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

Respondent ID: 200

Organisation name: Medilink UK

Type of response: Document
Medilink UK response to David Nicholson’s Innovation Review

The following response comes from Medilink UK, the National industry support service for the life sciences & health technology industry. In our process we sought to capture the day to day responses we as an organisation get from companies working to get best practice and breakthrough technologies adopted by the NHS. We also requested a response from some of our member companies which we have attached as an appendix to this document. The questionnaires have also been fed in to the ABHI response to help give a solid industry view.

The Medilink UK response seeks to identify three topics that we feel have been exercising healthcare business and industry the most over the past few years in regard to the adoption of best practice and breakthrough technologies, and then goes on to propose some solutions.

**Topic 1 “The Innovation Game”** How the “I” word has been allowed to sideline the critical need to adopt and diffuse current global best practice and breakthrough technologies into the UK healthcare system.

There are existing stimuli for creating new and innovative technologies and medicines through the auspices of the Science Councils, BiS, TSB etc. Surely the challenge for the NHS is to

1. Adopt current best practice and breakthrough technologies which are being utilised in other global healthcare markets
2. Diffuse existing single site adoption of best practice and breakthrough technologies, across the whole of the NHS.

In the past under the old political administration there were various attempts to push innovation seeing the DH and NHS introducing a whole raft of initiatives because there existed a target based regime(18 weeks, QIPP and waiting times etc). As potential beneficiaries of this approach industry would have to ask what has been the impact of these attempts by NHS boards and the Department for Health to “shoehorn” from the “top down” innovation in to a system which they themselves readily admit they have no command or control of.

**Q.** Will devolving decision making down to a level closer to the clinician be a potential game changer for the adoption of best practice and breakthrough technologies?

**A.** Only if industry can clearly gain access to the new influencers and be able to clearly identify who at a local and regional level will be responsible for delivering the efficiencies required, whilst at the same time being accountable for the best quality of care being delivered to a more informed and demanding customer. Industry has many times experienced products which represent best value for money, that deliver the savings required by the NHS customer, still not being adopted for the most arbitrary or spurious reasons.
**Solution**

Medilink UK would propose a raft of localised adoption initiatives and services combining to produce a national dispersal approach for best practice and breakthrough technologies, including:

A local and national audit, carried out jointly between industry and the NHS, of non-adopted and adopted but not dispersed, best practice and breakthrough technologies. Once produced, this audit would provide an updatable set of local and national uptake metrics. These metrics could then be used to strengthen the use of penalties and incentives to change adoption behaviour within the NHS.

The development of a national quality standards would be developed from the above activity, and would produce a paradigm shift within the culture of the NHS by embedding uptake of “best clinical practice” into management objectives whilst Incentivising procurement to become “enablers” of best clinical practice, rather than pushing against it. This could potentially be achieved by revising job objectives to focus on value not just price.

Local and national strategic oversight of tariffs to avoid perverse incentives such as the current penalisation of outpatient and home-based procedures versus those performed in the day-case setting (This requires strong local and national leadership on this issue).

Local and national "showcasing" initiatives and settings should be provided encouraging whole scale adoption and dispersal of best practice (ref: NHS Showcase hospitals HCAI initiative.)

Prior to the above showcasing activity the NHS and industry need to work with best practice and breakthrough technologies on nationally recognised pre-adoption evidence requirements. (ref: topic 2)

**Topic 2. The right sort of evidence to drive adoption and diffusion in the NHS**

Bearing in mind that only 5% of NICE’s output is medical technology-related, how does industry generate the evidence required by the NHS in order to create scalable adoption? Even if there is a positive NICE evaluation, there is no compulsion in the system to adopt or even to consider the adoption of said technology.

If a technology or product has been assessed, adopted and regularly used in other global healthcare systems, why is this not considered to be admissible evidence for the NHS?

If a technology or product has been evaluated, trialled and then adopted and used in one of many hundreds of pilots conducted at either a local or regional level within the NHS, why is this not considered to be sufficient evidence for adoption and diffusion outside of the orbit of the pilot location? (Even if a pilot is conducted at a national level, as with the Whole System Demonstrator for Tele Health, there appears little if no compulsion to adopt.)

If a technology or product has been assessed and championed by a NHS or DH Innovation initiative, created with the sole purpose of addressing what Derek Wanless describes as the slow
and late adoption of innovation in the NHS (National innovation Centre, Regional Innovation Hubs, National Technology Adoption Centre, Centre for Evidence Based Purchasing and the current ITAPP program), why is there still no sign of systemised adoption of the resulting best practice?

There is obviously a distinct gap between the NHS’s desire for the creation of evidence and its ability to process the evidence in order to facilitate adoption and diffusion. This is due, mainly, to the fact that there is a lack of any accountability for not making evidence-based decisions within the NHS, and there are insufficient incentives within the system to take on board any type of evidence which changes existing practice, causing the status quo to constantly prevail.

As an industry we have heard recent rhetoric from senior NHS directors and the Department around the need to introduce a “Comply or Explain” regime within the NHS in order to drive through the reforms and savings targets. Perhaps there is a similar reward and accountability role to be played by the National Commissioning Board and the localised commissioning structures with regard to the adoption of evidence-based best practice.

**Solution**

There needs to be a simplified evidence and business case pathway at local and then national level to speed up the adoption and dispersal of best practice and breakthrough technologies, which will importantly reduce the cost to procure for the NHS and the cost to serve for industry. Medilink UK would propose the creation of the following initiatives and services:

Innovation and procurement surgeries, managed jointly by the Service and industry, delivered at a local level and paid for by industry, which would provide UK companies who are either developing or have developed best practice and breakthrough technologies and need to understand what is required in the form of evidence and data to promote adoption and dispersal of said technologies through the NHS. These surgeries will allow SMEs and large companies to save time and money whilst saving the NHS time and money. They will also provide a stream of best practice innovations for the NHS ITAPP / QIPP pipeline, as well as potentially widening SME involvement in NHS procurement, which is stated government intent.

Medilink UK recommends that the NHS invests more resource into MTEP and ITAPP and encourages the implementation of MTEP, NICE Guidelines and the ITAPP outcomes in order to influence best clinical practice and link to nationally agreed CQUIN metrics. This would Increase the value of CQUIN which in turn would amplify the implementation signal to the Service.

Medilink UK recommends that medical technology evaluations be unbundled from clinical trial protocols and methodologies and introduce specialist ethics approvals provision.
Topic 3 “Nothing for me! Without me!”

Will the reforms really mean choice for patients, will the voice of the customer truly be heard, and if so how will that voice be articulated into demand?

The challenge over the next few years is how the NHS can work with patients and industry to understand the emerging opportunities and subsequent demand for the adoption of best practice and breakthrough technologies (stimulated by factors such as social media and internet technology) whilst at the same time delivering efficiency savings to NHS management.

How can clinicians and workers respond to this demand, if they themselves are not responsible for being up to date with the current state of art in clinical practice and technological advances?

How can industry play their part in helping to make sure that they are appraised with all the information on current state of art in global best practice and breakthrough technologies?

Solution

Previously the department Health Innovation Education Clusters created at a local level. In the instances where these are operating well, they provide a unique opportunity for clinicians, academics and industry to look at particular challenges within the Service. Working together to stimulate innovative breakthrough technologies and service solutions. They also looked at the workforce education implications of service redesign brought about by disruptive innovative technologies.

One of the most interesting things industry has learnt in its interactions with commissioner and clinical groups, is how prior to the interaction commissioners and clinicians were basing their estimates of demand and even framing tender requests around old practice and old technology and product, because they had never had the time or opportunity to appraise themselves on what currently state of art. We felt at least the HIEC’s could provide an environment where this could be expressed.

In working with these HIEC structures as they formed it always struck us that if a HIEC were given appropriate non tokenistic engagement with the patient community who have an interest in their challenge area. You would have the potential to create communities of interest who would research then champion evidenced based best practice adoption back in to the service.

Not only would we recommend patient involvement in these communities of interest, we would, informed from our past experience of these type of initiatives, recommend that they be governed by patient interest. This may counter existing practice of...

1. Academia dominated partnerships which ultimately create the need for further research.
2. NHS/Department led partnerships which ultimately protect the status quo and current practice.
3. Industry led interactions which could be seen as only interested as shipping more existing or new product.
There would in fact be the possibility of producing pragmatic results which benefit the patient experience whilst being weighted with the need to deliver healthcare cost effectively

Appendix

Medilink UK Survey Responses

Dear Tony

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 that you have found useful.

We have been delivering an award winning (3x HSJ, 1 x NAPC and 2 x Medilink) community cardiology service for a primary care trust.

Would the NHS like to know how to deploy a community cardiology service at scale, with all the software needed, all the boxes ticked and provide true vertical integration. If so then please contact me.

Why are Independent sector providers viewed with such scepticism and caution, we are over-governed in order to deliver what are viewed by many NHS so called managers, many politicians as "acceptable services" when in fact they are excellent services often delivered at a lower cost than the NHS can deliver at.

Patients unfortunately have a perception that Independent sector providers will rip off NHS organisations and deliver a sub standard service. Like any industry sector, when an error is made, it needs to be investigated, learning needs to take place and measures put in place so it doesn't happen again. Such business principles are common sense and are laid down in many businesses in the form of BSI ISO 9001:2008. These are robust internal management tools that enable vertical audit and are subject to annual inspection by auditors. This is distinctly different to a company that is certified by a third party organisation to meet ISO 9001 and does not have robust inspection and re-certification procedures. The cost for this is relatively small and should be encouraged further and successful companies with BSI Accreditation be seen as predictors of beaconicity.

Many NHS organisations are also insular, there is a culture of one. The NHS is that, National not regional, although commissioning needs need to reflect local pressures. There is no reason why a service that works well in one part of the country cannot be used in another. If it has been done once successfully, why do we need to waste time and effort and much needed cash in allowing someone to try and duplicate the service from scratch. I am aware of the Innovation Centre etc, how much private sector initiative and best practice is in there?

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?
They need to open their eyes, look at what works, look at their needs and either ask for help in setting up the service themselves or bring in an external organisation to do it for them. This should not be seen as failure or incompetence. The collaborative nature of sharing best practice not only reduces financial expenditure but improves patient outcome.

There should be a list of which companies can do what. So if commissioner or GP A, wants a service B, he can go and look up a list of qualified providers, at the click of a button, they should be able to contact them all.

**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?

We are willing to share our experiences and collaborate with NHS organisations.

The move towards AQP rather than having to duplicate huge volumes of paperwork is a great step forwards, but let's see it enforced and adopted by all not just a few organisations. This isn't rocket science.

Under the previous Government vast sized long term contracts were given to large multinationals which have not yielded the success expected, hopefully the current government will learn from their predecessor's mistakes and award contracts on merit.

Many NHS organisations had their budgets top sliced to prop up these contracts and were effectively forced to use providers when better quality or cheaper alternatives were available locally. How is this progress?

**Any other comments?**

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

As a Director of a SME healthcare company, I get very frustrated by the excessive paperwork, red tape and the unequal partner status. SMEs are prepared to take risks but we should not be abused and held almost at gunpoint due to organisational inefficiencies.

Whilst guaranteed minimum volumes would be a step back, there should be some measure in place to offer baseline activity over the time of the contract. It is unfair to expect companies to go through the tender process, AWP or AQP processes, put in place equipment and staffing only for the goalposts to move at a later stage or preference be given to larger providers.

This country has a huge amount of talent to share not just internally but with the rest of the world. We are the envy of the world with our healthcare system but it is creaking around the joints not just financially.

This government's steps are what is needed, but organisational resistance to change and the insular culture makes it very difficult to make effective progress at a rate that is needed. The problem is not at governmental level but at local level, where political infighting, personalities and personal ambition detract from the job in hand which is improving services for patients, improving outcomes and saving money.

You keep asking of third party organisations such as the private sector what to do, we are not a free consultancy service. We don't like having to respond to a scoping exercise to give our ideas and IP to organisations. We don't like spending hundreds of hours working up a tender response for it to be given to the incumbent because that is easiest to do.
I don’t like being threatened by someone at SHA level because I challenged a decision that was made. Perhaps I should have gone public after she accidentally included me in a number of replies to colleagues. Thankfully she apologised.

Dear Tony

There are better-qualified people than me to comment on this issue but what we’ve noticed with all our work into the NHS is that there are so many disconnects throughout the organisation – up/down, across, between patients/clinicians. Think the failure of what was to be the ‘panacea’ of the NHS - the IT system - embodies where it’s all going wrong.

Here’s the solution: get everyone who works in the NHS unified in a common sense of purpose (keep all Britons healthy) and facing in the same direction as they’re all doing thing ‘the NHS way’ (excellently, innovatively, carefully etc). That would free up the front line to take decisions. That would bring about CONTROLLED innovation providing it was slipstreamed with good working practice – eg you can’t have everyone going off spending £40,000 a piece of kit. Those decisions would probably have to go a multi-discipline committee but those decisions are rare in comparison with the common custom and practice which is what’s stifling so much innovation/talent and discretionary effort in the NHS from what I hear.

Dear Darren

I found that I did not have much to say about the NHS spreading of innovation; I have not worked in the NHS for more than 20 years and I am not in front line contact with the NHS (only contact is on the R&D side).

From afar, the introduction and spread of innovation would appear to be a classic change management case. I attach a paper on the classic traps.

Some small comments follow.

*General comment on culture in general:* Obsolescence and stagnation occurred in Japan and China a few hundred years ago when, for different reasons, the cultures became introverted and contact with foreigners was suppressed. Innovation was discouraged in favour of maintaining the tradition of the ruling classes, setting society back for 100’s of years. Today it seems in the UK that we regard innovations as costly, the promotion of the Industry as exaggerated, academic medicine as superfluous and take the accountant’s view that it is good if the work of innovation moves to the cheapest region of the world. This culture pervades both public and
private institutions, and works against innovation in the UK. Professor Sheridan has written about this and about the decline of academic medicine in the UK, which I believe touches on some of the issues.

Culturally, there has to be a focus on research and innovation. The best Hospital based clinical groups are constantly measuring the outcomes of their patients and constantly trialling new ideas (not necessarily trials associated with the Industry, they may be low tech, low cost trials). As a consequence they continually implement small changes that they believe will benefit the patient. You have seen my slides on recruitment (available if needed).

**Small vs large:** the Finnish consortium of ICU units has largely moved to electronic record keeping and these records can be combined for data analysis. As a consequence, prospective studies can be performed easily using data normally recorded and indeed Finnish ICUs have a higher level of electronic record keeping compared to the typical UK counterparts. The lesson might be to allow streamlining of the data collection between similar units with a similar purpose, rather than build an all-encompassing, expensive system that doesn’t satisfy everyone. Small focussed projects might serve as good pilots before widespread dissemination.

**Who owns innovation?:** Observers often say that innovation should be created by Academia, the NHS and Industry – that no group in particular “owns” innovation. In this respect, I think Medilink EM is working in the right direction by bringing together the three groups and building trust / finding common ground.

**How to engage industry:** My thought would be to work with industry to establish the unmet need. At least in the therapeutic areas I work in, this has not been well done in the past although I note the the NHS is now setting out unmet needs in eg cardiology. I suppose global unmet needs will drive the large companies, local needs may excite the SMEs.

This is all I can think of for now, hope it is helpful,

Best Wishes,

Raymond
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 and Medilink UK are supporting them in this. 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 response to Medilink East Midlands is **5.00pm on Thursday 11th 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:

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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.

I was recently asked to give a presentation on “The Inhaler Landscape in 2035 – A Speculation” to a group of the leading workers in the field of respiratory drug administration concerned with the future technical development of portable and other inhalation devices. The Conference is reported in *J Aerosol Med & Pulmonary Delivery* 2010; 23: Supp 2: S25-28.
Whilst developing this presentation I came across work at Harvard Business School by Clayton Christensen on the nature of innovation and how innovative technology enters society. I drew heavily on his work and particularly his book "Seeing What's Next. Using the theories of innovation to predict industry change" (Christensen, Anthony & Roth, Harvard Business School Press 2004). I developed this presentation further and discussed the approach at a London Conference “Dry Powder Inhalers” under the Management Forum banner this year.

A key idea in Christensen’s work is to give a useful perspective to innovation, which I suggest for NHS purposes might facilitate how innovation is managed. I listened to a presentation on innovation in the NHS at an East Midlands meeting recently and was struck by the unstructured nature of the management of innovation. There was understanding of innovation per se, but not how to dissect, understand and manage it.

In brief:-

Innovation can be separated into three classes, sustaining, disruptive and revolutionary.

Sustaining innovation is an idea/proposal that builds on a known system e.g. a modern railway engine is composed of add-ons from Stevenson’s Rocket but is basically the same idea – a power pack driving wheels running on iron lines. Modifications to surgical instruments, drug formulations etc are probably all sustaining in character.

Disruptive innovation is where a proposal/idea appears that will do a known task in a completely different way e.g. the slide rule was replaced by the electronic calculator; gelatin film photography was replaced by digital photography. The new idea might be cheaper and therefore very attractive, or more expensive but offer new opportunities.

Revolutionary innovation is infrequent and generally is unmanageable and unpredictable in its effects e.g. the Industrial Revolution, and a better example more recently, the Internet, which is busy undermining the legal system, creating billionaires and threatening governments. The NHS might look at identifying and allowing sustaining innovation to be managed locally, with appropriate guide lines. Disruptive innovation has definite characteristics e.g. will be opposed by incumbents who have an interest in prolonging the status quo of a current idea, may be scorned by “experts”, looks silly and expensive etc and needs a mechanism for picking it out of local management and developing in a separate area. It will be generally more risky and expensive but generates real change and is the type to look out for.. Revolutionary innovation is fortunately rare…. !

### 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?

I suggest some group needs to be able to distinguish ideas that are sustaining and are built-ons to known methods. They could be developed locally.

Crucially they need to be able to recognise ideas that are disruptive and might be better developed in a “protected” environment (3M had “skunk works” for these).

### 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?

95% of the ideas coming forward will be sustaining innovation.
It is really difficult to recognise where disruptive innovation is needed as there will be opposition of some sort (actually it is quite easy in one sense at the moment since the UK needs to innovate or perish!"

However this task, disruptive innovation, should in my view be the real task of academics certainly (new knowledge), possibly industrial groups.

For example in the field of portable inhalers, all the current ideas are clearly classifiable as sustaining innovation proposals on one of the three types of inhalers we have had for the last 50 years viz pressurised, dry powder and nebulisers. New dry powder inhalers occur by the score and are little new, just improvements. But patients have real difficulty using inhalers properly (see a vast literature e.g. Inhaler mishandling remains common in real life and is associated with reduced disease control. Melani et al; Respir Med 2011 Jun;105(6):930-938.Epub 2011 Mar 2.)

To leap forward we need a disruptive innovation and I would like to try to get academic groups as well as my own start-up company to look at the potential of nanoparticles in respiratory drug administration.

Thus, a group or groups in the NHS might be temporarily convened to identify where disruptive innovation is needed and employ academic groups to focus on these.

(You have probably already done it of course!)

5.

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

Yes. It’s not easy!
NHS Chief Executive Innovation Report
Survey for ideas to increase the spread of innovation

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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.

The German system uses a nominated individual Kränkenkasse (KK) [health insurance fund] to review the application for reimbursement of a technology/medical device/technique. Once approved the other KKs allow the listing of the tested technology – without carrying out their own assessments. One of the issues all companies with innovation face is that the individual Hospital Trust or PCT in the UK
seem to think they need to ‘reinvent the wheel’ by insisting on an assessment – even if it has been carried out in a separate Hospital or Community Trust or an NHS Assessment Centre. Since the scenario between each geographical Trust or PCT is unlikely to be significantly different, this is frustrating to manufacturers and is wasteful, over time, of earlier clinical and cost effective practices. There is also a disconnect between Industry and ‘NHS Management’ that precludes the formation of a perfect triangle with the Clinicians being the third side. In the USA, Innovation goes directly from Industry to Clinician, with ‘Management’ only being involved when a pricing/terms aspect is introduced. Their influence only becomes predominant when Innovation becomes routine and uptake is highly significant. Until that point the access to ‘Innovation Budgets’ allows pioneering approaches by enthusiastic centres.

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?
As above – accept the findings of NHS Assessment Centres/Assessing Trust or be penalised for failing to do so.

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?
As above, get input from all those parties [if appropriate] in one location and present that as the example case for others to action in their similar practice.

Any other comments

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

A very simple one – any organisation who has more than 5 people sitting on ‘formularies’ or ‘product assessment committees’ is a waste of space. Make decisions quickly and get innovation in place. If any further information – from other locations or from actual use of a technology/medical device/technique – changes the view of that benefit [clinical or financial], it can be removed from use. The NHS is paralysed by the key fears of its clinical and management staff – “if I actually make a decision and anything goes awry, I will be blamed and could lose my job” End result is no-one makes a decision on innovation until much later and with significant clinical and cost benefit being lost in the interim period. They also cannot be bothered to go through the rigmarole of the many layers of bureaucracy and committees to bring in something new – inertia always wins. In the past a clinical judgement by a doctor or nurse to introduce innovation was discussed with colleagues in formally and tried accordingly. If it worked they kept it in the procedure; if not it was disc
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### 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.

Much can be learnt from the study of national/international best practice, however, much can also be learnt from the retrospective analysis of initiatives which failed to deliver as expected.

### 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?

In an uncertain and changing work environment it is perhaps unsurprising that innovation is not always viewed as a priority. In order to fully embrace innovation a consistent work environment is essential which includes clear and effective communication channels, a clearly delineated chain of command and an acknowledged/formal dissemination path for innovation (amongst other things). Without both effective communication and a specified person to take overall responsibility for the dissemination of innovative practices, innovation will never spread widely enough to become embedded as good practice. The adoption of innovation needs to become a self fulfilling prophecy – the benefit of innovation means that future innovation will be embraced - however, both time and pro-active support are essential to allow this pathway to mature.

In future the NHS will have to work with Social services to ensure seamless “health and social care” is delivered in an optimal manner. This agenda clearly provides major opportunities for innovation around ‘products’, ‘services’ and ‘systems’ that will help deliver this goal. This will mean developing new business and service models underpinned by the relevant products and services - it should be a rich theme for innovation as the old healthcare delivery models are replaced by new delivery modes, and this an area of innovation where best practice can be established and applied form many other sectors.

**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?

From an academic perspective, there are two significant issues around securing NHS take-up of effective innovations, namely identifying who, within the NHS super-structure, is the most appropriate person to approach to initiate the take up of the idea outside the environment of its creation (which may or may not involve participation with an element drawn from the NHS), and the financial burden associated with moving an innovative idea from the proof of concept stage to a fully fledged intervention. The first issue could be resolved by more effective communication from the NHS, and the NIHR can play a significant role in addressing the second – currently the NIHR Research Design Service provide excellent advice about the structure of research projects and their methodologies; however, for more advance concepts that require supply chains etc, their advice is less robust. This may be an area where more could be done to support innovation e.g. by drawing on best practice from tech. transfer offices in the HEI sector.

**Any other comments**

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

Medicine is an evidence based science, and the adoption of innovative methods or techniques will only be facilitated if sufficient evidence is presented. Attempts to curtail the evidence trail will lead to the innovation being viewed with scepticism, and will damage the process of getting innovations adopted by users. Whilst it is essential that innovation is embraced and adopted, this must only happen once the innovation is fully tested and shown to be suitably effective – this stage in the innovation pathway is time consuming but cannot and must not be rushed for the sake of heralding a new dawn. The evidence assessment cycle is only complete once the results are published in peer reviewed documents or journals. Without this step, findings will not be incorporated into the formal evidence base (NICE and NHS Evidence) or into other systematic reviews. It is equally important to fully report negative findings to sensibly limit the continuing trials of unsuccessful innovations.
Introduction
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The survey
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<th>Name of Organisation:</th>
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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.
**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?

Uptake and proliferation of innovative products are hampered by the current procurement systems and despite efforts to centralise and simplify procurement difficulties experienced by companies have been exacerbated by an extra layer of bureaucracy imposed by Foundation Trusts. Whilst we all appreciate securing best value should be a priority, receptivity to new products and methodologies remains an issue with cost at point of entry to the NHS being the main consideration and little or no weight being given to other considerations such as reduction in bed days. A more effective costing model, used by all procurement officers would be most welcome— and I do realise the challenge that presents.

There are a number of trusts that have provide themselves to be open to new ways of working and have some way in changing the culture within their organisation but these are few and it has not been possible to share good practice effectively due to the "not created here" culture. With the demise of the SHAs this will be even more difficult I fear as there will be no incentive for trusts to work together and share innovative ways of working. A way for trusts (primary and secondary) and GP commissioners to collaborate on specific patient pathways as pilots would add value and has already been done in some cases but ensuring that the evidence base for the efficacy of the impact is robust and readily adoptable by others requires support.

**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?

I think a lot could be achieved by using a common costing model for new products and methodologies developed by the stakeholders (NHS, industry and academia). Furthermore, adoption of new products takes time and support and an independent, small, roving team to support open innovation, with costs possibly shared between a group of trusts could potentially ensure that new products are systematically trialled – yes some may not be fit for purpose and will fall by the wayside but conversely good opportunities will not be missed.

**Any other comments**

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

I’m well into my second decade working at the interface of academia/industry/ NHS and despite many initiatives (ICT, culture change, organisational ……) not much seems to have changed. The receptivity of NHS workers at all levels to new and better ways of working is encouraging but it is demoralising to see so many good ideas cast aside as they don’t fit adequately into an antiquated model. As a citizen and professional I would love to see system wide change but as a patient I will be content with hospitals in my area being the very best they can. Given the size of the NHS perhaps a bottom up would be more effective in the long run?
**NHS Chief Executive Innovation Report**
Survey for ideas to increase the spread of innovation

**Introduction**
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**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.

Many parts of the NHS do not now have good central points of contact for the identification, development, adoption and commercialisation of innovations in the NHS. Funding for the bodies that were set up to carry out much of that work (The NHS Innovation Hubs) has been drastically cut or removed altogether. I believe that this was short sighted. This has left the role in the hands of individual managers at individual Trusts who do not have the experience or time to carry out such functions.

The University Sector has successfully applied the use of technology transfer managers, acting in a similar manner to the NHS Innovations Hubs, to carry out the similar function in University Sector. Without dedicated national or regional teams, such as the Hubs, to identify and promote the adoption of innovations, then I do not believe that matters will improve in the NHS.
**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?

I believe that the regional NHS Innovation Hubs (or something similar) need to be reinstated with adequate funding. This requires teams of people who are used to identifying and promoting innovations, rather than individual managers at individual Trusts who will not be focused on that aim.

**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? The Hubs did provide a central point for contact between the NHS and industry. Getting back that central points of contact is important.

**Any other comments**

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

I must point out that I have no direct links with any of the NHS Innovation hubs. However, I have worked with them in the West Midlands and NHS Innovations South East as a patent attorney for them. It is quite clear that the demise of many of the hubs now means that many local Trusts are missing opportunities to develop innovations. I believe that the Hubs were trying, with very minimal resources to do that and the reinstatement of such a hub based system would assist the NHS.

Dear Darren et al

I've taken a look at the survey. My response is very simple, and doesn't need a form – read, understand and implement the findings of NESTA on Innovation.

This is meant most sincerely.

Kind regards

Graham

Graham English
Director
Fontis
NHS Chief Executive Innovation Report
Survey for ideas to increase the spread of innovation

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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.

Crowd sourcing is the latest buzz term being bandied about by those charged with nurturing innovation in large organisations – gathering free IP is another description. The NHS certainly has no shortage of feedstock in this regard but achieving a faster take up of ideas is quite
another thing. The links below include topics and responses by design professionals contributing to Linkedin forums – lots of insight here but no firm conclusions or directions.

http://www.linkedin.com/groups/Front-End-Innovation-41615?home=&gid=41615&trk=anet_ug_hm
http://www.linkedin.com/groupItem?view=&gid=111879&type=member&item=62725559&qid=90c22773-1443-4191-956e-cf7bfe9ba203&trk=group_most_popular-bttl&goback=%2Egmp_111879

Incentives and buy-in seem to be the major prerequisites in adoption – in the final analysis this is as much about culture as it is about best practise or the latest methodologies. In terms of spread, this is probably down to comprehensive internal PR and ensuring a grassroots understanding of the importance of innovating.

**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?

Incentives and buy-in….Get teams together and download the ideas in group sessions. Encourage people to get involved……but, ensure the results are acted upon – People also need to see that their ideas and enthusiasm are recognised and rewarded. It’s not rocket science – this sort of thing has been going on in industry for years. You must have champions.

**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?

PR is at the centre of this – moving hearts and minds is one thing but getting people off their butts to do something is quite another. Sweeteners might help - bundling the message with fun activities, using celebrity endorsement, organising competitions (ahhh!!) You must have champions.

**Any other comments**

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

You must have champions…

**NHS Chief Executive Innovation Report**

**Survey for ideas to increase the spread of innovation**

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Note: Triteq are a design house carrying out medical product designs for many companies from early stage to large multinationals. The responses are based on our experience of many companies; however we are restricted in the detail we can provide because of non-disclosure agreements with our clients. As such the responses are highly product based rather than service based.

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**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.

The pace of adoption of a new product within the NHS is very slow, this can often be many years from the initial design. The speed depends on the marketing strategy of the companies selling the product. Often they will use a paid clinical trial as a pre-marketing tool to get buy-in from potential NHS contacts.

The sell into NHS is also difficult due to the budgeting structure within the NHS. The cost of a device may be initially high causing an issue with the initial buy price, however the cost saving could be in patient treatment time, or in the number of repeat treatments or home treatment rather than hospitalisation. Each of these has a different budget and there doesn’t seem to be much account taken of the total business case for a product when buying.

This causes the development of products to be based on different business models, such as deliberately designing in a disposable element to create an on-going revenue stream and providing the actual device at cost plus a small margin. This will cost the NHS far more in the long term but is far easier to sell. This practice is common place in new product designs for the NHS now and it is increasing costs in waste handling and disposal over the medium to long term.
In addition, NHS Trusts often have their own buying strategy and it can seem like a complete re-marketing of the product for each area rather than a unified acceptance of a business case for a product.

**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?

Often new devices require a change in working practices to be adopted. This is often part of the business case for the device. This change in work practices is often the most difficult part of a product introduction and education of the intended users is key. Again it would be good if this type of training were available to help with identification and use of best practice for new innovations.

Funding to commercialise innovations is also sparse because investment capitalists see the investment return as being very long term for medical product development. As such it is high risk. More grant funded developments of innovative products should be available from the NHS if a substantiated business case can be created for the new innovation.

**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?

Academia is notoriously slow at providing services on a commercial basis, however they do provide a knowledge base on which to base new innovative products. Some universities such as Manchester, Imperial, Oxford and Cambridge are set up to help commercialise innovative ideas. Most other universities do not consider this. It would be very useful if they all did.

Getting the initial design and business case correct is the key to commercial success and quick adoption.

I have never seen any local authority help with new product development or adoption in any way, however they could help to access many elderly patients and provide input for product improvements or new requirements.

**Any other comments**

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

There are lots of innovative ideas in the NHS which have a good business case in terms of reducing the amount of hospital time required. I am aware of many which would save the NHS a considerable amount in the long term, save lives and improve quality of life of the patients.

However, because the private investment funding is not available due to the risks involved in medical product development, and because little grant funding is available, the projects are stalled. Without a fundamental change in the way these innovations are funded there will be little progress in getting the innovations to the product stage. A technical review and a business case review should be carried out and if the innovative idea stands up to this critical analysis then funding should be provided for the development directly from Government, Grants etc.

**Dear Kevin**
Graham Hall, MD, Brandon Medical Ltd; NHS Decision making process is averse to change. Decisions are often made by teams of NHS employees where one person’s job is to promote the change (innovation) while the rest of the people in the room try to find a reason not to change. The predominant culture is ultra conservative.

Evidence and Trials. The culture of working with industry to develop new ideas into innovative products and process is broken. Lots of products and processes don’t need formal clinical trials but they do need engagement with hospitals and clinicians to develop them and make them suitable for the NHS to adopt. ISO9000, ISO13485 and the Medical Devices Regulations all require industry to ‘validate’ processes and products. This is very difficult for SMEs because there is no system to engage with the NHS to do the validation.

No Roll Our Process. We see fantastic implementations of innovations on individual sites that are never rolled our across the NHS. The NHS doesn’t seem to have any strategy or process for rolling our successful innovations.

Lack of engagement with local industry. I think there should be an industrial liaison department set up in every hospital with responsibility for generating a joint programme of development work between the hospital and the local medical companies. This should aim to develop the products/service that the companies specialise in.

NHS and TSB “pull” projects don’t help most companies. The NHS and TSB dictating what they want is a good idea but it can’t help most of our industry. Each company is a specialist in its own products and services, so being told the NHS/TSB wants something you don’t do is of zero value. Companies are experts in their products and services and often know much better than the NHS client what can be done to create improved outcomes for the NHS. It would be much more effective for the NHS and the companies, if there was a focus on developing the products and services that our companies specialise in to create better outcomes for the NHS (and hence more marketable products to export).

Phil Western, MD, Network Medical Ltd: Further to your request for submission of suggestion for the future meetings with the NHS.

After many many years, I have actually stopped this process because there is very little interest, from their side, to review the situation. Corporations that are small, although innovative, have no voice with the upper management of Government and so this becomes a total waste of time on my side.

This country is missing one huge opportunity for the creation of jobs in the community mainly due to the absolute resistance to change from the top from a very small number of people.

You know very much my views and you will also know how vocal I am in these matters so you will I am sure, be quite surprised at my attitude but ‘in ignorance there is bliss’

Best Regards

Phil has traditionally been very vocal on matters relating to NHS procurement and adoption - he has written letters to Ministers on this subject in the past but in the last few months he had decided to give this up as a bad job and focus his attention on more productive matters e.g. international sales.
These are the only two responses that I have received possibly because of holidays but more likely that our members are fed up at being asked for input but not seeing any change on the ground. Hope this helps