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

Respondent ID: 119

Organisation name: Cambridge University Health Partners

Type of response: Document
Response to the call for evidence and ideas: NHS Chief Executive Innovation Review

Cambridge University Health Partners (CUHP) is a not-for-profit partnership organisation. Its members are the University of Cambridge and its principal NHS partners: Cambridgeshire and Peterborough NHS Foundation Trust; Cambridge University Hospitals NHS Foundation Trust; Papworth Hospital NHS Foundation Trust.

CUHP has two overlapping roles, both of which are relevant to this call for evidence. It is the partnership vehicle for the Academic Health Science Centre (AHSC) in Cambridge. It is also the contract holder for the Cambridgeshire and Peterborough Health Innovation and Education Cluster (HIEC).

The AHSC partnership supports innovation in a variety of ways, most obviously, through the production of new knowledge through research. This is mostly non-commercial research, funded by the NIHR, MRC and medical research charities. Commercial research is also supported through the conduct of clinical studies and expert advice on methodological development. Clinicians are engaged with industry in the commercialisation and development of new products. The research and education-intensive character of AHSCs means that they are powerful vectors for the transmission of innovation. Education, training and development, both pre and post registration, not only provides up-to-date knowledge but equips clinical practitioners with the cognitive skills and disposition required for innovation. The role played by clinical academic leaders in national practitioner networks, together with their prominence in their academic fields, means that there are many opportunities to disseminate knowledge and initiate new collaborations. Visiting research fellows add to the circulation of individuals and the sharing of ideas that contributes to open innovation.

We see the HIEC as overlapping with the AHSC in purpose, but being more focused on education and innovation, as opposed to research, and with a wider geographical spread. The Cambridgeshire and Peterborough HIEC is aligned closely with local service priorities and has funded a range of innovative, clinician-initiated educational programmes. These fall under the broad heading of long-term conditions and include service user education. It has also engaged with local industry networks to increase connectivity between the NHS and industry, thus maximising potential for open innovation. CUHP is currently working with various NHS and industrial partners in bidding to the Technology Strategy Board for further funding. Nested within the AHSC, the Cambridgeshire and Peterborough Collaboration for Applied Health Research and Care (CLAHRC) has pulled interdisciplinary and improvement research through into practice.
CUHP is also notable for its location in one of the UK’s leading innovation economies, the Cambridge sub-region. The work of the HIEC represents one example of how this co-location is being exploited. There are many other examples, for example research and capacity-building collaborations with pharmaceutical and contract research organisations. The development of a commercial science park on the shared NHS/university Cambridge Biomedical Campus is another major area of opportunity. The grouping of NHS, university, private companies, professional/social networks and research institutes in Cambridge comprises in its totality a technoscientific complex that is of national importance.

In this response, we focus on actions at national level, as this is where we think change is most needed.

National science and technology policy has, for the past two decades, emphasised the importance of creating conditions that promote innovation. The response of the Department of Health has been fragmentary, cautious and disrupted by over-frequent re-organisation.

A brief overview of the current landscape for innovation in the NHS supports these assertions. The NHS Institute for Innovation and Improvement has done much to develop products that are relevant to NHS needs, but its future is now uncertain. NHS Improvement has sustained the clinical collaboration approach, which has proven effective, but appears to operate on parallel tracks to the Institute. NHS Regional Innovation Hubs have had variable success but are also now facing an uncertain future. Some central initiatives such as the National Technology Adoption Centre appear well-conceived but their work and impact is not widely understood. Other central initiatives, such as the National Innovation Centre appear duplicative of regional hubs. The East of England SHA has worked hard to draw in wider stakeholders through its innovation council. However, measures such as its Regional Innovation Fund competition have probably cost more in abortive bidding than the modest sums awarded. Beyond designation, the Department has shown little continuing policy interest in Academic Health Science Centres, although the competition-based approach towards funding allocation adopted by the National Institute of Health Research has proved advantageous for these centres of excellence. NIHR remains generally focused on research production but has, in Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) funded at least one initiative that includes requirements for research application. Health Innovation and Education Clusters appear to have filled a gap for local innovation networks. This role is likely to become more important as commissioning structures become more fragmented and the intermediate tier more remote. However, funding for most HIECs will currently end in 2012. A final observation is that the budget for all these initiatives, excluding CLAHRCs, probably amounts to no more than £150-200m pa. This can be contrasted with the c£2bn of public funding allocated to health-research (NIHR and all research councils/TSB) combined and the £100bn+ service budget of the NHS.
Our conclusions are that the centre should rationalise the current landscape for innovation, creating local innovation networks that will counter-balance the centralising forces currently evident in the re-organisation of the NHS and maintain local engagement for innovation. An obvious first step would be to integrate HIECs and Regional Innovation Hubs and to provide recurrent funding for such networks. A more radical solution would be to re-run the AHSC competition with rules less focused on research excellence and more on excellence across all three strands of the tripartite mission (research, education and service) with additional requirements for systems leadership and industrial engagement. Again, recurrent core funding should be provided for successful centres.

Without rationalisation, sustained purpose and continued investment in some sub-national infrastructure it is very difficult to see how innovation will be nurtured in the NHS of the near future.

30 August 2011