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

Respondent ID: 198

Organisation name: National Specialised Commissioning Team

Type of response: Letter
Dear Review Team,

RE: Innovation in the NHS

Introduction

The National Specialised Commissioning Team commissions a range of highly specialised services under the auspices of the Advisory Group for National Specialised Services (AGNSS), and co-ordinates the work of the Specialised Commissioning Groups. Our experience is with innovation in highly specialised services. Hence our comments are limited to innovation in those services.

Innovation in highly specialised services differs in certain respects from general innovation. The key difference is that ‘rapid diffusion throughout the NHS’ means ‘made available rapidly to all patients throughout England’ not ‘provided in all NHS Trusts throughout England’. The National Specialised Commissioning team and its predecessors have over 20 years experience of introducing new technology to the NHS and ensuring equality of access to these technologies, when proven and cost-effective, by patients throughout England. Highly specialised technologies are by definition complex and technically difficult. Many are also potentially risky technologies. Due to the rarity of the interventions, the evidence base is not always as strongly documented as one would want. It is one of the difficult tasks of AGNSS to assess the strength of the evidence before it. See example one below.

Three examples among many may illustrate the scope for introducing new technologies:

Example 1 - ECMO

Extra corporeal membrane oxygenation (ECMO) is being made available to all eligible patients in England following a careful process of development and evaluation. A decision was taken by the then NSCAG to introduce adult respiratory ECMO, containing it to University Hospitals of Leicester NHS Trust on the basis that a trial was undertaken. The decision to fund was controversial due to a lack of evidence of effectiveness. The CESAR trial was a landmark study funded by the health technology assessment programme. This demonstrated the value of the technique. Ironically, use of ECMO during H1N1 probably did
more to persuade peers of the value of the intervention then the trial itself, as they saw patients they had given up hope on return alive. Press coverage also raised awareness amongst clinical staff. The evidence of benefit from the CESAR trial has been followed by a procurement exercise (currently in progress) to ensure that enough capacity (approximately eight sites) is available in England to meet needs, without wasteful duplication, and that all providers meet specified quality standards for the delivery of the effective but complex treatment. Safe use of the technique has been spread by peer review and bespoke training, supported by clinical standards and guidelines.

Example 2 - Enzyme replacement therapies

Enzyme replacement therapies for lysosomal storage disorder are an innovative technology in the very rare disease field. They were introduced into the NHS under national commissioning arrangements which allowed rapid diffusion under controlled conditions, including uniform clinical eligibility criteria and annual clinical audit data on 100% of patients treated. In addition the Health Technology Assessment programme funded a programme of research into quality of life in all patients with lysosomal storage disorders.

Example 3 - Severe combined immune deficiency

Babies and children with severe combined immune deficiency throughout England have benefitted for many years from the national service provided in Newcastle and London. The innovation benefit of this arrangement has been the constant dialogue between the two services to modify the conditioning, treatment and monitoring protocols necessary for success. This constant stream of small innovations has produced a dramatic change in outlook for SCID patients.

The severe combined immune deficiency service also illustrates the benefit of international collaborations: gene therapy and thymus transplant programmes have been successfully developed in collaboration with researchers in other countries. This illustrates the importance of allowing clinicians in the highly specialised services time and space to develop international contacts.

Provider issues

We believe that there are two key local barriers to innovation in provider Trusts – finance and risk aversion. Finance needs no further comment – many innovations, even if cost-saving, need some up-front spend.

Risk aversion is more complex. Clinicians may be risk averse for fear of being sued. In a commissioning relationship, however, risk aversion is influenced by the choice of monitoring metrics. In solid organ transplant, for example, the current metric of choice is post-operative survival. This may potentially discourage clinicians from innovative techniques in sicker patients on the waiting list. Using survival from listing, rather than survival from operation, as a metric might overcome this problem.

Peer review

NSCT facilitates collective annual review meetings for each of its services, enabling the clinical teams from different providers to meet and present results and innovations to each other. This facilitates the sharing of learning and maintains a competitive tension to drive further innovation.
Potential lessons to be derived from the NSCT approach

Whilst the NSCT only handles rare interventions, it provides a highly specialised environment for:

- Creating centres of expertise with relatively high levels of activity;
- Audit and developing an evidence base in a relatively short period of time of these rare conditions;
- Enabling spread when the technique is present, such as in ECMO.

Whilst AGNSS takes decision on rare / complex interventions, NICE and the NHSCB could take a more proactive stance regarding its interventional procedures guidance. Often, there is too long a delay between being able to state that something is safe to use and then moving on to have sufficient evidence to state that it is clinically sound and cost effective, and should be the procedure of choice. More often it is the manufacturers who work to gain clinical interest with no system to gather independent data.

Lessons could be learnt from the way NSCT proactively commissions from just a few sites whilst the evidence base is being gathered and clinical guidelines / standards can be developed across team. Bespoke training programmes have then been put in place to facilitate spread. Laparoscopic bowel surgery is an example where NICE did finally produce a technology appraisal guidance rather than just a procedures guidance. This finally persuaded the clinicians to become involved in expensive retraining, which was possible by a formalised training programme overseen by the National Cancer Action Team (NCAT). There was always a dilemma as to the extent patient care should be used to drive change prior to sufficient surgeons being trained.

The NHS is not strong in providing such post graduation training on a national scale: too often it is left to commercial companies or charities to fund scholarships, which tend to engage clinicians only at the beginning of their careers rather than later on, hence adoption and spread can be very slow.

I hope these comments are helpful. We would be pleased to contribute to any further work as a team in this area.

Yours sincerely,

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