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

Respondent ID: 285

Organisation name: Nottinghamshire Healthcare NHS Trust

Type of response: Online
### Respondent ID:

285

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Please choose the description below that best fits your organisation’s main role:

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What can the NHS and NHS Commissioning Board learn from national and international best practice to accelerate the pace and scale of adoption of innovations throughout the NHS?

My own experience over the last five years of being involved in one of the “No longer a diagnosis of exclusion” pilot sites and the IAPT programme is that the NHS has an extraordinary wealth of innovation and creativity that starts with the contact and clinical staff, the patients/users and informal and formal carers. That innovative reservoir has created an outstanding service for people with personality difficulties and disorders in Nottinghamshire (NPPDNet) and some wonderful work in the IAPT initiative but both initiatives have also illustrated the extraordinary capacity of the NHS to strangle its own innovation by spending huge sums on innovation but then having no transition and development strategies and by applying a very naive and reductionist bureaucracy on funding (and then reducing this to chaos in a change of government).

For mental health and social care three changes would create a climate much more conducive to real innovation, including real cost savings:

1) the “pinch points”, often the research framework within the NIHR that supports these such as the HTA and NICE, need to recognise that the models that come out of pharmaceutical and technology evaluation such as the RCT simply don’t transfer well to psychosocial interventions and problems of complex psychological and social aetiology such as most mental health problems, personality disorder and the forms of disability and disaffection that create sink estates, and underclass and the tinder for riots. HTA/NICE/RCT models are brilliant innovation testing points that can allocate causality for drug and inert (i.e. non-human) technologies. However, no research models will produce true causal attributions for psychosocial interventions and problems and the attempt to produce these by transferring models from physical health care creates an evaluative structure utterly unsuited to improve mental health and social care. This is to some extent acknowledged by Rawlins’s own, excellent, 2008 paper. “De testimonio: on the evidence for decisions about the use of therapeutic interventions.” Lancet 372(9656): 2152-2161. For my own, lay oriented summary of some of the issues for group and social interventions see Evans, C. (2010). "Death, taxes, certainties, groups and communities; or NICE and the deathly hallows." Therapeutic
2) The use of routine data collection by services, which has improved dramatically in the last 10 years, should be promoted not just to manage things through excessively simple, often politically self-serving traffic light systems but to encourage genuinely high powered statistical and health economic exploration of its enormous complexity but its ultimate capacity to produce real monitors of innovation and change. IAPT was a spectacular example both of how much data CAN be collected, but then of how crassly politicised and naive its analysis would become rendering it almost completely useless for promotion of real innovation in psychological therapy services.

3) There needs to be a real recognition that much innovatory change in health care, even physical health care but spectacularly in MH & social care, is a sociological, anthropological and political phenomenon not a technological and "natural science" one. That needs a real shift not only to a very different quantitative evaluation framework (see my #1 and #2 above) but also to much more radical endorsement of sociological and anthropological research methods, particularly qualitative and hybrid methods. This will take some political courage but will pay dividends if such methods can be endorsed.

**What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

The word "rapid" is itself dangerous: good innovations that can really spread and do good are often revisionist and gradual not revolutionary, no matter how against the zeitgeist that may sound. In Mental Health and Social Care, my own area, the best take at least two years to implement and then five or so to embed into routine practice and often fail to make the transition to routine practice as they are seen as "easy cuts". Much rapid change is then strangled unless it is part of a network and has access to managerial and economic power. All significant change initiatives should have clear 2, 5 and 10 year transition plans and the national board should expect such plans to look at all costs including transitional costs.

Clear, ring fenced budgets for innovation partnerships and networks should encourage collaboration around innovation. The CLAHRC programme had some good ideas but was probably too large, too "lumpy" and too much driven by central ideas of research propriety and inducement to pseudocollaboration to secure the awards to represent real progress. However, the next generation of CLAHRCs should offer real opportunity to revise that design and springboard off the more successful collaborations to promote real local collaboration with ring fenced funds for genuinely innovatory ideas.

**Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?**

Nothing specific to add to the above.

We would like to be able to follow up interesting comments and case studies. Can we contact you for this purpose?

Yes

Do you want to be kept in touch with the next steps in this process?

Yes

Do you want to be included in a wider community of interest?
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<td><strong>What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?</strong></td>
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<td><strong>Certainly in MH and social care the purchaser/provider split, though intended to promote initiative and innovation, often stifles it.</strong> Joint commitments of purchasers and providers to innovatory work should be expected though how that will sit with even the revised new plans for the NHS it is hard to see.</td>
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