NICE Technology Appraisals in the NHS in England (Innovation Scorecard):
to September 2018
Published 11 April 2019

The Innovation Scorecard reports on the use of medicines and medical technologies in the NHS in England, which have been positively appraised by the National Institute for Health and Care Excellence (NICE).

Key findings

What do we measure?

- 144 medicines
- 6 medical technologies
- 6 groups of medicines used to treat major conditions

What have we found?

For the 12 months from October 2017 to September 2018*** (compared to previous 12 months)

- 74% medicines prescribed more
- 5 medical technologies were used more
- All medicine groupings were used more

* Cardiac rhythm management devices covering 3 technology appraisals are referenced from the National Cardiac Rhythm Management Devices 2015/16 Annual Report.
** Separate medicine groupings for stroke by care setting i.e. GP and hospital.
*** Reported as Defined Daily Doses (DDD), Actual Daily Doses (ADD), mgs, vials, tablets, units, implants, pads, interventions or pens/syringes per 100,000 of population or QOF register in England.
NB: Medicines are those reported on the Innovation Scorecard.

Source: NHS Digital

Author: Prescribing and Medicines Team, NHS Digital
Responsible Statistician: Simone Chung

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www.digital.nhs.uk
enquiries@nhsdigital.nhs.uk
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This is an Official Statistics publication

This document is published by NHS Digital, part of the Government Statistical Service

All official statistics should comply with the UK Statistics Authority’s Code of Practice for Official Statistics which promotes the production and dissemination of official statistics that inform decision making.


This product is relevant to members of the public and other stakeholders to support the understanding of compliance with National Institute for Health and Care Excellence (NICE) Technology Appraisals (TAs) and other guidance. It will allow them to understand the quality, reliability and potential pitfalls and issues with the data and to stimulate discussion.
Background

In December 2011 the Department of Health (DH) set out plans to support the development, adoption and spread of innovation in the NHS. ‘Innovation, Health and Wealth, accelerating adoption and diffusion in the NHS’ (IHW) is part of the Government’s Plan for Growth and the Life Sciences Strategy. One of the actions identified in the IHW paper aims to drive implementation of NICE Technology Appraisals (TA) and reduce variation by publishing information that relates to levels of variation and compliance with NICE TAs, locally, as stated:

‘Working with industry, the Department of Health, NICE, the NHS and the Health and Social Care Information Centre, we will develop and publish a straightforward Innovation Scorecard, designed to track adoption of NICE Technology Appraisals at a local level’.

IHW committed the NHS to establish a NICE compliance regime to ensure the rapid and consistent implementation of NICE TAs throughout the NHS. This regime was introduced in January 2012, and includes a new requirement set out in the Operating Framework, binding the NHS to comply with NICE TAs. The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE TAs where clinically appropriate.

The Accelerated Access Review (AAR) commissioned by the government in November 2014 sets out recommendations to speed up access to innovative healthcare and technologies, to improve efficiency and outcomes for NHS patients. The final report released in October 2016 makes recommendations to make it easier for NHS patients to access innovative medicines, medical technologies, diagnostics and digital products, improving efficiency and patient outcomes.

The AAR makes a number of references to the development of the Scorecard in particular its role in measuring the uptake of medicines and potential to measure other technologies. It also makes a specific recommendation “5.7. There should be a single, accessible source of information on the uptake of technologies for the NHS, patients and industry”. It proposes that, in future, the Innovation Scorecard should be the single source of information on the use of innovation in the NHS. It should be owned by NICE and used by the rest of the Accelerated Access Partnership, particularly NHS England and NHS Improvement, to hold the system to account and assess the progress of local areas.

The Innovation Scorecard is published quarterly by NHS Digital on behalf of the Office for Life Sciences, with the first publication in January 2013. This work is informed by collaborative working with colleagues from the Association of the British Healthcare Industries (ABHI), Cabinet Office, DH, NHS Digital, the NHS, NHS England, NICE, Office for Life Sciences, and the pharmaceutical industry.
**Introduction**

The Innovation Scorecard aims to improve transparency within the NHS of what treatments recommended by NICE are available at a local level within Trusts and CCGs as well as national and NHS England Region levels. The Innovation Scorecard has been published with the intention of assisting the NHS in the identification of variation, which, through discussion, can be explained, challenged or acted upon. It is not intended to be used for performance management.

Information on compliance with NICE guidance by NHS organisations is not centrally collected. Due to limitations in the data available, and to improve transparency, the Innovation Scorecard reports on variation based on a range of different data sets. The data sets currently used in the publication include:

- Prescription data from NHS Prescription Services, part of the NHS Business Services Authority
- Hospital Pharmacy Audit Data from IMS Health
- Pharmex data from Commercial Medicines Unit (CMU) at NHS England
- Volume purchase data from NHS Supply Chain
- Hospital Episode Statistics (HES) data from NHS Digital
- Mid-year population estimates from Office for National Statistics
- Defined Daily Doses (DDDs) from World Health Organisation Collaborating Centre for Drug Statistics Methodology
- Cardiac rhythm management devices annual audit report from the National Institute for Cardiovascular Outcomes Research

The resources available for this publication include this report with associated background quality report, an estimates report, csv data files, guidance documents, key facts infographic and an online web platform.

Notes on publication:

1. 7 new medicines added.
2. Refreshed key facts infographic.
Main findings
The Innovation Scorecard measures use of 144 medicines which includes 6 medicine groupings for the prevention of stroke (NOACs), multiple sclerosis, acute coronary syndrome, diabetes and hepatitis C as well as 6 medical technologies including Debrisoft® monofilament debridement pads, 3M Tegaderm® CHG IV securement dressings, spinal cord stimulations and cardiac rhythm management devices in the NHS in England.

This includes 7 new medicines compared to the previous release of this publication in January 2019.

For the 12 months from October 2017 to September 2018 (compared to the previous 12 months):

- 74% of medicines were prescribed more
- All medicine groupings were used more
  - Medicines used to treat acute coronary syndrome has increased by 5%
  - Medicines used to treat diabetes has increased by 34%
  - Medicines used to treat hepatitis C has increased by 3%
  - Medicines used to treat multiple sclerosis has increased by 12%
  - The use of NOACs in Primary Care has increased by 38%
  - The use of NOACs in Secondary Care has increased by 14%
- All except one of the medical technologies were used more
  - The use of Debrisoft® monofilament debridement pads has increased by 10%
  - Interventions of spinal cord stimulations have decreased by 2%
  - The use of 3M Tegaderm® CHG IV securement dressings has increased by 7%
  - Implant rates of pacemakers and defibrillators are gradually increasing

When interpreting the data there are a number of considerations:

- medicines can be used to treat multiple conditions
- a condition can be treated with various medicines
- one medicine may displace another, for example, for treatment of hepatitis C telaprevir and boceprevir (a decrease of more than 170% in use) is an older class of medicine than ombitasvir-paritaprevir-ritonavir (which has had an increase of over 570% in use)
• for a typical uptake curve the rate of increase is rapid in the early years but eases off over time
• Reported data on medical technologies are a proxy to utilisation because no use data is available

**New medicines on the Innovation Scorecard**
There are 7 new medicines on this release of the Innovation Scorecard. 5 out of these 7 new medicines are used to treat cancer, 1 for multiple sclerosis and 1 for skin conditions.

**New medical technologies on the Innovation Scorecard**
There is no new medical technology on this release of the Innovation Scorecard.

**Medicines with increase in use**
For the 12 months from October 2017 to September 2018 (compared to the previous 12 months):

- There were 84 individual medicines which recorded an increase in prescribing. This is based on the 114 (out of 144) individual medicines which had some prescribing in every quarter of the most recent 24 months.
- The range of increase in prescribing for medicines which were prescribed more was between 0.5% and 1,551%, with an average rate of increase of 97% and a median rate of increase of 25%.
  - 21 medicines had increased more than the average i.e. more than 97% increase
  - 20 medicines had at least doubled, i.e. over a 100% increase.
  - 2 medicines had at least a 10-fold increase, i.e. over 1,000% increase.

Table 1 shows the 5 medicines along with the high-level conditions with the highest increase in prescribing.

**Table 1: Top 5 medicines and high-level conditions with highest percentage increase in use from October 2017 to September 2018 compared to the previous 12 months**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>High-level condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>carfilzomib</td>
<td>Cancer</td>
</tr>
<tr>
<td>daratumumab</td>
<td>Cancer</td>
</tr>
<tr>
<td>mepolizumab</td>
<td>Asthma</td>
</tr>
</tbody>
</table>
NICE Technology Appraisals in the NHS in England (Innovation Scorecard) to September 2018

Notes:
1. This is based on medicines reported on the Innovation Scorecard only.
2. Only medicines where there has been some prescribing in every quarter of the most recent 24 months were evaluated.
3. Medicines are in alphabetical order and not by percentage of increase.

Medicines with decrease in use
For the 12 months from October 2017 to September 2018 (compared to the previous 12 months):

- There were 30 individual medicines which recorded a decrease in prescribing. This is based on the 114 (out of 144) individual medicines which had some prescribing in every quarter of the most recent 24 months.

A decrease in prescribing should not immediately be interpreted as a concern. It may be attributed to a number of factors including the arrival of a newer medicine, substitution (where a medicine is used for another indication), safety recall/alerts issued on that medicine or a barrier to uptake e.g. poor clinical consensus.

Table 2 shows the 5 medicines along with the high-level conditions with the highest decrease in prescribing.

Table 2: Top 5 medicines and high-level conditions with highest percentage decrease in use from October 2017 to September 2018 compared to the previous 12 months

<table>
<thead>
<tr>
<th>Medicine</th>
<th>High-level condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>axitinib</td>
<td>Cancer</td>
</tr>
<tr>
<td>daclatasvir</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>elbasvir–grazoprevir</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>simeprevir</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>sofosbuvir</td>
<td>Hepatitis C</td>
</tr>
</tbody>
</table>

Notes:
1. This is based on medicines reported on the Innovation Scorecard only.
2. Only medicines where there has been some prescribing in every quarter of the most recent 24 months were evaluated.
3. Medicines are in alphabetical order and not by percentage of decrease.
Medicine groupings

Medicine groupings were introduced to the Innovation Scorecard in January 2016 and have been developed by analysts and pharmacists at NHS Digital, ABPI, OHE, NICE, OLS and NHS England.

These medicine groupings have been designed to show the combined use of medicines where:

- There are a number of medicines as options for treatment of a specific condition
- One TA covers more than one medicine for the same indication
- Two or more TAs cover the same specific condition

It is more informative to compare uptake of combined options for treatment than only showing uptake of the individual medicines in isolation.

The published medicine groupings will only include those medicines with a positive TA. All other treatment options which may be available will not be reported in the Innovation Scorecard. Medicines with discontinuing use that have been replaced by newer medicines may also be excluded from the group.

There are 6 medicine groupings published in this release of the Innovation Scorecard. The use of medicines to prevent stroke (NOACs) is reported separately for primary care and secondary care due to the specific conditions they are being used for. All other medicine groupings report use in the NHS as a whole i.e. covering both primary and secondary care.

- For the 12 months from October 2017 to September 2018 (compared to the previous 12 months):
- All medicine groupings continue to be used more

Medical technologies

Medical technologies on the Innovation Scorecard were suspended pending the development of an inclusion criterion. This has now been established and medical technologies were reintroduced to the Innovation Scorecard in the July 2017 release.

Additional programmes other than the TA process designed to promote the rapid and consistent adoption of new or innovative technologies where these have been demonstrated to offer particular advantages to patients and/or the NHS compared with current practice considered medical technologies include:

- Diagnostics guidance (DG)
- Medical technologies guidance (MTG)
- Medtech innovation briefings (MIB)
The medical technologies on this release include 2 medical technology guidances and 4 technology appraisals.

**Medical technology guidance**
- The Debrisoft® monofilament debridement pad for use in acute or chronic wounds
- The 3M Tegaderm CHG IV securement dressing for central venous and arterial catheter insertion sites

**Technology appraisal**
- Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin
- Implantable cardioverter defibrillators and cardiac resynchronisation therapy for arrhythmias and heart failure
- Dual-chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome and/or atrioventricular block
- Dual-chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome without atrioventricular block

For the 12 months from October 2017 to September 2018 (compared to the previous 12 months):
- All except for one medical technology were used more
Background Quality Notes

This section of the report aims to provide users with an evidence-based assessment of the quality of the publication outputs by reporting against the nine European Statistical System (ESS) quality dimensions and principles¹.

In doing so, this meets NHS Digital’s obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics², which is based on three pillars:

- **Trustworthiness** is about having confidence in the people and organisations that produce statistics and data.
- **Quality** is about using data and methods that produce assured statistics.
- **Value** is about producing statistics that support society’s needs for information.

Due to the provisional nature of some of the data included in the innovation scorecard, some figures may be revised from publication to publication as issues are uncovered and resolved. Where a refresh of data occurs, it will be clearly documented in the publications. Users should always use the figures in the latest publication to ensure they are the most up to date figures available.

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¹ The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However, more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency, and security.

Accuracy and Reliability

Accuracy and reliability relates to the proximity between an estimate and the unknown true value.

Statistics in this publication are based on data from:

- Prescription data from NHS Prescription Services, part of the NHS Business Services Authority
- Hospital Pharmacy Audit Data from IQVIA
- Pharmex data from Commercial Medicines Unit (CMU) at NHS England
- Volume purchase data from NHS Supply Chain
- Hospital Episode Statistics (HES) data from NHS Digital
- Mid-year population estimates from Office for National Statistics
- Defined Daily Doses (DDD) from World Health Organisation Collaborating Centre for Drug Statistics Methodology
- Cardiac rhythm management devices annual audit report from the National Institute for Cardiovascular Outcomes Research

Prescription data from NHS Prescription Services

NHS Prescription Services, part of the NHS Business Services Authority, process prescriptions dispensed in the community and returned to them for reimbursement. The data collected as part of this process is provided through an online application, ePACT2 (electronic Prescribing Analysts and Cost tool) which gives authorised users access to prescription data.

ePACT is a service for pharmaceutical and prescribing advisors which allows real time on-line analysis of the previous sixty months prescribing data held on NHS Prescription Services' Prescribing Database. Data is updated on a monthly basis (6 weeks after the dispensing month).

Prescriptions written in England and dispensed in England, Northern Ireland, Wales or Scotland are included.

Primary care data covers prescriptions prescribed by GPs, nurses, pharmacists and others (excluding dentists) and dispensed in the community. For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Note that the sum of the CCG data provided in this publication will not match the England total available elsewhere as a small proportion of the national data cannot be attributed to a specific CCG.

While most of the data relates to prescribing and dispensing activity in primary care, additional hospital data (secondary care) is also available for those prescriptions written in hospital but dispensed in the
community (formerly known as “FP10HP” prescriptions). This data has been included at national and Area Team level reporting.

All prescriptions which are prescribed in England and dispensed in the community in the UK need to be submitted to NHS Prescription Services if the dispenser is to be reimbursed and so coverage should be complete. If a prescription was issued, but not presented for dispensing or was not submitted to NHS Prescription Services by the dispenser, then it is not included in the data. The prescription item is recorded in the month in which NHS Prescription Services received it. In the majority of cases prescriptions will be issued, dispensed and submitted to NHS Prescription Services in the same month. However, prescriptions can be presented for dispensing up to six months after issue, and the dispensing organisation may submit the prescription for payment late. Prescription data may be attributed to organisations which have since closed. An issuing organisation may have closed before a prescription is dispensed and NHS Prescription Services may also receive prescriptions late from an organisation or a prescription pad from a closed organisation may still be in use by a prescriber previously at that organisation.

NHS Prescription Services quality assures the data they provide. They state that due to the complex and manual processes involved there may be random inaccuracies in capturing prescription information which are then reflected in the data. Currently the prescription processing activity is internally audited to 99% accuracy (i.e. at least 99% of prescriptions are recorded accurately).

NHS Digital believes that there is no reason to suggest that any analyses have been adversely affected by the data quality issues raised.

Further data quality details are available from NHS Prescription Services: http://www.nhsbsa.nhs.uk/PrescriptionServices/3751.aspx

Pharmex data from the Commercial Medicines Unit

Product volume (Pharmex) data has been supplied by the Commercial Medicines Unit (CMU) at NHS England. It has been used within the Scorecard with the agreement of the National Pharmaceutical Supply Group (NPSG).

This data is collected from hospital pharmacy systems and represent medicine purchases made through these systems.

- Pharmex data are published in volumes (mgs or international units) to show variation.
- The data is reported under the hospital Trust purchasing the medicines. However, these ‘Trusts’ are purchasing points. A Pharmex Trust could be a single site, a group of sites, the whole Trust or a collection of Trusts depending on local arrangements of pharmacy purchasing systems. This means that some Trusts
may be shown as making no purchases of certain medicines even though these are used.

- Pharmex covers about 95% of hospital Trusts. Coverage may be lower at Region level due to missing data or non-contributing Trusts.
- The CMU is aware that the data has partial coverage of medicines delivered via homecare or where supply is outsourced.
- Some medicines are purchased through other routes outside the pharmacy systems, and do not appear in the Pharmex data. These include purchase by departments within the hospital other than pharmacy, outsourced outpatient pharmacy dispensing services or purchases from specialist companies who provide commercially prepared IV solutions and ready-to-use premixed medicines.
- In some cases the purchases shown are negative. This indicates that the Trust returned more than they purchased in that year.
- In some cases, Trusts have disagreed with the data extracted from the Pharmex system.
- The data is not standardised to allow for the differing demographics and needs of the local population and specialist services of Trusts.

Although there may be a delay between purchase and dispensing or supply of the product, hospitals would not usually hold significant quantities of product in the pharmacy. Over a 12 month period purchases are considered to be close to actual usage.

**HPAI data from IQVIA**

Unlike primary care, there is no central NHS collation of information on medicines issued and used in NHS hospitals. IQVIA collects and collates data on a commercial basis, based on issues of medicines recorded on hospital pharmacy systems. Issues refer to all medicines supplied from hospital pharmacies to wards, departments, clinics, theatres, satellite sites and to patients both in out-patient clinics and on discharge.

- The data is reported at National and Region level.
- IQVIA collects data on the quantities of medicines issued (packs). The costs in the HPAI datasets are calculated from quantities by IQVIA using the Drug Tariff and other standard price lists.
- The HPAI data does not include any volume measure equivalent to an item, as used in primary care, nor does it include the physical quantity and contains no equivalent to the number of Defined Daily Doses (DDDs). NHS Digital has calculated DDDs
for this publication in order to be able to collate and compare primary and secondary care medicine use.

- Over 99% of NHS beds across England are covered in the data provided, which is grossed up by IQVIA to provide national figures. However sub-national figures are not adjusted in any way and will be an under estimate if Trusts do not contribute data. Note that IQVIA revise figures as new data becomes available and so any figures may be different when extracted on a different occasion.

- IQVIA is aware that the data has incomplete coverage of medicines delivered via the homecare route or via outsourcing, though has included any homecare data obtained from other sources.

- Some medicines are purchased through other routes outside the pharmacy systems, and do not appear in the HPAI data. These include purchase by departments within the hospital other than pharmacy, outsourced outpatient pharmacy services or purchases from specialist companies who provide commercially prepared IV solutions and ready-to-use premixed medicines.

- Data is provisional; hospitals can resubmit and adjust their data in subsequent submissions to IQVIA.

- The data is not standardised to allow for the differing demographics and needs of the local population and specialist services of Trusts.

This data is used with the permission of IQVIA.

**Volume purchase data from the NHS Supply Chain**

NHS Supply Chain provides patient-focused healthcare products and supply chain services to the UK’s National Health Service (NHS).

NHS Supply Chain manages the procurement and supply of a wide range of products used by the NHS. The data provided relates to the transactions managed by them and is accurate financial information. Some NHS organisations may purchase these products via other routes which are not included here.

All purchase data is requested, where available from NHS Supply Chain for Medical Technology products from the published online catalogue.

Data from NHS Supply Chain is used to report on the use of medical technologies at NHS Region level only. As such, 2%–8% of data received will not be mapped to NHS Region level and is excluded.

**Hospital Episode Statistics (HES) data from NHS Digital**

HES are compiled from data sent by more than 300 NHS hospitals in England and from some independent sector organisations for activity
commissioned by the NHS. NHS Digital liaises closely with these organisations to encourage submission of complete and valid data and seeks to minimise inaccuracies. While this brings about improvement over time, some shortcomings remain.

The HES Data Quality (DQ) Notes highlight any specific known issues with the data to be considered when analysing the data. They are designed for HES system users and those requesting extracts. This is a single repository and replaces individual DQ notes published every month and can be found at: [http://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics/the-processing-cycle-and-hes-data-quality](http://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics/the-processing-cycle-and-hes-data-quality)

HES data is used to calculate the denominator for reporting at NHS Trust level. HES data is also used as a proxy to utilisation for medical technologies where specific interventions were recommended. Medical technologies on the Innovation Scorecard are reported at NHS Regions level only. As such, approximately 2% of the data will not be mapped to NHS Regions level and is excluded.

**Population data from Office of National Statistics (ONS)**

The resident population figures used in this publication are taken from mid-year population estimates published by ONS. The year used varies depending on the time period for the numerator.

**DDD data from World Health Organisation Collaborating Centre for Drug Statistics Methodology**

DDD (Defined Daily Dose) figures are taken from the WHO Collaborating Centre for Drug Statistics Methodology.

DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. It is an international standard, developed to allow comparisons when studying drug utilisation. The DDD is a unit of measurement and does not necessarily reflect the recommended or Prescribed Daily Dose.

DDDs are available for individual drugs/medicines and combined products. New and amended DDDs, including those for combined products, are released twice annually i.e. May and December and updated to the ATC/DDD Index on January. This means that new and updated DDD figures will take effect from the October release of the Innovation Scorecard onwards, with historic data updated accordingly.

DDD figures, updates and methodology can be found at: [http://www.whocc.no/](http://www.whocc.no/)
Cardiac rhythm management devices annual audit report from the National Institute for Cardiovascular Outcomes Research

The 11th annual report for the National Cardiac Rhythm Management (CRM) Device Audit presents the official record of CRM device procedures and quality issues related to the provision of CRM devices between 1st April 2015 and 31st March 2016. Recommendations are made based on these findings. The report covers centres in England, Scotland, Northern Ireland and Wales.

The report is aimed at a wide range of people and institutions with an interest in CRM device services. This includes those who need a factual record of procedure numbers: by hospital, area, nation within the UK. It also details the UK’s performance in the context of the European Union and its near neighbours. This is also the first year of a planned programme to increase the focus on quality and outcomes (clinical and technical) of CRM device procedures. It will therefore be of interest to patients, doctors and allied health professionals involved in CRM, hospital managers, clinical governance leads, commissioners, and government agencies including National Institute for Health and Care Excellence (NICE) and the Medicines and Healthcare Products Regulatory Authority (MHRA).
Relevance

*Relevance is the degree to which the statistical product meets user needs in both coverage and content.*

Medicines which meet the inclusion criteria of the Innovation Scorecard are presented at National (England) and NHS Region level, and where available, at STP, CCG and NHS Trust levels, by calendar quarter.

Medical technologies which meet the inclusion criteria of the Innovation Scorecard are presented at NHS Region level by calendar quarter.

The statistics presented for the medicine groupings are currently published as experimental official statistics. These are new statistics which are still undergoing development and testing in terms of their ability to meet user requirements.

The medicine groupings are available in a separate dashboard on the web platform tool and users can see both the grouped uptake and the values for each individual medicine within the grouping. As such, medicines which form part of these medicine groupings will not be included in the individual medicine dashboard.

The web platform tool shows use of individual medicines, medicine groupings and medical technologies over time i.e. by calendar quarter, and at different NHS organisation levels i.e. National (England), Regions and where available, CCG and NHS Trust.

The release in October 2017 introduces a new NHS organisation level i.e. STP for individual medicines.
Comparability and Coherence

Coherence is the degree to which data that is derived from different sources or methods, but refers to the same topic, are similar. Comparability is the degree to which data can be compared over time and domain.

There will be on-going developments with each Innovation Scorecard publication. Users should always use the figures in the latest publication to ensure they are the most up to date figures available. Previous Innovation Scorecard publications can be found at: http://digital.nhs.uk/data-and-information/publications/statistical/nice-technology-appraisals-in-the-nhs-in-england-innovation-scorecard

The Prescription Services data presented here differs from that presented in the NHS Digital publications based on the Prescription Cost Analysis system. This is because the PCA database is based on all prescriptions written in England, Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England only and includes prescriptions written by dentists and hospital doctors.

The data reported as ADDs, DDDs or mgs in this publication will not match other prescribing data published by NHS Digital, which are generally reported as items and cost.

Users can misinterpret the data as relating to numbers of patients, but care should be taken as the data relates to volumes of medicines not to individuals.

Changes to the figures over time need to be interpreted in the context of changes in available medicines and changes in NHS practice. For example, a reduction in items dispensed for a particular medicine may be due to the introduction of alternative medicines, or a change in prescribing behaviour, especially in the length of treatment each item is intended to cover. Additionally, a change in prescribing practice could also be due to drug safety updates as published by the Medicines and Healthcare products Regulatory Agency and its independent advisor the Commission on Human Medicines.

Details of drug safety updates can be found at: http://www.gov.uk/drug-safety-update

Sales and purchases data reflect when medicines and medical technologies were purchased and not when they were actually used. Sales and purchases may differ between quarters due to economic reasons rather than medical reasons. For example Trusts may bulk buy in one quarter but use the product in several subsequent quarters.

Local level data (Regions, STPs, CCGs, Trusts) will not add up to national data due to unidentified organisations which are included in the national totals but not against local level organisations.

NHS organisations differ widely in the populations they serve so data at National (England), NHS Regions, STPs and CCG levels are standardised by the estimated resident populations.
For hospital Trusts data the number of FCE days of hospital care for the time period under consideration (taken from the Hospital Episode Statistics data) has been used to standardise the data. The values vary significantly, with more specialist hospitals, for example, the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust reporting fewer than 10,000 days of hospital care per year, whereas larger Trusts such as Bart’s Health NHS Trust report over 800,000 days of hospital care per year.

Trust level data should not be compared with the national, Region, STP or CCG data due to the differing data sources and standardisation methodologies applied.

This scorecard covers some highly specialised medicines and technologies so differences in use across organisations are to be expected.
Timeliness and Punctuality

Timeliness refers to the time gap between publication and the reference period. Punctuality refers to the gap between planned and actual publication dates.

This report is published quarterly and reports on data which is approximately six months in arrears. The publication date is determined by the availability of the data and allows adequate time for the compilation of the report including all other publication outputs.

The main limitation for the timeliness of the Innovation Scorecard is due to the contractual agreement with one of the main data suppliers for prescribing in Secondary Care. The contract for use of this data stipulates that the time period to which the data refers to must be at least six months in arrears before it can be published on any open website.

New medicines with a positive recommendation on published TAs are made available on the Innovation Scorecard approximately six months in arrears. This is to align the reporting periods on the scorecard taking into consideration the contractual limitations of the availability of data.

Organisational changes are published in line with the reporting periods of the Innovation Scorecard and are not relative to the publication dates of the releases. This means that for an organisational change which takes effect from April 2016 will only be reflective from the January 2017 release of the Innovation Scorecard onwards and where possible, historic data updated on the new releases.

Similarly, DDD refreshes are also implemented in line with the reporting periods of the Innovation Scorecard, and not relative to the publication dates of the releases.

New and amended DDDs, including those for combined products, are released twice annually i.e. around May and December. The ATC searchable index with DDDs is updated in January and is to be used for prescribing from January onwards. This means that new and updated DDD figures will take effect from the October release of the Innovation Scorecard onwards, with historic data updated accordingly.

This publication has been released in line with the pre-announced publication date and is therefore deemed to be punctual.
Accessibility and Clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

More detailed data on primary care or prescriptions written in hospital but dispensed in the community may be requested from Prescription Services.

Requests for HES should be made to NHS Digital and for Pharmex purchase data should be directed to the CMU at NHS England. Requests regarding HPAI data should be sent direct to IQVIA, and for industry data direct to the relevant company. Requests for NHS Supply Chain data should be directed to NHS Supply Chain.

The publication may be requested in large print or other formats through the NHS Digital's contact centre: enquiries@nhsdigital.nhs.uk (please include 'Innovation Scorecard' in the subject line).

This report provides a high-level summary of the medicines reported on for the current publication as well as some analysis of utilisation comparing the current 12 months with the previous 12 months.

Also available is a key points infographic and frequently asked questions as well as some contextual information where applicable i.e. DDD list.

Guidance documents on details of the underlying data as well as methodology specifications for the medicine groupings are provided as resources of the publication.

Data is presented on a new web platform tool following an initial release in January 2017. This new tool has been developed in response to a user consultation undertaken in early 2016 specifically to enhance user experience in accessing the data, making it easier for commissioners and users to find information on what medicines are available in their region and allow for easier comparison with other areas.

User feedback is welcomed to feed ongoing and future developments.
Assessment of user needs and perceptions

This section describes the processes for finding out about users and uses and their views on the Innovation Scorecard publication.

Comments on the Innovation Scorecard publication can be made through various media:

- NHS Digital general enquiries email enquiries@nhsdigital.nhs.uk and/or telephone number 0300 303 5678
- Twitter @nhsdigital

A user survey of the Innovation Scorecard publication in Feb 2016 was conducted to collect feedback on the content and display of the current publication. The results of the survey will be used to ensure the publication remains relevant to users. Some of the recent developments in response to the feedback received include:

- Key points infographic to summarise the contents of the publication
- A web platform tool to enhance user experience in accessing the data
- Refreshed reports with user friendly commentary and charts
- Guidance documents on the underlying data
- Specification details for the medicine groupings

The Innovation Scorecard strategic group and technical working group consist of a range of stakeholders whose views have been used to continuously develop this publication.
Performance Cost and Respondent Burden

This section describes the effectiveness, efficiency and economy of the statistical output.

For the figures from the Prescription Services, the figures used in this publication are collected as part of the process of reimbursing dispensers for drugs supplied. The publication therefore uses an existing administrative source. For purchase data and hospital dispensing data the Trusts are not compelled to provide the data and do so voluntarily. HES data is from an existing administrative source.

Confidentiality, Transparency and Security

This section describes the procedures and policy used to ensure sound confidentiality, security and transparent practices.

The data contained in this publication are Official Statistics. The code of practice for official statistics is adhered to from collecting the data to publishing. Further details can be found at: http://www.statisticsauthority.gov.uk/monitoring-and-assessment/code-of-practice/

This publication is subject to the standard NHS Digital publication scheme established to fulfil the requirements of the Information Commissioner for government agencies. Further details can be found at: http://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/publication-scheme

This publication is subject to a standard NHS Digital risk assessment prior to issue. Disclosure control is implemented where this is deemed to be necessary in accordance with the protocols associated with the underlying data sources. Further details of the risk assessment are available in NHS Digital's Disclosure Control Procedure can be found at: http://content.digital.nhs.uk/media/23395/Disclosure-Control-Procedure/pdf/Disclosure_Control_Procedure.pdf

Methodology specification documents on medicine groupings and FAQs are provided in the list of resources for this publication. Also provided is a Guide to underlying data which describes the csv files provided as open data.
This publication may be requested in large print or other formats.

Published by NHS Digital, part of the Government Statistical Service

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