THE UNIVERSITY OF WARWICK

Growth, Innovation and the NHS

A report published by the Industry and Parliament Trust and The University of Warwick

Notes from Policy Event Meeting on 'Growth, Innovation and the NHS'

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April 2012

science & technology for health

Healthcare for the digital age

INTRODUCTION

In light of the NHS Innovation report published in December 2011, the discussion at this meeting concentrated on two major themes related to the review's remit. The first was supporting innovation in health services and health products in the UK, and the second was reform of NHS procurement systems. Much of the conversation focused on how best to implement the review's findings, engaging in particular with its emphasis on reducing variation in the service, inculcating an innovation culture, and collecting and disseminating data more systematically. The respective roles of the centre and the local provided the foundation for each debate and members stressed the need to renegotiate the boundaries between these institutional entities going forward.

INNOVATION: OBSTACLES AND SOLUTIONS

Speakers praised the track record of both the UK and the NHS in terms of service and technological innovation. However, attendees highlighted a number of obstacles that prevented efficient dissemination of innovative solutions across the country, and, if not addressed, suggested they would continue to block this diffusion in the future. It was suggested that opening up the NHS to innovation in service and product design was especially important in the current climate because of the ability of reform to save lives and money on the one hand, and grow small and medium enterprises on the other. As one attendee highlighted, a recent randomised controlled trial into Assistive Technology (AT) managed to reduce mortality by 45% for those using AT by comparison to a control group. Adopting such technologies nationwide could therefore have a significant impact for patients and their families, as well as preventing costlier and more drastic life-saving interventions later in a patient's life-course.

Data and Communication

The first obstacle that participants discussed was the collection and availability of data on the results and uptake of innovation. Several members recalled instances in which service providers had spent significant levels of resources developing solutions to problems that had already been solved in similar ways elsewhere. They argued that increasing the visibility of innovations and their results would not only prevent a duplication of effort, but would also help ensure that new forms of best practice would spread far quicker than is currently the case. In this regard, some discussants suggested that new forms of communication would also be needed if innovative solutions were not to be simply overlooked. They suggested that the media held a significant stock of communication expertise that was currently under-utilized and that the impact of medical messages may be greatly enhanced though employing these skills more thoroughly in data dissemination.

Other contributors, however, disagreed that simply collecting and disseminating data would be enough to create an impetus for change. These discussants lamented the impotence of National Institute for Health and Clinical Excellence (NICE) to enforce its guidelines, despite the strength of its evidence. In line with a number of reports into innovation over the last decade, these members recommended the creation of a new body to collect data on uptake and ensure that those institutions not following best practice were forced – or at least strongly encouraged – to comply.

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These attendees discussed the savings to be made by standardising the use of medical technologies, with one speaker highlighting the potential £1 billion annual saving that could accrue through nationalized use of oesophageal dopplers across all hospitals.

Systemic Problems: Funding and Competition

Concern not only focused on the lack of data, transparency and centralisation in the system. They highlighted further systemic problems that prevented uptake of innovative solutions even when data were available.

It was mentioned that competition both within and between Trusts thwarted attempts to take up new care structures and health care products – a phenomena that one participant warned would only intensify once the prospective changes to the NHS are made manifest. Some contributors pointed to a prevalent attitude of 'not invented here' amongst Trusts as a significant block to innovation. They argued that this form of local pride saw practitioners and administrators reject new products and service arrangements no matter how effective they had proved elsewhere. Other speakers suggested that this unhelpful competition between Trusts was stoked further by the financial reward system embedded in the NHS. If improved results brought improved financial rewards from both the Government and new clients, they proposed, successful Trusts had a disincentive to share their new ideas and products with counterparts elsewhere as doing so removed their competitive advantage. Similarly, these discussants indicated that prevailing financial arrangements also provided a disincentive to creativity. They pointed to the bureaucracy of the tariff system, arguing that finding a tariff for new products and service arrangements could often be so difficult (and ultimately fruitless) that potential solutions may never be developed in the first place, let alone disseminated.

Other speakers felt that financial arrangements were also responsible for the disappearance of communities and pockets of innovation in various parts of the country. For instance, one member discussed an example of a Welsh A&E team who had produced a very effective model of service delivery only for the new organisation to slowly disintegrate soon after establishing itself. Attendees pointed out that one reason for this disintegration – as in other cases – may be that a lack of funding was forthcoming to sustain these models once developed. Once again, contributors were frustrated at these decisions, given the capacity that these innovation solutions had demonstrated to save money as well as lives in both the short and long run.

NHS PURCHASING REFORM

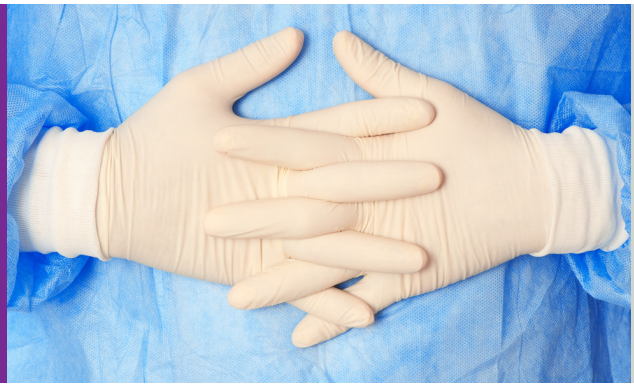
A similar range of themes and opinions structured the discussion of procurement arrangements in the NHS. Members praised the ability of certain new institutions to introduce efficiency, drawing particular attention to the recently-created NHS Supply Chain, which was on course to meet its 10-year target of £1 billion savings by 2016.

The Centre and the Local

Once again, questions of centralisation and devolution came to the fore in discussion. Almost all members agreed that a greater degree of centralisation was needed in NHS procurement, though the extent of this recentralisation was up for discussion. Some participants argued that the duplication of effort on national, regional and local levels led to gross variations in spending patterns across the board. They gave examples of how different institutions could buy the same products, from the same supplier, but end up with vastly different prices. In this sense, contributors proposed that billions of pounds could be saved in procurement if the NHS's economy of scale could be utilized more effectively. Not only would significant amounts of costly, duplicated bureaucracy be cut, but orders could also be placed in bulk, thereby introducing greater bargaining power for the NHS.

Participants pointed to the success of NHS Supply Chain (NHS SC) as a case in point. The NHS SC, they argued, effectively linked over 1,000 health authorities and organisations with over 700 suppliers, many of which were small and medium-sized enterprises. Through centralising purchasing in this institution, Trusts and other health organizations could make use of the NHS SC's size to reduce expenditure on common healthcare products and rarer medical technologies. In having a central point to access when sourcing clients it made navigating the bewildering arrangements and bureaucracy of the NHS significantly easier for SMEs – the back-bone of the Government's growth plan. Currently, the difficulty and expense that firms had in accessing the NHS market made it extremely difficult for smaller SME's to participate without access to such larger institutions.

However, attendees also sounded notes of caution here. Firstly, some contributors warned against micro-managing the decisions of Trusts and health commissioners. In contrast to those who felt the need to completely centralise operations procurement, these speakers argued that innovation came from the grass-roots and proposed that centralizing purchasing may prevent the flexibility in decisions that innovation required. Secondly, attendees suggested that new performance indicators would be needed to effectively measure the changes in purchasing decisions made by healthcare commissioners. Under current – and likely future – arrangements, there is no requirement for a decentralised authority to accept central recommendations on service reorganisation or on the purchase of different medical technologies.



Discussants pointed to the slow take-up of new gloves within NHS SC Trusts as an example in this regard. Despite the potential for the NHS to save several million pound if these Trusts changed the type of gloves they purchased, only 60 per cent of health authorities followed the NHS SC's recommendation to do so. It was argued that even these decisions were delayed by local emphasis on pilot schemes. Just as in the previous discussion, members emphasized the need to measure take-up as well as cost reductions if mortality and cost were to be reduced effectively.

CONCLUSION: THE CENTRE, THE LOCAL AND INNOVATION

Although no consensus on the exact extent of centralisation emerged, discussants agreed on the need for a renegotiation of the trend towards disaggregating the health service. Some members suggested that models for organisation existed in the private sector, pointing to Tesco as an example of a national organization that has successfully blended centralisation of policy and purchasing with local data production and variation in implementation. Other speakers added that the role of a strong centre was to provide a friendly environment for the local task of innovation, both encouraging and spreading best practice to the benefit of health care providers and patients.

The general discussion recognised that negotiating the boundary between the local and the centre was an historic problem that has impacted upon the operation of the NHS since its inception almost 65 years ago. Moreover, attendees made it clear that simply providing institutions with data would not be enough to motivate them to make changes. Instead, systemic alterations would be required, by either strengthening the centre or removing disincentives to innovation and saving. Contributors also recognised that the NHS was currently in flux, with the effects of proposed cuts and structural changes in the purchaser-provider relationship being unclear. With the future currently so uncertain, it was suggested, it might now appear to be the perfect opportunity to discuss innovation in services and procurement. Action now, members agreed, can improve results in future.

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For further information about the breakfast, or to register your interest in attending a future roundtable discussion please contact Ottilie Marchmont OttilieMarchmont@ipt.org.uk

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