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

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Executive Summary

Every day, advances in medical technologies help save the lives of patients in the NHS by enhancing treatments of many life-threatening diseases and long-term conditions. It is estimated that in the UK alone, 38 million people come into contact with a medical device every day.

Modern healthcare offers patients presenting with ill health dramatically improved treatment outcomes and quality of life, compared to the past, in part because the continuous innovation in medical technologies is changing the way health care is delivered.

Demand for healthcare is set to rise as an aging population, the growing prevalence of chronic diseases, and increasing public expectation continue to exert pressure on already stretched resources. The NHS faces unprecedented change to meet these challenges and must evolve to stay ahead of these societal shifts.

The NHS needs innovations in medical techniques and equipment to constantly make improvements in delivering high quality patient care, and for the medical technology industry – a key UK manufacturing sector - developing innovations is a key driver for long term growth. The ABHI welcomes the innovation review as it presents an opportunity to align these common strategic pillars.

In addressing the barriers to innovation adoption and diffusion, as we see them, there needs to be a balance. Strong leadership and mandate from the top must support and enhance the culture and ability to execute from the ground. This twin approach should be overlaid with the influence that patients can bring to bear to drive change.

We offer the following recommendations:

1. **National leadership and levers**

   The NHS Commissioning Board must offer strong, national strategic leadership to advocate the role of innovation in assisting the NHS achieve its QIPP targets.

   This means a focus on monitoring and rewarding innovation uptake, specifically the need to:

   a) Develop a flexible and strategically orientated payment system to incentivise innovation uptake in both acute and community settings,
   b) streamline access to funding of innovations, and
   c) Establish a compliance regime which measures and monitors uptake of innovation against national standards, ensuring variances in spread of “best clinical practice” in localities are scrutinised and remediated.
2. **Expediting local execution**

Enhancing the culture and ability to drive execution from the ground requires the development of fit-for-purpose operational systems and processes. The first two recommendations are local actions. The others require both national and local actions.

**Recommendations:**

a) **Delegating accountability in local organisations**

At a local level, Clinical Commissioning Groups (CCGs) and provider trusts should delegate accountability to individuals tasked with responsibility for innovation uptake. These individuals must have the necessary strategic oversight, empowerment and “risk appetite” to drive the change necessary in their organisations that will result in innovations being implemented.

b) **Align procurement processes to clinical needs**

Procurement processes must be fundamentally re-shaped to become strategic enablers of innovation adoption. This includes basing purchasing decisions on specifications drawn up by clinicians that focus on solutions that achieve required clinical outcomes rather than a simplistic version of ‘Most Economically Advantageous Tender.’

c) **Minimise the “always pilot” culture**

Greater national coordination is required to trial innovations consistently such that local organisations do not continually pilot but rollout innovations based on experience and findings of early adopters.

d) **Harness patient involvement and influence**

Local and national HealthWatches, as a conduit for patients to feedback their experiences, have an opportunity to use the patient voice to improve access to innovations. To do this effectively requires coordination between local HealthWatches and HealthWatch England via a patient-orientated function in the Commissioning Board.

e) **Emphasis on achieving outcomes across the whole patient pathway**

Quality standards and clinical indicators must be outcomes based and define levels of care across whole patient pathways. Innovations that can aid the achievement of the outcomes being targeted should be explicitly referred to and clinicians encouraged to embed them in each step of a patient pathway.

f) **Adopt a longer term view to investment that breaks down budget silos**

The positive impact of innovations must take into account the value brought across different budget cycles and silos. Breaking-down silos and bridging budgeting cycles requires greater collaboration between commissioners and persons in provider Trusts, across care settings, able to picture a strategic and whole system view of efficiency savings that can be generated by investment decisions.

g) **Strategic partnering with industry**

Current initiatives, e.g. the Innovative Technology Adoption Procurement Programme, show that the medical technology industry has potential solutions to assist the NHS meet the challenges it faces. To realise these solutions Board-level sponsored strategic relationships with industry must be the norm rather than the exception in the NHS.
Introduction

ABHI welcomes the opportunity to contribute to the NHS Chief Executive Innovation Review.

ABHI is the industry association for companies operating in the UK medical technology sector. We represent over 240 member companies, both large multi-national organisations and small British-based businesses. Our purpose is to promote the benefits, value and adoption of innovative, safe and effective medical technologies to ensure optimum and high-quality patient outcomes in the UK and key international markets.

In providing our response, ABHI uses the term “innovation” to describe medical technologies which are: a) a new or novel technologies that offer a beneficial step change in care delivery, and b) those that are in use at the moment, and form an integral element of existing best-in-class clinical practice but are not consistently used across the NHS.

We provide a number of recommendations, describing the context first and, where relevant, the actions required by national and local organisations. Where possible we provide international comparisons. The issues need to be considered in total as part of a strategic, system wide approach to adoption and diffusion of innovation.

The core themes of our suggestions are

- National leadership to deliver vision and strategy
- National levers – optimising financial and non-financial levers
- Expediting local execution – optimising operational systems and processes
1. National leadership to deliver vision and strategy

It is essential to articulate a clear vision and strategy for the role of innovation in delivering efficient and effective care.

A clear opportunity exists given the economic situation that the NHS currently faces. The QIPP initiative is a powerful strategic driver to focus and align resources to address that economic challenge.

In any other setting, this type of challenge would have resulted in the development of sweeping and long term plans and overhauls to operations. These would be focused on, amongst other things, organisational form and business models, identification of priority areas for productivity improvements, and re-consideration of investment decisions in light of the appraisal of the first two elements.

The NHS has not had to contemplate such issues before. It is recognised that potential solutions lie in the re-design of care pathways that minimise clinical variation and improve productivity over the long-term. An increased use of technology has a key role to play in such concepts.

Yet, seen from an industry viewpoint, QIPP has so far been used to justify procurement practices and other demand-based approaches to generate short-term savings. It has not focused on the rapid revamp of services for long-term sustainability.

ABHI RECOMMENDATION

There is a need for continued and stronger national advocacy of the role of innovation in the achievement of QIPP targets.

It is essential that the NHS Commissioning Board provides strategic national leadership for ensuring that innovation is commissioned and then deployed in provider organisations in a consistent manner that improves outcomes and drives up the quality of care. As a priority it must:

- Set and monitor achievement of innovation adoption against national standards by developing a monitoring and compliance regime,
- Ensure that tariff and other financial mechanisms clearly incentivise NHS organisations to embed innovations in their care delivery processes – it is vital that the Board’s tariff activity is led by someone who is charged with service development rather than simply with existing finance flows and their governance; this requires a major change in culture,
- Create a framework that supports and encourages integrated care to break down budget and clinical silos,
- Ensure that Clinical Commissioning Groups (CCGs) explicitly recognise relevant innovations in their commissioning, and are held to account for their delivery,
- Act on patient feedback and experience to improve access to innovations, utilising HealthWatches both locally and nationally
- Provide a conduit for relationship building and strategic partnering with industry, as described in ‘Developing the NHS Commissioning Board’, published July 2011.

It is highly desirable that this national leadership function for innovation sweeps up the existing relevant activity of the NHS Life Sciences Innovation Delivery Board.

Within each CCG and NHS provider trust, leadership arrangements must be put in place at Board level to ensure that innovation adoption is a strategic driver of change.
2. National levers – financial and non-financial

2a. Develop a flexible and strategically-orientated payment system

The adoption and diffusion of innovations is strongly affected by the mechanisms that incentivise NHS organisations to more readily incorporate innovations into service delivery.

The current Payment by Results (PbR) tariff system is a remuneration method for providers which has evolved as a data-heavy financial control tool. It records and remunerates activity and as such has supported the activity-based improvements seen in secondary care, e.g. 18 week initiative, by paying hospitals for delivering more episodes of care.

From an innovation adoption perspective it has key drawbacks:

- It lacks flexibility to readily incorporate new technology
- It is not a strategic enabler for service transformation outside hospital
- It tends to accentuate perverse behaviours such as treating patients in hospital who might successfully be treated in the community

ABHI RECOMMENDATION

Tariff can be an incentive to deliver best in class clinical practice. It now needs vision and strategic leadership to achieve its full potential and we touch on this question of leadership in section 1.

i. Leadership of the tariff

The role of the NHS Commissioning Board in tariff development should be expanded to provide that leadership by merging the following roles into a single “National Tariff Office”:

- 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.

ABHI does not believe that a clear case has been made for separating tariff management and pricing activity as between the NHS Commissioning Board and Monitor; and that this is even more so following the Listening Exercise and the Government’s decisions as regards development of a market. The National Tariff Office should therefore be a joint activity between the Board and Monitor.

ii. Tariff governance

There needs to be greater engagement with a variety of stakeholders, including industry, in the strategic development of the tariff. The clinical senates, together with the broader advisory system envisaged for the Board at national level (p21 of “Developing the NHS Commissioning Board”), should be central to this. The existing arrangements for tariff governance, developed in response to the 2006 Lawlor Review, have served both their purpose and their time, and a new system of governance is required.
iii. Tariff development

The quality of data used to set reference costs must be improved by focusing on a cohort of accredited hospitals with the expertise in bottom-up costing, rather than utilising data from all NHS hospitals.

The length of time to incorporate innovations in the tariff needs to be reduced. If an innovation payment is approved there is still a long, drawn out process to ultimately incorporate the increment permanently into the actual tariff. Furthermore, where an innovation requires a new procedure code (OPCS) to describe it and a new or update HRG classification to ensure that providers are remunerated, the classification and coding system does not rapidly respond to this need. A new OPCS code can take up to 3 years to be implemented and a new HRG up to 6 years to be developed!

In order to support the management of patients with chronic conditions, a tariff development approach is needed which recognises that much of care delivery should occur in non-hospital settings and closer to the patient’s home. This warrants optimisation/integration of care across patient pathways overlaid by a remuneration system which is focused on the total cost of delivering care for patients over a defined period or pathway.

Acute providers are currently penalised if patient are readmitted within 30 days of discharge. This should be augmented by incentives that aid hospitals to work in partnership with other providers that will manage the ongoing care of patients.

iv. Innovation in the tariff

Existing tariff levels may not be sufficient to cover the incremental expenditure of an innovation which offers considerable cost and clinical benefit over an incumbent, though it may be more expensive.

- The current innovation payment mechanism remains relatively unknown and little understood across the NHS, and involves an arduous, time consuming process to compile a business case. There is no guarantee of success as commissioners do not see innovation payments as a way to fund technology but more as a burden on their budget.
- Use of the existing PbR exclusions mechanism is subject to local decision making and “rationing” is increasingly common.

Best practice tariffs need to be constructed with input from clinicians across the care pathway to sufficiently cost all elements of best in class clinical practice such that innovation is not stifled. The best practice tariff for hip fracture is an excellent example. It was developed with multi-disciplinary clinical input and pays a premium for hospitals that engineer best practice into care pathways. Outcomes are monitored through the National Hip Fracture Database and to date this approach has led to significant improvements.

Tariff mechanisms should reward clinical practices that improve patient outcomes as well deliver efficiency and productivity. The “Commissioning for Quality and Innovation” (CQUIN) system is one that has the potential to be a powerful reward lever.

To be fully effective, CQUIN needs to be aligned to national schemes, e.g. national service frameworks, or strategic aims. In this fashion they drive consistency to support the objectives of national campaigns when targeted to areas where improvements in patient outcomes are much needed.
2b. Streamline access to funding

A core issue that slows the adoption of innovations is accessing funds to pay for them. This is particularly relevant when an innovation in service delivery is outside of existing commissioned services and/or the current tariff system but also applies to more general situations.

Innovation funding is managed by different NHS organisations, ranging from SHAs to PCTs to specialist commissioning groups to individual hospitals. Given the variety of “owners”, how and what these funds are used for can be extremely varied, and the process of applying for funding can be extremely complex.

Industry struggles to identify and then engage with budget holders, the eligibility criteria to access funds may vary across geographies, and how funds are prioritised to address many potential needs is unclear.

**ABHI RECOMMENDATION**

*Funding available for innovation needs to be radically re-designed.*

*Innovation funds, in the various forms that they exist, should be consolidated nationally under the ownership of the NHS Commissioning Board. When budgets are allocated to CCGs, any contribution to fund innovation should be separated, with clear rules stating how they can be used. This approach should be developed by clinical senates in consultation with a variety of partners including other clinicians, managers, commissioners, patients and industry.*

*The focus has to be equitable access, through a transparent, consistent, simple and nimble process for engaging with budget holders to obtain funding.*

*The ABHI has previously commented on the need for ring-fenced funding for directly commissioned specialised services to be held by the NHS Commissioning Board and this approach, that appears to be informing plans for specialised commissioning, may offer an example of how to set consistent national standards in this case.*

2c. Establish a compliance system

In a diverse and complex system, mandating what needs to be achieved within a time limit delivers results. Significant improvements seen in the NHS have been driven by service frameworks which set targets and then measure and monitor achievement of these within an agreed time-scale, e.g. 18 week initiative, cancer treatment.

There is a case to mandate the adoption of proven and effective innovations that improve patient outcomes and efficiency of care, e.g. those which are NICE approved.

This may not always be practical, and an alternative compliance system is advocated where organisations and clinicians are required to justify why innovations that aid the delivery of best in class clinical practice are NOT used. Monitoring whether the best in class clinical practice is routinely applied in care settings ensures that as many patients as possible have access to innovations which generate high quality outcomes.
ABHI RECOMMENDATION

The NHS Commissioning Board, in conjunction with clinical senates, should develop a compliance regime, by patient pathway, which measures, monitors and incentivises the use of innovations where these will improve standards of patient care.

To support this, the NHS Commissioning Board should, across care pathways, benchmark:

- the use of innovations, and/or
- the level of implementation of NICE guidelines and appraisals, and other recommendations of best practice in care pathways.

This can then be used to monitor and assess the variation in “best clinical practice” across the country, in conjunction with the HealthWatches, and drive remediation plans.
3. Expediting local execution

In section 1 and 2 we articulated specific national activities to address barriers to innovation adoption and diffusion. These will be effective when balanced by measures which enhance the culture and ability of local organisations to drive execution from the ground.

This requires fit-for-purpose operational systems and processes.

In the recommendations made below, two require local action and the others require both local and national actions to effect.

Actions required at a local level include:

- Delegating accountability in local organisations
- Aligning procurement processes to clinical needs

Actions required at both a local and national level include:

- Minimising the “always pilot” culture
- Harnessing patient involvement and influence
- Emphasising the achievement of outcomes across the whole patient pathway
- Adopting a long-term view to investment that breaks down budget silos
- Strategic partnering with industry

We provide the detail on these measures below beginning with the actions required at a local level.

3a. Delegating accountability in local organisations

On the premise that the adoption of medical device innovations will typically involve service improvement and redesign, then the rate of adoption is directly proportional to the rate at which changes to care pathways can be made. As the latter is a complex and slow change process it has a knock-on effect on medical device innovation adoption.

The NHS operates with a conservative mindset – understandably so given the consequences of failure. It is also a bureaucratic system with multiple stakeholders responsible for clinical delivery, each with different interests and perspectives.

As such it is very difficult to identify functions within NHS organisations critical in ensuring successful implementation proceeds at pace.

ABHI RECOMMENDATION

Strong clinical input is needed in strategic planning within Clinical Commissioning Groups (CCGs) and providers. Where this analysis identifies innovations that are deemed critical to care delivery, each organisation should delegate accountability to individuals tasked with responsibility for innovation uptake. These individuals must have the necessary strategic oversight, empowerment and "risk appetite" to drive the change necessary in their organisations that will result in innovations being implemented.
3b. Align procurement processes to clinical needs

Whilst strategic clinical decision making is necessary to ensure the focus on outcomes that need to be achieved across care pathways, there is the need to keep in mind the purchasing decision that ultimately has to be made. It is rare to see the involvement of procurement staff, from an early stage, in multi-disciplinary teams tasked with clinical decision making. Yet, purchasing decisions are often THE critical element of the innovation adoption process, and need to be handled in conjunction with the clinical decision rather than as an after-thought.

ABHI RECOMMENDATION

The outcomes needed to be achieved across patient pathways need to be translated into specifications which can then be used to tender for solutions. Clinicians must be responsible for devising specifications aided by procurement teams – often it is the other way round, with the result that procurement is driven by a simplistic version of ‘Most Economically Advantageous Tender’ that does not address best outcomes for patients at best value.

Procurement processes must be fundamentally re-shaped to become strategic enablers of innovation adoption. This involves:

- Ensuring that tender evaluation criteria place greater emphasis on value, i.e. greater weighting towards quality and outcomes offered by innovations rather than the crude price of that innovation,
- Implementing performance measures which consider value over the long term rather than annual cost savings,
- Improving market/clinical knowledge of procurement staff, for example through participation in training on medical device technology and how it contributes to clinical processes.

3c. Minimise the “always pilot” culture

The culture in the NHS is such that innovations in service delivery have to either be trialled or piloted by each and every organisation as a first step to wider adoption within that organisation. This results in a slow and cumbersome process with bespoke programmes being designed locally for each organisation or not at all.

It is recognised that there will be a need to trial and investigate new innovations which are introduced to the market. However, with such a process, the aim must be to accomplish this in a systematic and robust manner which gives confidence to other potential users to simply implement.

The scale of use of medical technologies can thus be improved if the learning and experiences of early-adopter organisations can be adapted and replicated in others.
ABHI RECOMMENDATION

There is a need to “industrialise” the piloting and subsequent rolling out of innovations across the NHS.

Programmes such as “Showcase” hospitals must be refined and consolidated into a cohesive, nationally coordinated system which offers the opportunity for specialist/expert centres, designed around clinical speciality, to flourish as “early adopter” sites.

The mandate for these should come from the clinical senates being setup by the Commissioning Board. The clinical senates will be able to ensure that learning is carried into commissioning decisions in a consistent fashion. The Commissioning Board and Monitor will need to ensure compliance of CCGs/providers (see below).

Results and experiences should be available to all via an information channel which builds on NHS Evidence.

Support for local adoption can be managed by whatever the Commissioning Board puts in place to build on the best experience of the NHS Institute, the NHS Technology Adoption Centre, NICE implementation, etc, to cascade learning to provider organisations and commissioners.

3d. Harness patient involvement and influence

The patient is arguably the most powerful force to drive the adoption of innovations at a greater rate. Their role in healthcare management is set to increase under the NHS reforms and the remit of the NHS Constitution. Greater devolvement of commissioning responsibility to a local level may mean inconsistencies in access to innovations across the country and patients must be empowered to challenge this.

ABHI RECOMMENDATION

Patients must be empowered to take greater ownership in their healthcare and the decision making process.

Routes by which patients feedback their experiences to local HealthWatch organisations must be established. Local HealthWatch may not have a clear view of the emergence of innovations nor of how local commissioners are performing against national benchmarks in terms of innovation in their treatment specifications. Therefore links with National HealthWatch and the Commission Board must be created, through a patient-orientated function within the Commissioning Board, by which patient feedback can influence decisions.

Local HealthWatch organisations, together with HealthWatch England, should hold to account CCGs and providers for equitable access to innovations that are shown to deliver improved outcomes at improved value.

An appeal process should be introduced, managed by the NHS Commissioning Board, Monitor and/or the Care Quality Commission, to challenge situations when proven innovations are restricted. This would uphold rights enshrined in the NHS Constitution and drive patient “pull”.

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3e. Emphasis on achieving outcomes across the whole patient pathway

ABHI welcomes the transition to a new performance management system which places quality and outcomes at the heart of standards of care to drive improvement.

The Outcomes Framework which underpins the system highlights that quality standards and clinical indicators will define what is expected from care across an entire patient pathway.

**ABHI RECOMMENDATION**

*Quality standards and clinical indicators must be outcomes based and incorporated into commissioning guidelines geared to drive improvements and not “more of the same”. The key is the focus on driving improvements above the status quo centred on the whole patient pathway. As previously stated coordination and leadership by the NHS Commissioning Board in this regard is critical.*

*Each quality standard should refer explicitly to innovations that can aid the achievement of the outcomes being targeted.*

*This should encourage clinicians to reconsider care delivery mechanisms, specifically how innovations in new techniques and equipment can support that aim. Innovations that meet or exceed these outcomes must be embedded in each step of a care pathway.*

*NHS organisations must be measured to assess their utilisation of recommended care pathways under the compliance regime described in 2c.*

3f. Adopt a long-term view to investment that breaks down budget silos

The NHS, more often than not, does not approach spend on innovations as investment appraisals that payback over a number of years.

Short-term budgetary challenges manifest as restrictions in referrals for standard treatments, or a reduction of procedures deemed to be of low value. This disregards the long-term consequences to the patient and the NHS. Patients may later present with more complicated conditions which are potentially more expensive to treat, or become a burden for another aspect of the health and social care system.

Short-term budgeting cycles mean that there is a reluctance to make the initial investment on high value innovations even though they offer efficiency gains and improved patient outcomes in the long run, i.e. not necessarily in the same budget cycle.

This is exacerbated by the silo nature in which budgets are held. Costs may often be incurred in one care setting/department but benefits accrue in others with no mechanism for those savings to be offset against the cost.
ABHI RECOMMENDATION

The positive impact of innovations must take into account the value brought across different budget cycles and silos.

The whole pathway approach requires greater coordination between multi disciplinary clinical teams. This is particularly pertinent given the complexity of disease management, especially the prevalence of long-term chronic conditions.

Breaking down silos and bridging budgeting cycles requires collaboration between commissioners and persons in provider Trusts, across care settings, able to picture a strategic and whole system view of efficiency savings that can be generated by investment decisions. A new approach is required on this front, given the long-term decline reported in UK healthcare productivity between 1997 and 2007: a fall of 4.3% whilst UK output per worker in the market sector rose by 25% in the same period.

3g. Strategic partnering with industry

Initiatives such as the Innovative Technology Adoption Procurement Programme, coordinated by the Department of Health, show that the medical technology industry has potential solutions to assist the NHS meet the challenges it faces. Industry is keen to build business-to-business relationships and is adapting to the changing landscape of the NHS to ensure that it continues to demonstrate value to its NHS partners.

ABHI RECOMMENDATION

Strategic relationships with the medical technology industry and the NHS should be the norm rather than the exception in the NHS.

ABHI is in the process of partnering with the NHS Confederation, with other industry partners, to explore the broad concepts in this report and how they will make a difference to innovation adoption. At a national level the value of such relationships is well understood. The Life Sciences Innovation Delivery Board (LSIDB) has begun to show how such relationships might work – see section 1.

This needs to improve at a local level. Board-level sponsorship is required, at CCGs and provider Trusts, of proactive and strategic partnering initiatives with industry. These require clear governance arrangements and performance measures to monitor progress. The culture of the NHS – which can be apprehensive about working with industry - needs to develop so that industry is viewed as a strategic service partner rather than a transactional supplier of goods and services.
Conclusion

In compiling this response to the Innovation Report survey ABHI proposes a number of recommendations based on the experience of member companies in their day-to-day interactions with the NHS.

Innovation needs to be seen in the widest possible context. The recommendations provided in this document are split, as much as possible, between those that are the responsibility of national organisations such as the NHS Commissioning Board and those that are dependent on local Clinical Commissioning Groups and provider Trusts. To be fully effective they need to be seen in total rather than as individual components.

We look forward to working with the Innovation Review team to provide further examples and evidence to substantiate our recommendations.