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Adopting strategies for intelligent procurement can pave the way for innovative technologies and improved diagnostics. Kathleen Armstrong reports.

Message in a bottle

One message should be coming through loud and clear by now: technological innovation needs attention in the NHS. Now, two new reports have laid down further evidence of the slow uptake of new technologies – and put forth a road to possible solutions.

Building on the findings of the Healthcare Industries Task Force (HITF), the reviews carried out by the Health Select Committee (HSC)[1] and the Department of Trade and Industry (DTI)[2] described how the "risk-averse" culture in the NHS "inhibited innovation", impacting on UK companies who were trying to develop and market new and innovative technologies which could lead to improved diagnostics and benefit patient care.

"Procurement systems have an impact on the competitiveness of domestic firms," concluded Arthur D Little in the report to the DTI which examined six healthcare sectors, including *in vitro* diagnostics, imaging and radiotherapy. The report went on to describe how centralised procurement systems and silo funding often forced small- to medium-sized enterprises (SMEs) to take their innovations overseas.

Product standardisation

This was echoed in the report from the HSC, whose main focus was telemedicine. The report criticised the lack of standardisation in the implementation of new technologies in the NHS, including the "uneven" adoption of NICE recommendations which led to "a creeping mix" of equipment. "While NHS trusts are clearly not averse to adopting technologies, they are not doing so in an integrated, rational or strategic way," it said.

While the introduction of payment by results and a three-year budget cycle may provide some hope by looking more broadly at patient pathways, the HSC warned: "Annualised budgets have left a legacy inasmuch as it has been difficult to demonstrate the utility of new technologies across discrete budgetary silos. Whether extending the budgetary cycle will break this down is open to question." It also emphasised the need for the NHS to adopt a longer-term view, to address the "NHS preference for short-term savings to be made as opposed to long-term advantages for patients."

For trusts or laboratories wanting to buy new technology, putting a good business case together, which shows the patient benefit as well as the cost benefit, is key to breaking through the funding barrier and convincing those who are less open to risk of short- and long-term effectiveness of new products. It was a good business case that enabled Royal Surrey Hospital to acquire a new automated histopathology system to enable more efficient processing of tissue samples and quicker diagnosis for patients. Although incurring a significant cost up-front, the trust was able to obtain funding from pathology modernisation funds by demonstrating the benefits the new system would deliver.

Another key to the trust's success was involving the right people in the procurement process – getting those who will use the system, or who will directly benefit from it to participate in the decision. Not only were key procurement and pathology staff taken to see the system in use but a consultant pathologist, who would benefit from the potential improved workflow, was also taken along, ensuring the buy-in of clinical staff. "In countries where clinicians are closely involved in the buying decision there is a better balance between value for money and meeting the patients' needs," concluded the report to the DTI.

Slow processes

The report said that: "a culture of conservatism and tightly controlled budgets discourage early adoption. This is exacerbated by the challenges in actually getting trials done in the UK." It criticised the "inefficient process" for getting a business case together for new diagnostic products: the business planning process, getting laboratory support and securing clinical director or trust board approval. The report described how patients in Sweden had access to the B-type natriuretic peptide (BNP) *in vitro* diagnostic test several years before patients in the UK. "Eighteen months to two years is the typical slow-down process in the UK for new diagnostic products," it said. "For CoaguCheck and the standardised INR (international normalised ratio) of Prothrombin time in whole blood coagulation testing, it took four years for UK market entry."

A spokesperson for the NHS Purchasing and Supply Agency (PASA) said that suppliers need to be able to demonstrate to NHS budget-holders the overall potential value of their technologies in comparison with existing products, establishing clinical- versus cost-effectiveness. But this can present a difficulty for small 'start-up' companies which have to compete with the big global players. JBOI, a small Oxford-based company which had developed a new mid-stream urine collection device lost its initial tender to PASA, despite prescription endorsement by physicians and successful clinical trials in an academic UK hospital. "The NHS purchasing decision appears to have been made on price, not on broad OJEC criteria and weighting factors," said the DTI report. The company, whose device is now being used in Australia, Ireland, Italy and the US, used the Freedom of Information Act to find out the reasons behind the decision and to query them – something that Orde Levinson, JBOI's director who developed the device, said he would encourage other companies to do.

Levinson said that the situation for small innovative companies is further complicated because, in order to submit a tender to the NHS, they need to prove that they are financially sound – which is not always possible for a small entrepreneurial company. JBOI managed to find a partner who could give it the financial backing it needed to eventually secure a contract.

The other deciding factor was the publication of the scientific evidence proving the effectiveness of the device. But, Levinson said, small companies often do not understand the protocols needed for clinical trials. He believes that the NHS could provide more guidance for small companies on how to put together a valid scientific case.

As a result of the HITF, there are now a number of strategies under way to improve the adoption of new technologies in the NHS, including the establishment of innovation centres whose role is to support and encourage the development of new technologies. The management of the DES has been transferred from the MHRA to the special projects directorate of NHS PASA. Sue Wilkin, head of the DES, said: "We are planning to develop the service and evaluate more innovative products, provide the NHS and Social Services with value for money comparisons and roll out a series of nationally agreed evaluation protocols." The structure, scope and funding of the DES is currently being explored through a series of workshops with key stakeholders (DES evaluation centre staff, industry, peer organisations, professional users and patient groups).

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To change the risk-averse culture of the NHS will not happen overnight and will certainly not happen without the commitment to put resources and time into challenging existing practices and procedures – and the changing face of healthcare. And suppliers, and laboratory, clinical and procurement staff in trusts and other NHS bodies will all have to take responsibility for making sure it happens.

References

1. Health Select Committee. *The use of new medical technologies within the NHS*. April 2005.
2. Department of Trade and Industry. *UK sector competitiveness analysis of six healthcare equipment segments*. November 2004.

Kathleen Armstrong is deputy editor of *MLW*.