

Advocacy: removing barriers and accelerating time to value

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January 2019

There are problems throughout the innovation pathway

From the start, with invention and trials...

“persistent nature of the gap between health R&D needs and the R&D that is presently funded and undertaken”

(Rottingen et al 2013)

... to the end with spread and adoption

“Of more than 25 000 reports published in six leading basic-science journals between 1979 and 1983, 101 included confident claims that the new discoveries had clear clinical potential, yet only five had resulted in interventions with licensed clinical use by 2003, and only one led to the development of an intervention used widely”

(Chalmers et al 2014)

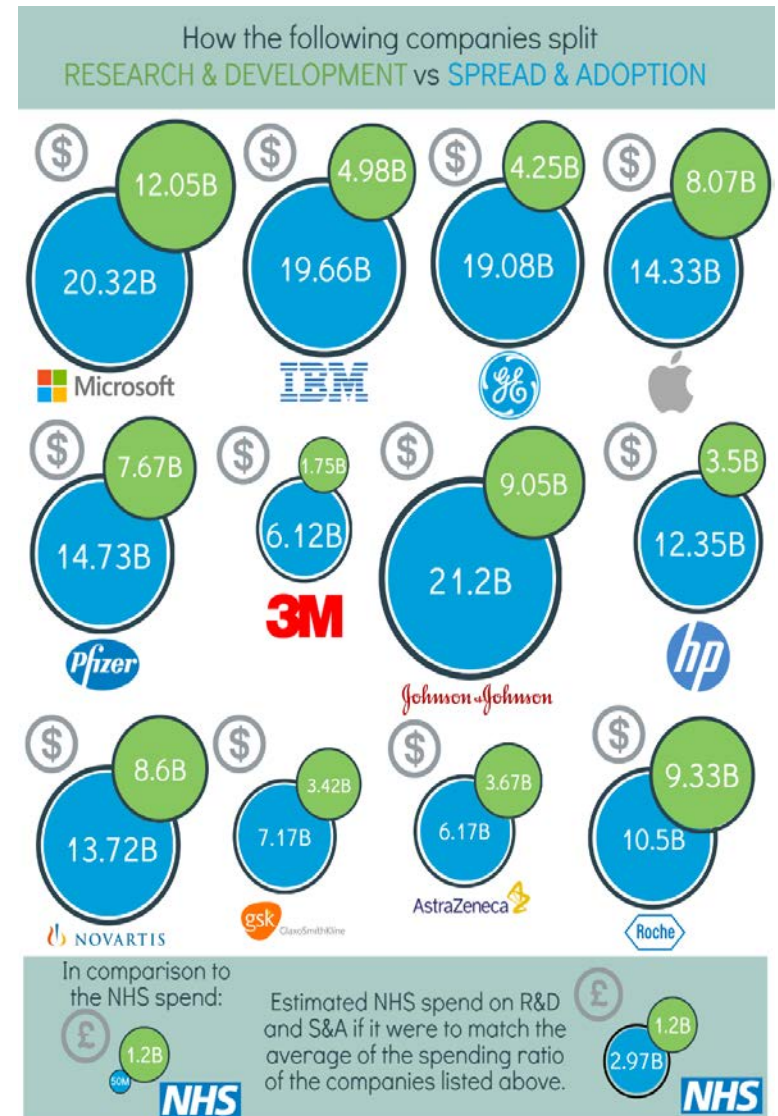
In summary

“Our problems with innovation are probably a product of the disconnected and disengaged research system producing innovations that the healthcare system has **neither capacity nor will to implement**”

(Walshe 2015)

Yet there is limited focus on addressing this

- Sustainability and transformation gets little attention compared to 'getting by' operationally
- Little is invested in building staff capability to deliver change or in retraining and redeploying secondary care staff
- Health Systems Research is a minority sport (7.5% of UK Health R&D)
- Spread and adoption gets less investment than R&D: see right



Circles are not drawn to scale.
All figures for companies listed are from:
2015 SG&A and R&D Expenses Figures -
Sourced from FactSet Fundamental.

Academic Health Science Networks

- **Build partnerships** between all organisations involved in healthcare: NHS, academia, social care, 3rd sector and industry
- **Identify and respond to common priorities** – helping make effective use of resources within and across STPs
- **Build capacity and provide expertise** across a range of areas: patient safety, PPI, informatics and evaluation
- **‘Import’ what’s working best** from other areas
- **Build national reputation of NHS organisations** and capitalise on their IP

Advocacy (i) King's Fund

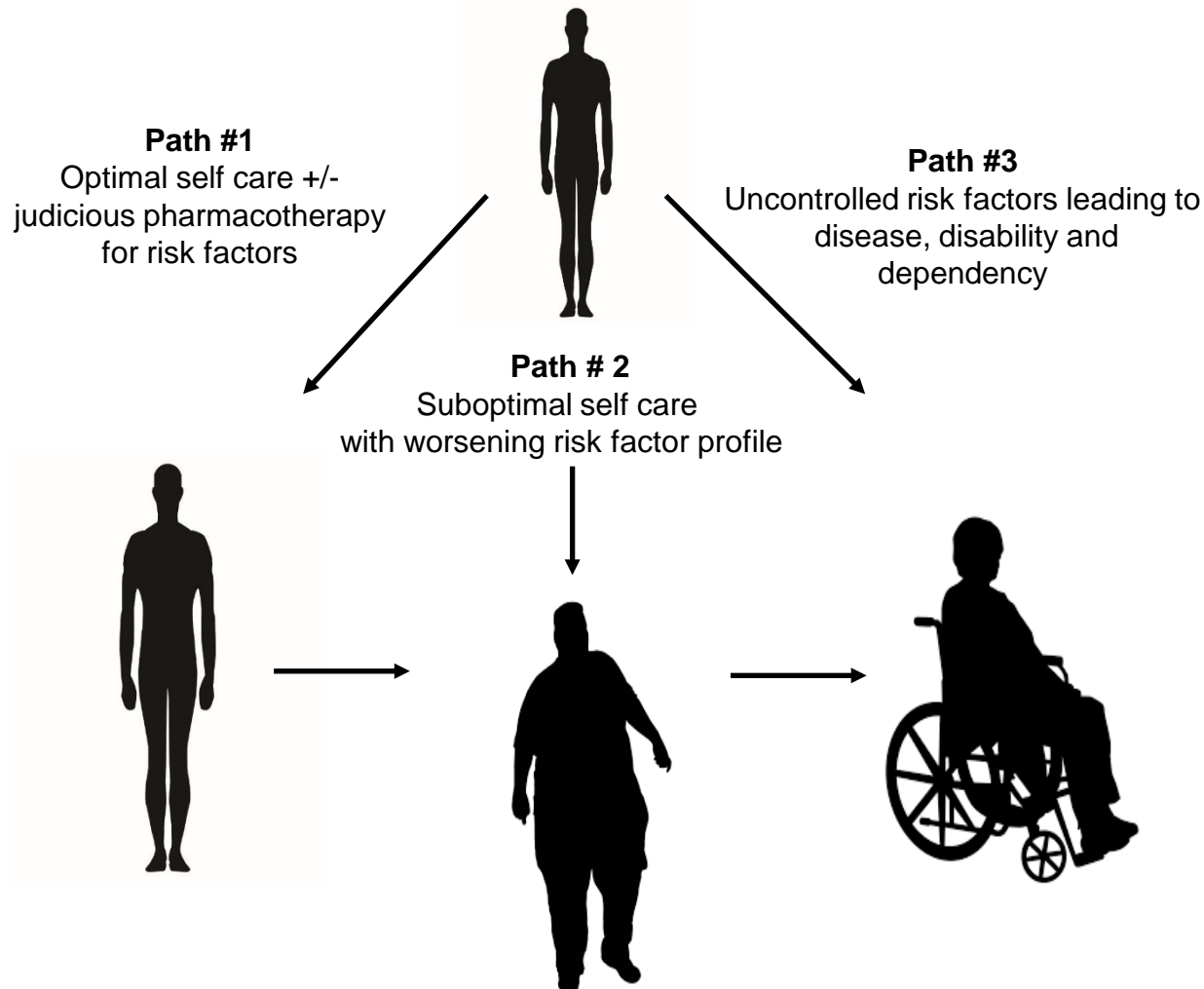
- 1:** Transferring even simple innovations from one NHS organisation to another is a complex process requiring adaptation, testing and re-evaluation.
- 2:** Few of the service innovations considered here are likely to spread across the NHS through passive approaches such as publicising them at conferences or producing toolkits.
- 3:** These case studies highlight the need to put '**boots on the ground**' for spread to happen, with senior clinicians to convince colleagues of **the benefits of experienced project teams** to support services in adopting innovations.
- 4:** However, lack of adequate resourcing is a major barrier to adoption and spread.
- 5:** The attitudes of local leaders and the working environment within providers have a significant impact on the speed of innovation and spread. **Some local leaders actively champion innovation**, while others encourage staff to focus on the day job.



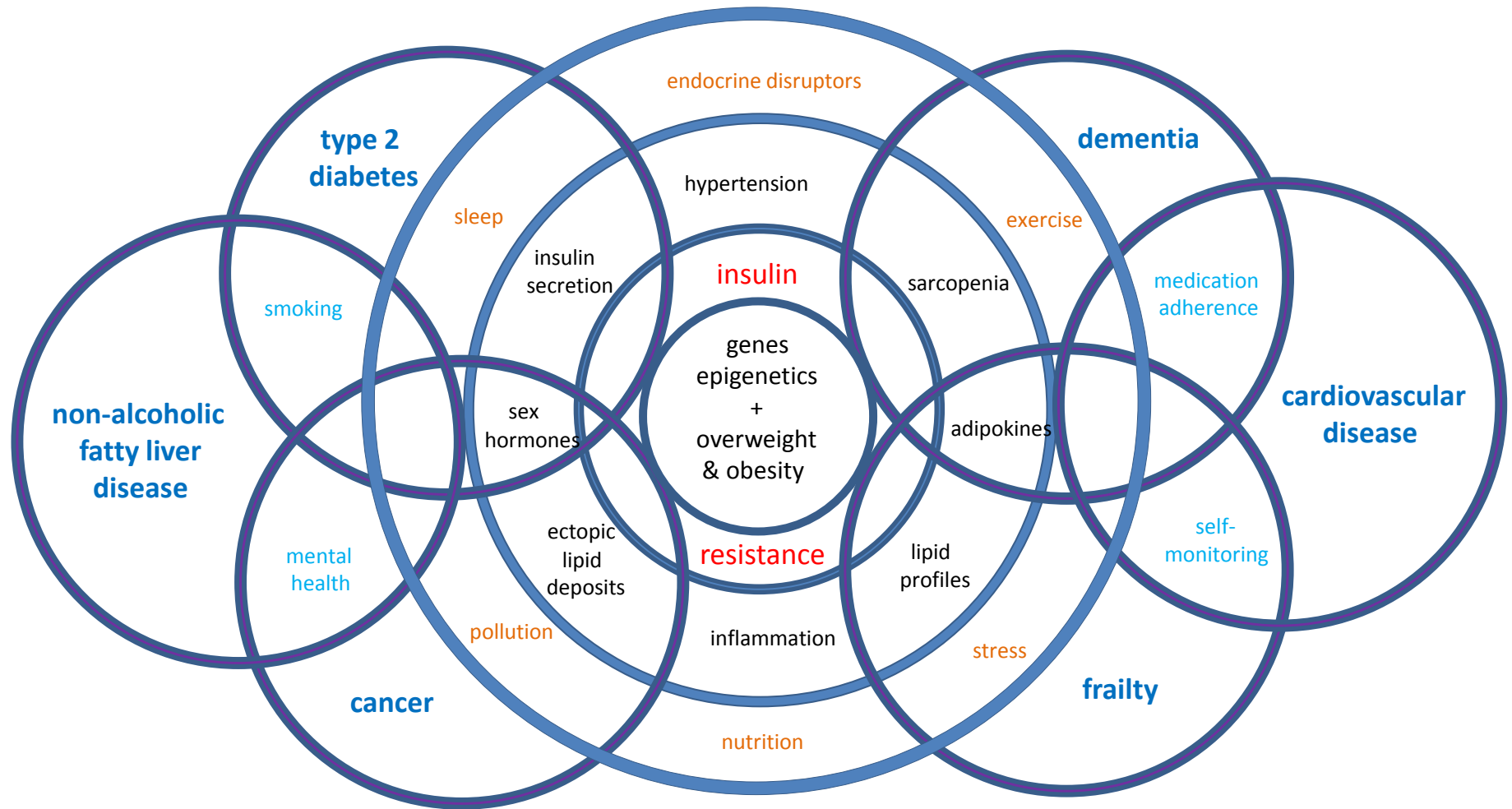
Advocacy (ii) Nuffield Trust

- 1:** The real opportunities to create efficiencies come from **long-term** transformational projects, with appropriate funding to support them. There needs to be a **shift from focusing on cost to focusing on value.**
- 2:** Innovations are often judged on a least-cost basis, or are expected to yield a positive **return on investment in the first year.**
- 3: Budget silos** make some parts of the system unwilling to invest in innovations that produce savings elsewhere.
- 4: Clinicians' lack of time** to prioritise innovation or the identification of problems, combined with a lack of incentives in the system to make time.
- 5: Innovation is too often viewed as a luxury.** Identifying the most pressing problems and looking for solutions is rarely built into anyone's day job – least of all clinicians.
- 6:** This is further compounded by a lack of clarity around how far chief executives should be involved in adopting innovation. **Chief innovation officers with board oversight of the innovation process could make a fundamental difference.**
- 7:** Where innovations require significant service transformation in order to realise savings, **involvement of leaders with oversight of the whole system and budget is often necessary.**

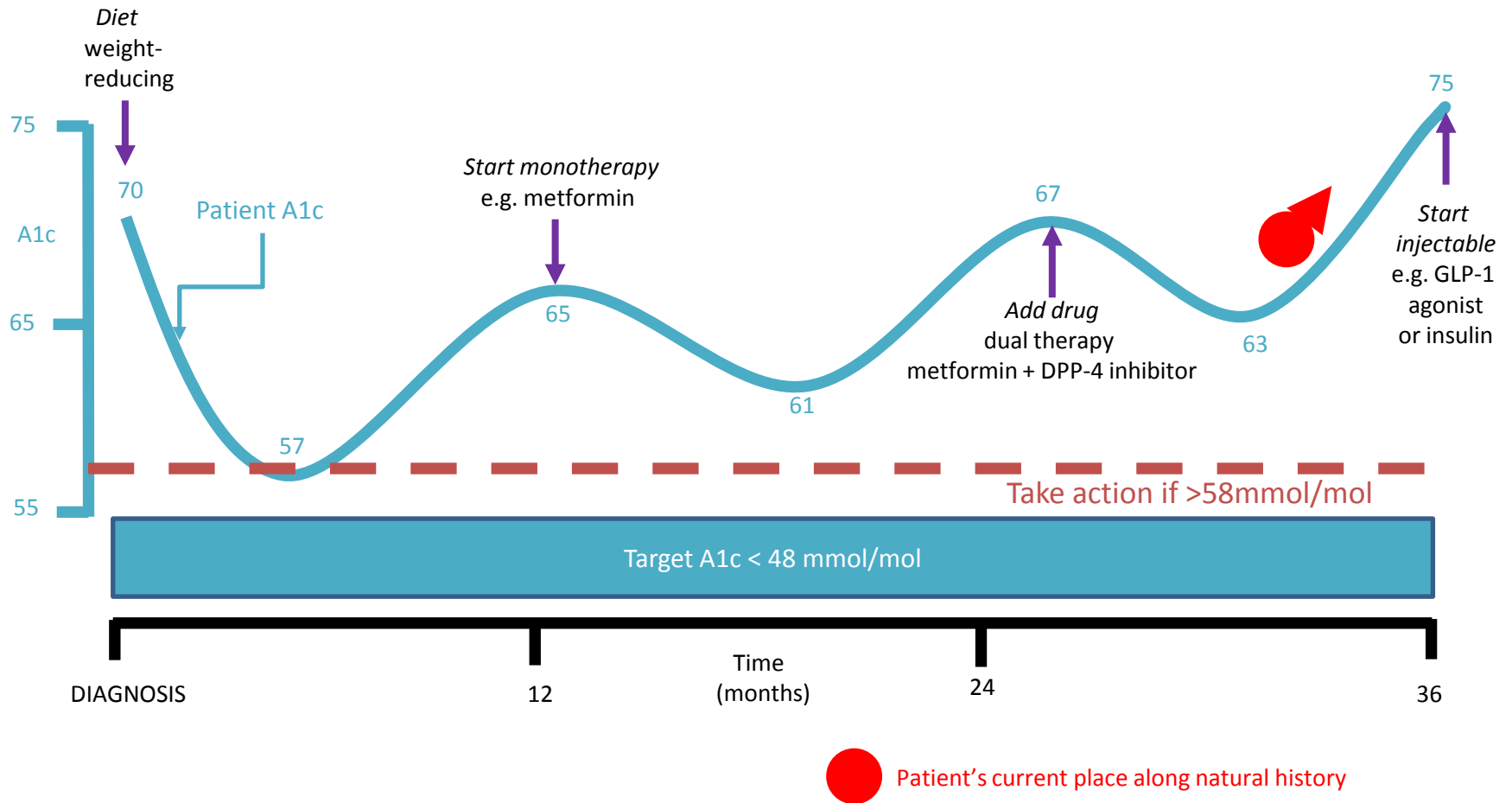
Paths to healthy ageing and preserved functioning



Cardiometabolic syndrome: an expanded definition



Citizen journey



Our top 3

1. A more holistic focus on people's care and patient experience
2. Faster triple integration of people's health and social care, physical and mental health care, primary and secondary care
3. A greater focus on value for money and ability to invest now to save in future years

Examples

Age UK's trained volunteer **Care Co-ordinators**

Patient Knows Best at Surrey and Sussex Healthcare NHS Trust

Technology Integrated Health Management (TIHM) for dementia at Surrey and Borders Partnership NHS Foundation Trust