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

Respondent ID: 142

Organisation name: Vantage Diagnostics Limited

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NHS Chief Executive Innovation Review Team  
Department of Health  
Room 2N16  
Quarry House  
Quarry Hill  
Leeds  
LS2 7UE

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Dear Sirs

**NHS Chief Executive Innovation Review - Call for evidence and ideas**

We welcome the opportunity to comment on the Innovation Review, and in particular on how the adoption and diffusion of innovations could be accelerated across the NHS.

Vantage Diagnostics Limited is a private sector organisation that produces innovative telediagnostic solutions currently used by hundreds of NHS GPs for thousands of referrals in areas such as NHS Hampshire, NHS Bristol and NHS Hillingdon. We are a small, UK-based organisation moving from the start up phase to growth with funds raised under the Enterprise Investment Scheme from investors convinced by our solutions. Independent audits and clinical reviews of those solutions within the NHS have already demonstrated both improved care and massive financial savings.

For example, between 20% and 25% of all visits to GPs involve dermatological issues and there are currently over 4 million dermatology referrals per year to secondary care within the NHS. Work done by a group in NHS Bedfordshire has indicated around £166m each year would be saved in direct financial costs to the NHS by shifting treatment of dermatology from hospital outpatient departments into the community – with hundreds of millions more potentially to be saved by, for example, shifting minor surgery from hospitals into the community.

Our Vantage Teledermatology (VTD) solution in NHS Hampshire recently won the South Central NHS Primary Care and Community Based Integration Award for its innovation, and was showcased at the Innovation Expo 2011 at ExCel. An independent audit by PricewaterhouseCoopers showed that in over 77% of cases referred through VTD GPs were given a management plan to manage the patient in Primary care rather than secondary care, with potential savings of between £619,000 and £1.5m on first outpatient and follow up appointments, on an existing spend of £6.6m. Further potential savings of between £1.8m and £2.3m, on an existing spend of £4.3m, were identified as a result of triaging minor surgery to the community instead of to secondary care. We attach an Executive Summary of the PWC report to this letter.

The weight of fact-based evidence of both clinical and financial success from both independent reviews and our own on-line management information system made available to all stakeholders is overwhelming. Feedback from patients, GPs, Commissioners and Consultants is extremely positive. Yet, despite the clear and accepted ability of our solutions in, for example, teledermatology radically to simplify clinical pathways, to improve care, to yield financial savings, to optimise resource allocation and to give patients and GPS rapid
access to expert opinion, adoption is slow and the barriers to adoption are high.

We have identified a number of reasons for this. Some are outlined in the Call for Evidence and Ideas. Others are not. Our senior management has considerable experience of these issues: our Chairman, Barry Clare, created Boots Healthcare International, the international “over the counter” consumer healthcare business, of the Boots Company Plc. Starting with sales of £100 million (80% UK), the business became the fastest growing OTC company in Europe, with sales in 2001 of £460 million and profits of £70 million. BHI was sold to Reckitt Benckiser for £1.93 billion. Our Chief Executive, Tony Angel, was for almost ten years worldwide managing partner of Linklaters which over that period moved from being an English firm of solicitors to one of the world’s most successful global law firms, with a turnover of around $2.5bn and 30 offices in 24 countries. We believe there is tremendous potential within the NHS for improving care and optimising resources and would like to see that potential realize for the benefit of us all.

Looking first at the barriers to innovation outlined in the review:

1. Poor access to evidence, data and metrics: Not only is access poor, but evidence, data and metrics are sometimes inaccurate, poorly chosen, not properly collected and imperfectly recorded. The drive to major national IT systems has been a barrier to faster small scale, integrated and effective solutions – like our own web-based information system. Also, there is often a fixation with existing processes and pathways, and to measuring them. Innovative solutions can radically impact on how things are done and it is critical that thought is given to measuring the correct data and metrics. We would urge a closer look at how solutions like ours have approached this issue in a radically simpler way.

2. Insufficient recognition and celebration of innovation and innovators: Within the NHS we also see other disincentives to innovation. Innovation means change, and for many NHS managers the risks and downsides to making changes are too high. There is a sense that maintaining existing systems and processes is the safer course of action. There is insufficient recognition that sticking with the status quo is itself a decision that must be justified. We need to find ways in which innovation that succeeds brings pressure to bear on managers to adopt the innovation much more quickly – the National Commissioning process may be helpful here.

3. Financial levers do not reward innovators and can act as a disincentive to adoption: This is a particular problem with the focus on budgets rather than cost. Innovation can involve upfront costs, or some initial double costs, because of the cost of double-running or dismantling processes. Radically simplifying pathways can involve redundancies, for example. Also, savings may be made elsewhere in the system than just by the particular budget-holder with the decision making power. There is often no mechanism for looking across multiple stakeholders to look at aggregate costs and savings. We have had occasions where our solutions are recognised to yield significant savings overall, but because they might adversely impact the particular budget of the Commissioner/decision-maker they have not been adopted. There needs to be a more effective mechanism for looking across the entire system.

4. Commissioners lack the tools or capability to drive innovation: This is sometimes true – in addition, however, the entire system operates against commissioners being innovative. For example, the perception that making wrong choices is
career inhibiting when innovation inevitably requires well-considered risk-taking. There needs to be cultural change - and also less suspicion of the ability of the private sector to contribute.

5. **Leadership culture to support innovation is inconsistent or lacking:** Often this reflects significant conservatism amongst professionals. There are many parallels to this behaviour – for example in the legal profession. The focus on the patient (client), the task-focused nature of the work, the years of training to be risk adverse – all these factors make looking at the wider framework, understanding that not changing is itself a decision and adopting innovative approaches challenging. This requires forward thinking clinicians to lead innovation but adequately supported by suitable other professional managers.

6. **Lack of effective and systematic innovation architecture:** We think that improved cooperation within the NHS and between the NHS and other sectors is critical here. Innovation is not developed in isolation. It comes from a range of stakeholders working together to develop solutions. The mechanisms for this are currently too hierarchical and formal, and often reflect suspicions amongst different stakeholders within the NHS. There is a need to encourage private sector involvement at all levels – and for more with small innovative companies rather than just major healthcare organisations.

More generally, we see better understanding of the rigidity and inefficiencies in current processes and systems, along with a focus on cost cutting and efficiency gains, as serving the stated goals of NHS Commissioning far more effectively than the short-termism driven by the current focus on budgets above all else. With a focus on saving costs, rather than simply annual budgets, innovation becomes more attractive and instinctive as a means of both reducing costs and improving quality of outputs long term.

Also, whilst we recognise the value of incentives such as regional innovation funding, the levels at which these are currently set are far too low. Commercial organisations would invest a far higher level of their resources in ‘R&D’ of this kind. The call for comment notes that these funds are highly oversubscribed and we see from our own experience – RIF funding was available to NHS Hampshire for our implementation of Vantage Teledermatology there – how important they can be.

Coupled with increased RIF funding is the importance of transparency and sharing of results. Evidence of successful innovations should be celebrated, shared and spread at all levels of the NHS, and the current NHS Evidence database relies on information from within the NHS only – submissions are not accepted from private sector organisations. We have found this causes delays

Crafting innovations that work involves risk and, from time to time failure. A culture of positive innovation should mean that, overall, the benefit of success outweigh costs of failure – but both success and failure are important elements on innovation. Managed risks with checks and balances are therefore essential for the long-term health of the NHS.

Currently, we find that the time it takes to tender and implement innovative projects is far too long (and costly). Innovation is often driven by SMEs like ours able to react quickly to new technologies, trends and gaps in the market. But the currently overly lengthy tendering process is far too costly for many SMEs who, by nature of their size and financial resources find the delay extremely challenging. There is a need to reduce bureaucracy for commissioning teams and to streamline tendering processes in order to keep innovative
SMEs active and attracted to doing business with the NHS.

Furthermore we need also to mention the conflicts of interest that exist amongst decision makers. The system forces them to look to their narrow interest and budgets, and they are not necessarily incentivised nor rewarded for improvements in terms of overall quality of patient care or financial performance. This in our direct experience, has lead to significant barriers to the adoption of innovative solutions, such as VTD, even when the objective evidence of utility is overwhelming.

We are grateful for the opportunity to comment and would like to be kept in touch with the next steps in this process and to be included in a wider community of interest.

Yours faithfully

Anthony L Angel
Chief Executive
tony.angel@vantage dx.com
+44 (0)7801 923 245
NHS Hampshire

Evaluation of Vantage Teledermatology (VTD) Pilot in Hampshire

Executive Summary
Executive Summary

NHS Hampshire conducted the first Vantage Teledermatology (VTD) pilot to be undertaken across six localities in the Primary Care Trust. PwC were commissioned to review the potential financial and clinical benefits of the service.

Financial overview

- NHS Hampshire spend on dermatology first outpatient and follow-up appointments was £6.6m in 08/09, having increased in recent years with rises in referral rates.
- Our review indicated that the implementation of the VTD service across the PCT could potentially deliver recurrent net savings of £619,783 to £1.5 million based on avoided first outpatient and follow up appointments.
- Savings will depend on the proportion of routine referrals that are sent to VTD (take up) and the increase in activity associated with the increased ease of access. Increases will need to be controlled at 20% to achieve the larger saving.
- On a spend of £4.3m on minor procedures and day-cases, there could potentially be additional recurrent savings of £1.8m - £2.4m supported by triage of patients by VTD to shift of minor surgery patients from secondary care to the community. However, this can be done only if there is capacity and capability in the community to provide the required services.

Clinical overview

- There was evidence of decline in hospital outpatient attendance from practices that used the VTD service for 30% or more of patients eligible for routine dermatology referrals.
- Of 835 referrals sent to VTD, in 77% cases, the GP was given a treatment plan to manage in primary care, and 23% were referred to secondary care.
- Of those where GP was given a treatment plan, in 36% of cases, minor surgery was recommended, although in some of these cases it meant the patient ended up receiving their minor surgery in secondary care because of lack of funding or capacity.
- A key finding was that 21% of VTD consultations that were referred to secondary care (6.2% of overall cases) were identified as two-week waits. In such cases, the service significantly reduced the waiting time for those patients who would have otherwise waited considerably longer.
- There was increase in net referrals (VTD + secondary care) over the pilot period which was estimated to be between 20-40% which can be partly attributed to ease of access to the Teledermatology service. It should be noted that although an increase in referrals will reduce savings, better access to a specialist opinion could be seen as an improvement in quality of care for patients.
- 95% of diagnosis and management plans were returned within 48 hours and there were no reports of any serious incidents during the pilot.
Patient and Stakeholder experience

- Patient feedback was positive with 85% either ‘satisfied’ or ‘very satisfied’ with the service and 90% stating they would recommend it to others

- GPs cited benefits of VTD such as decrease in patient waiting time, effective triage, rapid turnaround time and ease of referral, with c.90% being satisfied or extremely satisfied with the service

- Clinicians also identified the service as an important tool in supporting dermatology learning and education

- Even if cost neutral, GPs agreed that VTD should continue and ideally be complemented with additional community services such as minor surgery or Tier 2 service

- Hospital consultants were keen to be involved as key stakeholders in shaping community dermatology services going forward

Key recommendations

- With further reassessment in 12 months, it is recommended NHS Hampshire consider continuing with this service and encourage higher take up of VTD across the PCT

- NHS Hampshire should strongly consider an assessment of current dermatological services in the community with a view of redesigning these services involving local and secondary care clinicians. Specifically, to achieve full potential savings, the PCT should ensure capacity and capability in the community to provide minor surgery services

- If appropriate controls were put in place by the PCT, such as clear guidelines to minimise increases in referrals to the more accessible service, and contractual agreements, usage could potentially be increased and larger savings could be achieved
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