design role currently held by the Information Centre, and the price-setting role currently held by the DH Payment by Results team.

There is a vast amount of experience and expertise in these bodies but a clear lack of coordination which would be improved by a ‘PbR/tariff office’ at the Commissioning Board.

We recommend two initiatives regarding PbR tariffs which we believe would have a positive impact on adoption of innovations as well as current best clinical practice:

1) Merge the roles of CfH, IC and PbR team in one single tariff office – with the aim of keeping the knowledge and expertise currently held in these teams

2) REDUCE THE LENGTH OF TIME between the launch of an innovation and its inclusion in the tariff system which can take up to 6 years. Most importantly at this stage: update the OPCS code catalogue every year rather than every 3 years. There is no transparency and no justification for updating OPCS codes (released by Connecting for Health) every 3 years rather than every year.

The below diagram is an illustration of the current ineffective system which has very clear and detrimental impact on the diffusion of innovation:

3) Increase the resources of the Information Centre so there can be a transparent process for HRG design. Currently there is no channel for outside stakeholders to change the HRG tariff paying for a procedure/device. We believe that there should be an online portal where these suggestions could be made and responded to.

<table>
<thead>
<tr>
<th>New product launch</th>
<th>New OPCS code submission</th>
<th>New OPCS code implementation</th>
<th>Reference Costs collected on new code</th>
<th>HRG tariff created or updated</th>
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<tbody>
<tr>
<td>Sept 2011</td>
<td>Sept 2011</td>
<td>April 2014</td>
<td>Up to April 2015</td>
<td>From April 2017</td>
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4) Improve the quality of Reference Costs underpinning the tariff prices by relying on a sample of hospitals with expertise in bottom-up costings rather than all of the NHS hospitals which create bad quality cost data.

5) Define a better governance structure for Payment by Results, with the input of the Industry Associations which can then define a clear strategic vision for the payment system and incentives.

3. Actions at a local level in the NHS

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?

   a. link individual incentive (finance, service management, procurement) to an element of innovation

4. Actions by NHS Partners

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?

   a. industry partners to provide coaching on effective change management techniques

   b. industry to suggest non-UK exemplars and facilitate introduction (this can also be done via clinical contacts)

5. Any other comments

Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?