The NHS is failing to adopt its own recommendations on innovation

In December 2011, the NHS launched Innovation, Health and Wealth, its strategy for making innovation and its spread central to what we do.

Innovation, it said, is 'an idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied'.

Clearly articulated objectives

The strategy highlighted six areas across the NHS where clinical commissioning groups and acute trusts could use technology to better help patients and ultimately save money, with some clearly identified high impact changes:

1. Rapidly accelerate the use of assistive technologies, aiming to improve at least 3 million lives over the next 5 years
2. Launch a national drive to get full implementation of oesophageal Doppler monitoring, or similar fluid management monitoring technology, into practice
3. Launch a 'child in a chair in a day' to transform delivery of wheelchair services
4. Require NHS organizations to explore opportunities to increase national and international health-care activity
5. Require the NHS to reduce inappropriate face-to-face contacts and to switch to higher quality, more convenient, lower cost alternatives
6. Require the NHS to commission services in line with National Institute for Health and Care Excellence – Social Care Institute for Excellence guidance on supporting the carers of people with dementia.

The language is quite precise: 'accelerate', 'full implementation', 'transform' and, most significantly, 'require'. These changes were not intended to be optional. And a deadline date for compliance was set for April 2013, at which point these ambitions were to be recognized as formal targets, and were to be the new prequalification requirement for Commissioning for Quality and Innovation (CQUIN) payments.

Variable performance

So how did they do? The Medical Technology Group submitted a Freedom of Information request to 211 clinical commissioning groups and acute trusts across England in October 2014 asking for a progress update; 189 (90%) responded. The consequent report *Innovation, Health and Wealth – A Scorecard* (Medical Technology Group, 2015) makes for sobering reading (*Table 1*).

At best, the adoption of these innovations aimed at improving millions of patients' lives is patchy and inconsistent across the NHS in England. NHS waiting times for wheelchairs for disabled children – among the most vulnerable members of society – can be 200 days or more. This is nearly 7 months. The average wait is 50 days. The target for getting children into an appropriate wheelchair is 1 day.

Use of oesophageal Doppler monitoring – assessing the fluid status of postoperative patients or those who have had an invasive intervention – varies across the UK. Just 40% of clinical commissioning groups – ranging from 16% in London to 67% in the south west – are working with local providers on intraoperative fluid management targets. And yet not doing so increases the risk of added complications, including organ failure and then, possibly, unnecessary and very avoidable patient mortality.

A missed opportunity

Clinical commissioning groups were tasked to work with UK Trade and Investment to increase national and international commercial activity. Although two-thirds of trusts have a strategy in place to make use of their intellectual property, only 6% of them had agreed payments relating to that activity – and these are concentrated in just

Table 1. Performance at a glance

Innovation, Health and Wealth recommendation	How did they do?
3 Million Lives: telehealth and remote monitoring designed to improve the lives of 3 million people in 5 years, by reducing emergency hospital admissions and hospital bed days	Just 45% of regions have agreed new models for technology provision with providers
Oesophageal Doppler monitoring: minimally invasive technology to assess the fluid status of patients and ensure they are safe	Just 40% of clinical commissioning groups were working with local providers on intraoperative fluid management targets
Child in a chair in a day: aimed to get disabled children into an appropriate wheelchair within a day, working with the charity Whizz-Kidz	Only 12% of trusts had developed an action plan around the delivery of mobility services for children
International and commercial activity: work with UK Trade and Investment to increase national and international health-care activity	Only 6% of clinical commissioning groups had agreed payments relating to international and commercial activity – and yet two-thirds of trusts have a strategy in place to make use of the intellectual property they developed
Digital by default: reduce unnecessary face to face meetings, for example through the use of email	Although clinical commissioning groups and trusts are working very well together, there is vast regional variation
Support for carers of people with dementia: commission dementia services in line with NICE–SCIE guidance	More than half of clinical commissioning groups had failed to formulate CQUIN criteria for this area – however, 94% of clinical commissioning groups are working with local providers to ensure carers receive relevant information where there is diagnosis of dementia

CQUIN = Commissioning for Quality and Innovation; NICE–SCIE = National Institute for Health and Care Excellence – Social Care Institute for Excellence

three regions: the south east, south west and north west. Yet the UK consistently innovates and is responsible for some of the most exciting health developments going on at the moment. Commercial strategies are only useful if they are implemented, and add value only when monetised to deliver cash in for further inward investment on more research and development, or to pay for improved patient care or service delivery.

Another challenge was to reduce unnecessary face-to face meetings; going digital by default, meaning less inconvenience for patients and better use of resources by service providers. Every 1% reduction in face-to face contact is estimated to save £200 million – money that can then be released to fund improved care elsewhere. Although clinical commissioning groups and trusts are working very well together, there is vast regional variation. No clinical commissioning groups in the eastern region reported payments for digital by default, compared with 36% in the south west region.

Turning potential into actual

Medical technology offers great potential to provide value for money to the NHS and taxpayers, and deliver genuine improved health care to patients. No-one disputes the thinking behind this, and with increasingly tight budgets, the need to make major efficiency improvements has never been more crucial. Clinical commissioning groups and trusts need to keep on talking the talk, but they must also be seen to be walking the walk. As long as they seem unable to buy in resources effectively – from low-end items like gloves and pills to long-term investment in information technology infrastructure – or learn from past lessons, we may not be surprised that we have not seen take up of simple measures to stop unnecessary accident and emergency admissions, or to speed up children getting wheelchairs they need. But it is still no less than catastrophic for patients. And at the same time, the clinical commissioning groups and trusts themselves are missing out on that portion of their income that is linked via CQUIN to achieving quality improvement goals (*Table 2*).

The Medical Technology Group believes that clinicians and patients will both continue to need better information about medical technologies so that they can make informed choices about the right medical care. So we will continue to engage with medical professionals over the appropriate use of technologies, disseminating guidance and best practice advice to commissioners, and delivering enhanced training and guidance for clinicians on the range of technologies available and how to use them.

This will deliver better patient outcomes. Early intervention with the right medical technology reduces recovery rates and the need for additional medical interventions. This minimizes medium to long-term costs to the NHS, allowing a change in approach from short-term cost reduction to long-term and sustainable cost-effectiveness. This is both common sense and business sense.

Conclusions

The Medical Technology Group remains sceptical that central reports from NHS England or the Department of Health are the most appropriate or successful way of embedding change into NHS decision making, budgeting, and mechanisms of evaluation and reimbursement. Historically, this approach has been shown to be ineffective as in the early stages of implementation it fails to persuade the decision makers at the clinical commissioning groups and trusts that the proposed improvements are closely aligned with their needs.

The Medical Technology Group does not make the rules, but the role of medical technology in addressing the efficiencies the NHS must realize is well recognized. Two upcoming government reports, Lord Carter's review of NHS Provider efficiency and the 'accelerated access review' into promoting the use of innovative medical products and devices within the NHS, will present opportunities to improve the quality and productivity of care delivery.

The Medical Technology Group hopes that both will include firm, practical and recognizably beneficial recommendations for clinical commissioning groups and trusts on how to implement necessary change at a national level in the NHS. The lessons of *Innovation, Health and Wealth* must be learned and put to effective use before the government reports are completed. BJHM

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Medical Technology Group (2015) Innovation, Health & Wealth – A Scorecard. www.mtg.org.uk/bulletins/innovation-health-and-wealth-scorecard (accessed 3 July 2015)

Table 2. Improving patient care through high impact innovations: % of clinical commissioning groups agreeing payments relating to each target area

	3 million lives	ODM/IOFM	Child in a chair in a day	International and commercial	Digital by default	Dementia support
North east		17%			8%	11%
North west	22%			11%	28%	46%
Yorks & Humber		8%			10%	40%
Eastern						85%
East Midlands	17%	22%			23%	29%
West Midlands	8%		10%		7%	57%
South west		21%		25%	36%	67%
South east	21%	13%	11%	13%	19%	37%
London	13%		5%		24%	50%

Key: blue = no activity; red = 1–25% (very poor); orange = 26–50% (poor); yellow = 51–75% (adequate); green = 76–100% (good).
IOFM = intraoperative fluid management; ODM = oesophageal Doppler monitoring.

KEY POINTS

- Six recommendations for improving the use of technology, published by the NHS in 2011, are not being adopted across the board, with some regions of the country drastically underperforming.
- Just 45% of regions have agreed new models for telehealth and remote monitoring provision.
- Children are still waiting on average 50 days for a wheelchair, despite the target being 1 day.