NHS Improvement – Supplementary written evidence (LSI0128)

Letter from Professor Tim Evans, National Clinical Director of Clinical Productivity, following an evidence session on 19 December 2017.

Thank you for your invitation to give evidence at the House of Lords Science and Technology Committee's enquiry into Life Sciences and the Industrial Strategy on 19 December 2017. Both Miles Scott and I enjoyed the session and hope the Committee found it useful.

I am writing to follow up on the request from Lord Oxburgh who asked for a list of examples of new technologies that are cost effective, offer clinical improvements and are less expensive that have not been widely adopted. Lord Oxburgh also invited comments on why this might be the case.

In my experience the most common cause of poor uptake of new technologies is a lack of rapid capital investment and training. One example would be the use of multi-parametric MRI screening for prostate cancer. Urologists and radiologists do not doubt the evidence showing its efficacy but upgrading equipment and training the workforce in its use will take time, and may be confined to specific centres.

NHS Improvement's Getting it Right First Time (GIRFT) initiative covers 32 specialities and is tasked with defining 'what good looks like' in each. It is a specific requirement for the national leads and supporting bodies to horizon scan and to be receptive to new technologies and therapeutic interventions approved by NICE that are shown to afford clinical advantages to patients. The introduction of these would represent a 'GIRFT metric' to be reported upon in the Model Hospital Portal, relayed back to trusts and in specific cases employed as part of the 'use of resources' assessment conducted by NHS Improvement on behalf of the CQC.

I approached GIRFT national leads for further insights on the barriers to integrating new technologies. The importance of definitive and timely clinical trials was highlighted as one of the major obstacles. There have been examples of new innovations which have been introduced without thorough assessment which have proved ineffective and in some cases have caused patient harm. We must ensure new innovations are appropriately researched and supported by high quality clinical trials to ensure they are of true benefit to patients. The cost implications of such trials can prove a major barrier for smaller companies whose innovations can only be supported by NICE if they are well researched.

As well as supporting the adoption of new innovations we must, of course, be aware of the need to cease undertaking procedures that evidence shows are no longer effective or efficient. One such example would be cemented hip replacements, which are now only recommended in certain circumstances. Data from the Model Hospital Portal shows that there has been a reduction in their use in response to its inclusion as a GIRFT metric. An appropriate fall in the rate of arthroscopy can also be attributed to the GIRFT programme.

In addition to the data outlined above, the Model Hospital holds data on the rates of uptake of new, NICE approved medications at trust level. Whilst variable, the data shows uptake is generally good. The nonsurgical GIRFT specialities will be looking carefully at this metric for specific new medications early this year.

Once again, thank you for your invitation to give evidence to the Committee. I would be pleased to meet with yourself and/or Lord Oxburgh to discuss how data from the Model Hospital should drive the uptake of clinical improvements and how this is overseen at trust level.

8 January 2018