Response to NHS Chief Executive’s Open Call for Evidence and Ideas

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INNOVATION IN THE NHS

EVIDENCE SUBMISSION FROM:
The National Institute for Health Research, Clinical Research Network

The NIHR Clinical Research Network comprises:

- The NIHR Clinical Research Network Coordinating Centre
- NIHR Cancer Research Network
- Comprehensive Research Network
- DeNDRoN
- Diabetes Research Network
- Medicines for Children Research Network
- Mental Health Research Network
- Primary Care Research Network
- Stroke Research Network

The evidence provided in this document represents the organisational viewpoint, which has been informed by the contributions from across the organisation.

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What specific actions do NHS bodies, and others, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?

1. Integrate clinical research with QIPP

Explanation of the issues

Clinical research is a major driver of innovation, yet research activity often occurs only in “pockets” in an NHS Trust, rather than being fully embraced as a pan-specialty core activity through institutional systems.

In order for clinical research to play its full part in stimulating innovation on a wider basis, it needs to be embedded in the key programmes and performance management mechanisms adopted by the NHS. The Quality Innovation Productivity and Prevention (QIPP) agenda is just such an institutional-level programme, but at present clinical research activity is not embedded within QIPP, but sits somewhat apart from it.

Innovation could be better supported if:

- the development of research activity was seen as intrinsic to delivery of QIPP, and embedded within it
- QIPP itself was improved to make it more effective

In relation to this last point, the innovation element of QIPP is, at present, insufficiently developed in comparison with quality, productivity or prevention. This is the case for a number of reasons:

- There is a fundamental tension between innovation and quality/productivity, which has resulted in innovation being an under-developed theme within QIPP. Innovation is born of entrepreneurialism, the testing of solutions (which may prove ineffective) and stepping into the unknown; it is seen by Trusts as potentially expensive, as it carries the risk of low return, as well as the potential for high gain. Quality/productivity, on the other hand, is dependent upon the reduction of “unknowns”, and usually carries the promise of budget savings, or at least stability. Given current economic pressures, it is therefore understandable that NHS Trusts focus more upon quality and productivity than on innovation. However, this can only do so much, and innovation through research is necessary if the NHS is to meet the challenge of the ageing population, and the greater demands this will place on resources in the longer term.

- The process approach to QIPP is counter-intuitive to fostering innovation. For example, the mechanism for embedding and managing QIPP is to develop a plan. This mitigates against the whole concept of innovation, which by its nature is opportunistic, and the progeny of a culture rather than a process.

- There is a need to embed QIPP (and, within it, clinical research) across the NHS governance process if innovation is to become standard practice.
Specific actions

- Bolster innovation within QIPP, and integrate clinical research as the driver of innovation, by making it mandatory that QIPP plans incorporate an innovation delivery plan. This should have clear performance indicators for clinical research, which align with National Institute for Health Research high-level objectives, and outline a mechanism through which new ideas can be captured and developed.

- Ensure there is visibility and accountability for QIPP delivery (and therefore clinical research delivery) at all levels of NHS governance
  - Each NHS Trust to appoint an Executive or non-Executive Director as innovation and research “champion”
  - Organisational QIPP Leads to be accountable to NHS Trust Boards for delivery of all aspects of the QIPP programme – including the innovation delivery element that will incorporate clinical research
  - All NHS healthcare providers (which in light of “any willing provider” will be wider than NHS Trusts) to receive regular innovation and research reports, to include an indication of how many innovation and research propositions have been proposed and adopted
  - All Commissioning Boards to receive similar reports for their catchment areas

2. Link NHS Trusts with life-sciences industry

Explanation of the issues

The commercial life-sciences industry is also a driver of innovation through product development and clinical research around those developments, yet both industry (specially small and medium-sized enterprises) and medical practitioners can find it difficult to make the appropriate links.

For SMEs, finding a “way in” to the clinical environment can be daunting, and as the prospect of NHS services being delivered by non-Trust providers moves closer, this situation seems likely to become still more complex and difficult.

Developing commercial relationships that could lead to innovative practice can also be difficult for clinicians. One reason for this is that innovation, because of its potential impact upon cost-saving, can be treated as an issue for managers to embrace – not the clinical community. However, it is often the medical practitioners, with their practical understanding of clinical techniques, who are best placed to embrace new commercial solutions, and see new possibilities for existing products or drugs.

Specific actions

- Develop closer relationships between the commercial life-sciences industry (which is at the heart of innovation) and NHS Trusts
  - Expand the remit of the Health Innovation and Education Clusters (HIECs) to act as local contact brokers between life-sciences SMEs and NHS organisations on a broader basis
  - Ensure that QIPP plans (which, as per the proposal earlier, should contain innovation delivery plans) incorporate a marketing strategy for the engagement of local life-sciences SMEs
3. Address issues with systems that disincentivise innovation

Explanation of the issues

The purchaser/provider funding model in the NHS can, in effect, create financial penalties for Trusts that adopt innovative practices. For example, NHS tariffs are built around discreet packages of payment for complexity of procedure and length of stay, not the overall effectiveness of the treatment from start to finish. As a result, an innovative treatment that costs more than tariff for complexity, but less than tariff for length of stay, will generate a lower level of income for the Trust – even if the innovation has brought about a net saving.

At present, the funding model for clinical research obliges Trusts to cover the excess treatment costs associated with research. This is clearly set out in HSG(97)32, which has recently been emphasised in the recent Government response to the Futures Forum review of NHS reform. Despite this, many Trusts are ignoring the guidance, and are not allowing research with excess treatment costs to go ahead – even though the outlay against these studies is off-set by savings gained from the adoption of findings from other clinical research studies.

Some NHS Trusts are not able to make provision for innovative practice and/or clinical research studies that lead to innovation because they contravene local practice protocols. This is clearly an issue, as research would not have a value if it were not challenging current practice. An example of this is that the Clinical Research Network has encountered PCTs that are blocking research because they believe it could prevent GPs from following local formularies.

The changes to NHS architecture will increase the proportion of private providers offering NHS patient care. Currently there is no provision for supporting research in this environment, and indeed private providers offering home treatment are subject to additional regulation, even when the treatment is the same as that provided within an NHS Trust. Our experience suggests that private providers are under pressure from their Boards not to participate in clinical research studies, even though these are the life-blood of innovative practice.

Specific actions

- Adapt the payment by results system to appreciate the total value chain of a treatment, both within a single Trust, and across NHS care boundaries. One way to do this would be compensate for the reduced income brought about through adopting innovative practice, by providing balancing financial incentives through the various quality incentive payment systems (eg the Commissioning for Quality and Innovation payment framework, CQUIN)
- Enforce HSG(97)32
- Develop an "innovation challenge" protocol - a system whereby research/innovative proposals can override local protocols
- Mandate new healthcare providers to embrace clinical research through QIPP plans
4. Empowering patients to drive innovation

Our experience of recruiting participants into clinical trials has shown that patients are passionate advocates of clinical research studies offering innovative treatments. This on-the-ground experience is borne out by the Association of Medical Research Charities’ research IPOS Mori poll showing that 93% of people want their local NHS Trust to be encouraged or required to support research.

However, patients often lack the tools to query the extent of innovative practice and clinical research activity in their local Trusts, and more could be done to record and highlight issues with patient access to trials that lead to innovation in treatment.

Specific actions

- Roll out information to patient groups regarding innovation delivery, so that it is open to patient scrutiny and interrogation
- Include questions regarding access to clinical trials and innovative treatments in Picker surveys

5. Dissemination of innovation to encourage wider adoption

Explanation of the issues

Whilst local development and ownership of innovative practice is important, innovations often remain at the local level, with no recognised and authoritative mechanism for broadening adoption out on a national scale.

Specific actions

- Provide a mechanism through which local practice can influence national adoption policy
- Use specialist clinician groups to encourage medical professionals to adopt effective new practices, if proven by research adopted by those groups
- Describe and promote examples of innovative practice that is delivering major savings in the NHS on the NHS improvement website
Dermatology Speciality Group - Comprehensive Research Network

This group is in the early stages of an initiative to see whether clinicians participating in studies of prevention of recurrent cellulitis (PATCH I, ID 4040 and PATCH II ID 4041) are prepared to actually implement the findings when they emerge later this year. It is an observational and preliminary study, but clinicians participating in the studies (around 20 centres in the UK) are being asked to reflect on whether they would actually adopt the study findings if a positive result was found. The Speciality Group is encouraging clinicians to commit before the results are available, and will be checking whether implementation of the results actually occurred some time after the results have been released. Given that much larger numbers of clinicians in district general hospitals as well as teaching hospitals are now involved in such large studies, the Specialty Group believes there is a far greater opportunity to work with health professionals in focusing on early implementation of positive results which they believe in, because they have been involved in such a study.

Stroke Research Network

Stroke CLARHC studies have focussed on specific innovations and are a successful model of where research meets service and quality improvement which should increase adoption of new practice across the NHS.

The three major evidence based treatments (aspirin within 48hr, thrombolysis, organised acute stroke care) for acute stroke illustrate challenges of implementing research findings.

The International Stroke Trial showed the benefits of starting aspirin with in 48 hour ischaemic stroke onset. This was rapidly adopted as it required no system change and was inexpensive.

In contrast, a mid-1990s US trial showed iv thrombolysis to be an effective treatment for selected patients within three hour stroke onset, but was not effectively implemented across the NHS until 2009-10 because Trusts were not incentivized to put the necessary imaging access and specialist support in place, and commissioners did not put their weight behind a restructuring/reorganisation of services to facilitate access to the treatment. A few clinicians and units who were persuaded by the evidence introduced thrombolysis protocols in late 1990s, but even after the drug was given a European license in 2003 there was minimal use across England.

It was not until the National Stroke Strategy was published in 2007 that clinicians had “permission” from the NHS (in the form of a NICE TA published in 2007) and an incentive (in the form of the Stroke Strategy Quality markers and the threat of acute services that could not offer thrombolysis being closed) from above to engineer change.

It has taken over 25 years since the meta-analysis was published showing the considerable benefits for the NHS to implement organised stroke care, which required a combination of national standard setting, tariff incentive and local implementation strategies. These initiatives demonstrate that clinicians need permission (national guidelines), encouragement (strategies) and incentives (best practice tariffs) in order to implement evidence. Also required is a robust mandatory national audit to ensure that changes implemented are not then lost when the national spotlight moves elsewhere.