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SUMMARY

The UK has always been a leader in medical invention - the challenge is to spread that innovation quickly and consistently. Despite a good track record of invention – often driven by UK universities, researchers and businesses – it finds it harder to provide quick, equitable access to new innovations. This avoidable variation – sometimes called the postcode lottery – hampers our ability to achieve the best health and wealth outcomes. Moving into a new decade, there is a substantial opportunity to do better.

New analysis, presented in this report, shows that if we were to match the performance of our international peers we could save an estimated 20,000 avoidable deaths each year. One of the (though not the only) key drivers of this is variation in access to best practise treatments, care models and technologies, with other countries consistently better at spreading innovation than the UK. Our model also shows a prospective economic dividend from addressing this worth an estimated £20 billion - through people remaining active in the workforce and the economic contributions of a strong life science industry. A further £10 billion could be saved from reduced costs related to health, social care and unpaid care. This annual benefit could also increase further in subsequent years, as more people benefit from access to health innovations.

Seizing this opportunity requires not just exciting science and bold invention, but an upgrade in our ability to realise the full potential of exciting advances across the NHS. There has been no shortage of health innovation policy this decade. It has particularly focused on what national bodies can do to make innovations more accessible and affordable for the system (a ‘supply side’ focus). However, less has been done to empower the NHS frontline (‘the demand side’) – the people who are expected to reach out, understand, implement and champion innovations in practice. This presents an opportunity for government to deliver on the promise of science, technology and health management advances, by investing in the capacity of the NHS itself.

This will be central to the Covid-19 recovery. Conditions like cancer and cardiovascular have been significantly impacted by the disease. For example, cancer ‘urgent referrals’ have dropped 75 per cent (Hiom 2020), while A&E presentations for heart attack symptoms have halved (Bakker 2020). Without intervention, this will cause increased demand in the coming years, and excess mortality. More ambition on the spread of innovation could help alleviate pressure across the whole country.

Progress is being made, but being even bolder on spread will be critical to delivering a ‘science based economy’. The Accelerated Access Collaborative (AAC) has been a welcome scheme, acknowledging the importance of spread as one of its six priorities. This paper outlines what bold delivery of this priority would look like – and quantifies the opportunity in terms of health and wealth gains.

IPPR’s research with people working in the system showed three thematic barriers experienced by the frontline, which should be immediate priorities. These are responsive to policy change and should become priorities for a more managed approach to the spread of innovation.

- A risk-averse culture, driven by the approach to performance management and focus on short-term targets.
- The sheer complexity of the NHS, coupled with a lack of networks, creating a ‘not invented here’¹ culture.
- A lack of resource, including a lack of financial support.

Covid-19 has proven such barriers are surmountable. The crisis accelerated many innovations, that had otherwise been taking decades. For example, 71 per cent of general practice consultations happened in face-to-face in 2019. As of April, 71 per cent were remote (RCGP 2020). Success like this can be explained by the center setting a clear ‘mission’. By mission, we mean they stated a clear goal, added flexibility to existing policy and regulation, provided resource, and then empowered local areas to deliver change in their setting, within the set framework. It is important that lessons like this from Covid-19 are reflected in how we approach the adoption and spread of innovation going forward.

1 This refers to a cultural phenomenon in the NHS where leaders strongly prefer innovations researched, piloted or created in their own setting – even if similar work has already been done elsewhere.

To learn the lessons of Covid-19, support recovery and ensure transformation in NHS provision, we recommend two key shifts in policy. Together, we define this as a mission based approach to the spread of innovation.

First, the centre must set the rules of the game in the long-term – by making minimum standards, accountability, roles and regulations clear. This will provide a predictable framework for innovation. It will also provide much needed permission to spread innovation, and provide direction to commissioners, providers and practitioners, helping them push in the same direction.

Policy recommendation 1: NHS England should publish National Service Frameworks. These should set ambitious and timebound targets for innovation – giving objective and rationale for a mission-based approach.

Policy recommendation 2: The Care Quality Commission should actively regulate on the basis of innovation. This means considering missed opportunities to innovate in their ‘needs improvement’, ‘good’ and ‘excellent’ ratings.

Policy recommendation 3: Value assessments should be centralised in the NHS. Local tendering processes do not have the technical expertise to make clinical differentiation between medicines - and their efforts to save money do not make sense in the context of a capped medicines budget. Government should ban such processes. They should also fix distributional problems with the voluntary reimbursement scheme for branded medicines, so local providers do not miss out when they invest in innovation. Government should finally ensure NICE have the capacity necessary to deliver quick, high quality and modern assessments that keep up with the science..

Policy recommendation 4: CCGs and ICSs should be jointly responsible for NSF implementation in an area – with a duty placed on them on the basis of ‘comply or justify’. In practice, this should mean publishing – and accountability for – strategies on catalysing, resourcing and supporting provider implementation of NSFs.

Second, there must be much more active support for local providers and commissioners. The goal must be to create an ‘innovation eco-system’ where the NHS workforce have the relationships and resources to engage with spread. Such a paradigm shift would create a step-change in the system’s performance.

Policy recommendation 5: There needs to be a shift in payment by activity to payment by outcomes. Incentives on innovation should be linked to the standards set out in the NSF. This shift should begin with the Clinical Excellence Award budget being reinvested into a new ‘Innovation Award’, with payments made to those measurably achieving the best performance against the criteria set as priorities in the NSFs.

Policy recommendation 6: The spread of innovation should be part of the NHS’s DNA. This means individuals should be both expected to spread innovation and rewarded for doing it well. The spread of innovation should be put into competency frameworks at all grades in the NHS, as a key skill within recruitment processes and as a criterion for appraisal and promotion outcomes.

Policy recommendation 7: Clinicians need time to innovate. Workforce funding streams should include bespoke time for clinicians to focus on innovation and adoption, with local freedom on how that is allocated to roles.

Policy recommendation 8: At an individual level, clinical networks should be formed, offering those working on innovation access to peer support and shared learning. At an organisation level, a ‘Health Innovation Challenge’ should be launched – following the model of the London Challenge. Providers with the best track records should be designated ‘anchor institutions’ and given responsibility for raising performance in their footprint. This should focus on peer-support and shared training. In return, they should receive small amounts of funding to pilot new ideas, feeding into future iterations of NSFs.

Policy recommendation 9: The demand-side needs access to the funding needed to support innovation. A transformation fund equivalent to £10 billion should be implemented over four years. This will support the commissioning and decommissioning of services and allow clinicians to ‘see the difference’ from a new practice before committing.

The progressive policy think tank

Citation: Thomas C, Quilter-Pinner H and Verma P (2020) *The innovation lottery: Upgrading the spread of innovation in the NHS*, IPPR. www.ippr.org/publications/the-innovation-lottery

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