Do I need a research paper to tell me that falling off a 200 foot cliff is probably going to kill me?

Why do we spend so much money training and educating microbiologists, virologists, Infection control specialists and then take away their ability to make decisions?

The Rapid Review Panel is the body that is tasked with deciding which medical device innovations related to infection prevention are of value. The RRP process of deciding which new and innovative products may have value in our NHS, is simplistic and almost child like in its structure and format.

For those who do not know how it works here is an insight;

Companies or individuals who have invented a new device or way of using something that has been used for some time are asked to submit a short form outlining the benefits there new product or procedure brings. They are asked to submit no more than 10 pieces of evidence including peer review research about their product or procedure. This is then submitted to a panel of microbiologists who score the evidence from 1 – 8. There is no opportunity for the panel to ask questions to clarify parts they may not fully understand (for whatever reason – an inventor may not be the best person to explain his own invention). Innovators have no opportunity to present the science behind their products at any point. In essence, this process is no more accurate than a GCSE exam in English. If the RRP does not understand, it simply awards the product a low score (the equivalent of "must try harder") regardless of whether it is a problem of understanding or the true nature of the product that is lacking. Is the reason for this, that there are far too many products for such a small team to review properly? The answer is most definitely yes! This then begs the question "How has this been done in the past?", How was innovation and progress made before RRP and NICE . The answer has always been to trust the people we have spent so much money educating. Trust them to make the right decisions based on their knowledge and experience, allow them to trust in their own judgement in determining the potential value of an innovation. Trust those intelligent experts to ask their network of colleagues for opinion if they are unsure, trust them to test theories and help improve products that will eventually improve the quality of care delivered by our health services. I am sure that mistakes were made in the past, and we all want to avoid making them again, but to retard growth and knowledge because you are afraid to make mistakes. If this attitude had been adopted through history, there would have been no innovation, no progress made in so many areas of our lives including Medicine.

How does the National Innovations Committee differ from the Strategic Implementation Group (SIG), or the UK Clinical Research Collaboration or the Healthcare Technology Cooperatives, or the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)? There are many more of these central bodies taking more and more decision making responsibility away from the local clinicians. Within our own hospitals committees now decide not just policy but have taken over clinical decision making. Committees such as "Clinical Governance" now tell Consultant clinicians if they use new procedures and medicines, regardless of the experience of the people sitting on the committee. Some of these committees seem to be repeating the same work, therefore there must be a significant amount of money spent replica ting the same work. With ever

increasing numbers of managers required to manage information that is of little or no importance or that could have been done months before by a suitably trained clinician.

What we see now in the NHS, at casual glance and to the unknowing eye, may look like progress, committees to look at many different aspects of our medical delivery, the reality is so much different. These committees have now become a part of the fabric of our NHS, to the point where clinical professionals are now frightened to make decisions that have not been passed through one or more these committees. The real value of a National Innovations Committee would be to coordinate and share best practices, as in the case of the productive operating theatre programme that is being rolled out across the NHS. There are many occasions where the same work that has shown to be a significant benefit is repeated across many Trusts at enormous costs to each – repeating work that has been done elsewhere. The reverse is also true as there is no need to repaeat work that has shown to be of no benefit. Surely if the inventors still believe it to be of benefit, then that is the time a central committee would be of value to review and potentially help with testing (not necessarily development). The people who become responsible for moving these innovations around are the companies who manufacture of distribute these products/ procedures. If they have shown to be a significant benefit to patient care, or reduction in cost, why is there no forum to share that work across the NHS? That surely would be of far greater benefit than the expensive, time consuming, simplistic system we have today. A great example of a good idea going wrong, is the continued use of alcohol gel inappropriately in the NHS. When introduced into regular use, alcohol gels were only supposed to be used when a sink was not available to wash hands properly. Now they have become accepted practice with no evidence of efficacy. If they were to be taken to the RRP today, they would be rejected out of hand, as they have never been shown to be of any benefit. In a system where they are tried locally first, they would be shown to be of no benefit quickly and with minimal costs or time. If they continued to stage 2 and reviewed by RRP, they would have again been rejected. This would now allow producers of persistent sanitizers to be looked at by microbiologists, the common sense of how they work, would make sense and more work would have been done in this area. Still more evidence of the ineffectiveness of the current system, is the fact that DHL (NHS procurement), would make far less money out of the NHS by selling persistent sanitizers into the NHS than non persistent, so there is a reason for them to not improve the quality of products they sell to the NHS, retarding progress yet again.

In many ways, what we see in our NHS is indicative of what we see in our society as a whole. Where management wishes to take control, there is an insidious transfer of decision making from the people doing the work and those overseeing it. In the NHS like many public funded organisations they will spend a pound to save a penny. The biggest problem with procedures/ protocols that start centrally, is that they rarely fit all. Once implemented locally they can evolve and change into something that is destructive not constructive if not managed correctly. Policies that are set locally generally will be managed locally.

Most people in the UK are proud of our NHS, because most of the people working in it do a great job. How long will this continue if they are no longer allowed to do any more than implement central policies. Why is that felt to be necessary now? Is the “where there is a blame there is a claim” culture starting to retard the way our healthcare professionals deliver care? Has that already arrived? Perhaps a review of the way our health service delivers innovation needs to start with a

review on how lawyers are allowed to continue a tradition of the law before justice?  Where right or wrong are not considered important, only the letter of the law.

The NHS like the bank of England needs to be removed from politics, to allow the people who deliver care, to do just that.

Article written by Andrew Kemp RGN  November 2009

Specialist Infection Control Nurse

AK Medical Ltd

akmedical@live.co.uk