Innovation is being squeezed out of the NHS

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- Dr Malte Gerhold
- Tim Horton

The crisis in health and social care, alongside political pressure on waiting times, has spawned a scramble for new ideas and innovations that can help 'save the NHS'. Yet there's no escaping the fact that turning things around will require a sustained period of investment, and action to address staff shortages.

But while there are no quick fixes, there are things that could be done right now to make a difference. And although innovation remains important, many of the steps that could make a difference in the short term are in fact well known – such as better use of existing technology, or process improvements to speed up hospital discharge and improve patient flow. The challenge is that with staff and services stretched to the limit, many organisations are struggling to put these kinds of changes in place and achieve the impact needed.

This shouldn't be surprising. Health Foundation research highlights how adopting the complex changes required in care is much harder than traditionally assumed. Doing it well requires resources, skills and headspace. The capacity and capability involved are often underestimated. And without good implementation, innovation amounts to very little.

There are several reasons behind this. Innovative teams and organisations often take for granted their own readiness and capability to innovate. But these factors are not necessarily shared by other teams and organisations, raising the question of how generalisable the experience of early adopters is. Just because an innovation has been successfully piloted, it doesn't follow that other organisations can adopt it overnight.

This has important consequences for achieving large-scale change in health and care services. While resources get lavished on innovators, pilots and vanguards, often the biggest hurdle is ensuring that other organisations can develop that same readiness for adoption – necessitating a rebalancing of resources from innovators to adopters. NHS England hopes, for example, for a 10% productivity improvement in pathology and imaging networks over the next 2 years from greater integration of AI – a figure based on the experience of early adopters. Just how achievable this is will rest on the wider sector's readiness and capacity for implementing these changes and whether the support on offer matches the challenge.

Another issue is the difference between putting an intervention in place and actually wringing the benefits out of it. Research shows there can be a time lag of years between installing health technologies and realising the productivity gains. That's because it isn't the technology itself that produces the gains, but the effective use of technology, which depends on the people using it and can require new roles, processes and ways of working.

Lord Carter's review of productivity in NHS hospitals, for example, highlighted the 'immaturity' of many trusts' use of established technologies; on e-rostering, for example, they found that while most trusts had invested in the technology, few were using its full functionality. This is also an issue for electronic patient records – current investment in this infrastructure by NHS England is welcome, but the real challenge is to change how care is delivered as a result.

In a world where political pressure focuses on the short term, it's a reminder that what matters most is not fast initiation of change but fast realisation of benefits for patients and staff. So, the government needs to fund 'the change', and not just 'the tech', helping teams to speed up this journey from initiation to optimisation.

Current funding and workforce challenges aren't just creating long waits and crowded hospitals. They are squeezing out the health and care system's capacity to innovate – to plan, test, reflect and learn, all of which are critical for organisations' ability to withstand crises and improve performance. It's critical that national policy ambitions recognise the pressures staff are under, and the challenges this poses for making successful change happen.

So, what could help? One option could be a dedicated package of support to help providers rapidly adopt and optimise solutions they've already identified as priorities. It could provide support for things like project management capacity, training, quality improvement expertise, rapid evaluation, and backfilling costs to free up staff time to implement change. These do not necessarily require large sums. But at a time of huge financial pressure, even small funding requirements like these can be a significant barrier.

Other types of assistance could go beyond funding, such as providing design expertise or peer network facilitation. There's a lot to be learned from the experience of the NHS Modernisation Agency in the early 2000s, which provided valuable support for the implementation of service improvements – in areas like emergency care – through funded collaboratives. All eyes here will be on the new NHS model for supporting improvement following the shake-up currently underway inside NHS England.

NHS England's Regional Scale Programme, set up to help scale remote monitoring, is one example of what small amounts of well-targeted funding can achieve. Evaluation suggests that during the pandemic, it was key in enabling effective adoption across participating sites. What's needed now is to apply this logic on a greater scale and support the implementation of a much wider range of service changes to enable recovery.

The way out of the crisis can't just lie in developing a fresh pipeline of innovations. It's also in the effective implementation of solutions already at hand.

Dr Malte Gerhold (@Dr_Malte) is the Director of Innovation and Improvement at the Health Foundation.

Tim Horton (@timjhorton) is an assistant director in the improvement team at the Health Foundation.

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