HSR UK response to the DHSC consultation on ideas for their Ten-Year NHS Plan

Q1. What does your organisation want to see included in the 10 Year Plan and why?

Health Services Research (HSR) is central to achieving the Government's overall aims for the NHS. Successfully changing how health services work depends on understanding the complexities of how they are organised, and how processes of change can be effectively achieved. Decades of evidence and experience shows that this is hard and often fails. HSR provides the evidence and expertise to ensure that the right change happens in the right way; it is a critical enabler for the 10 Year Plan as a whole. We therefore want to see HSR incorporated as a central enabler of the 10 Year Plan; we set out what that means below.

HSR UK is a membership organisation dedicated to the promotion of health services research in policy and practice. The collective voice of UK health services research, we connect researchers with health service leaders, managers, and clinicians to drive improvement and innovation in the NHS and care system. We are a self-supporting network with a diverse membership of individuals and organisations across university research centres, NHS bodies, research charities, think tanks, health professional and patient groups and the private sector. Hosted by the Nuffield Trust, HSR UK is an independent charity advised by an active Board of Trustees including health service leaders, funders, early career researchers and leading academics.

We work with our members to support the next generation of health and care services researchers, representing health and care services research (HSR) to policy makers, NHS leaders and practitioners, and working in collaboration with the research, policy, and practice communities to create, share and implement the best evidence to inform NHS and social care practice. We also convene the foremost HSR conference in the UK each year

This response is submitted by Judith Smith, Pete Bower, Tara Lamont and Cat Chatfield on behalf of HSR UK and our member organisations. Centre leads from our member organisations have commented on and contributed to this response.

HSR focuses on improving the quality, accessibility, and organisation of health services in the NHS and social care settings and beyond. These include testing new ways of delivering high quality and safe care, assessing how to better collect and use patient

experience data, exploring new ways of organising NHS and social care services to improve outcomes and trying new ways to spread knowledge and evidence through health care services. Using health services research, we can better understand and improve care received in our health system. Unlike other sectors of research that may focus on development of clinical treatments, HSR focuses on how these interventions impact health outcomes. By translating scientific and medical innovations to better inform health care, health services research translates cures into care.

Examples of HSR include research about roles and deployment of the NHS and social care workforce, evaluations of new and emerging innovations such as neighbourhood teams and the use of AI within care pathways, and the health economics of new forms of care such as providing surgical hubs or virtual wards.

What we want to see included in the 10-year plan:

- Plans and proposals that draw clearly on the extensive health services research evidence base about what works, where and why, and that systematically include an HSR dimension to generate new evidence where needed. Applied research into policy questions and delivery and quality of services has historically been under-resourced in relation to biomedical research, but these are critical areas of uncertainty and potential gains from knowledge on optimising delivery of services and deployment of staff in times of constraint.

- An emphasis on the importance of using HSR experts to synthesise existing evidence to inform and respond to plans. policies and proposals for new service direction and innovations is vital. HSR UK members can do this, e.g. via NIHR-funded HSDR evidence synthesis centres.

- A clear commitment to evaluate progress with each aspect of the reforms – not just on clinical outcomes but also through a broader HSR lens to ensure that their impact on critical priorities of access, patient experience, health inequalities and safety are evaluated. The benefit can be seen from prior experience such as evaluation of programmes such as the Vanguard sites, research into stroke service reconfiguration and seven-day working studies. Co-commissioning services and evaluation also offers a way to reduce risk – for example assessing whether concerns around patient safety issues and the physician associate role are supported by existing evidence and in what contexts more research is needed.

- Reach into the HSR community, which has the expertise and potentially extensive capacity for rapid and longer-term evaluation of service innovations, for example

through NIHR-funded rapid evaluation and national evaluation teams and Applied Research Collaborations (ARCs) as well as local HSR centres and departments. Examples of such evaluations include the use of AI in outpatient diagnostics (RSET team – shift from analogue to digital); integration of hospital and primary care services (BRACE team – shift from hospital to community) and more. Investment in expanding established research capability should deliver a return on investment in understanding what elements of the 10 year plan should be pursued and what is not delivering for patients and the public.

- Leverage the experience of the HSR community at working in close collaboration with local practitioners, service leaders, think tank partners and policy makers in undertaking and rapidly reporting on research and evaluation findings. Examples include: pulse oximetry in home and social care settings during the pandemic; different forms of virtual wards; what works or not in establishing and running neighourhood teams; the extended role of community pharmacy in delivering primary care and supporting self-care; dementia care co-ordinator service; improving the uptake, experience and implementation of interpreting services in primary care; developing further the role of the NHS App. Invest in and use the capacity of existing teams generating rapid evidence to inform policy - for example evidence on understanding the prevalence of foetal alcohol spectrum disorder to inform public health policy to prevent it - to ensure policies in the plan are evidence-based.

- Build on the HSR community's experience and skill in working in partnership with patients and the public in determining priorities for research, designing studies, doing research, and sharing evidence and findings. This is arguably a more established way of working in HSR than it is for usual NHS service planning and development. This includes focussing on pressing societal issues – for example improving home-based palliative care for older people; as well as working with marginalised communities to improve maternity care for people with learning disabilities or cancer care in prisons.

- HSR evidence and experts can really help inform choices about service priorities and development, how to avoid implementation pitfalls, what evidence to use to support plans, how best to evaluate their progress, and ensuring that plans and innovations draw on the best of UK and international evidence, also contributing to that evidence base for the future.

- Finally, a strong commitment to transforming the health and wellbeing of the NHS and social care workforce, recognising that without trauma informed and healthy psychological working environments staff will not be retained, and the workforce crisis will deepen. All elements of the 10-year plan depend on staff delivery. Adopt evidence that suggests an individual approach alone has failed and system wide culture change is required to shift the dial on this entrenched problem. Responsibility for staff wellness needs to sit with boards not just wellbeing Guardians.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

- There is a powerful and important evidence base that offers insights into why this long-standing policy priority – to shift funding and care from hospital to community settings - has not been implemented as intended.

- This evidence base draws strongly on health economics (re the role of funding incentives and approaches to payment), management research (re the need to attend carefully to investing in management capacity and change processes), medical sociology (re how professions can be enabled to change their working practices and approaches to care provision), user-led research (re how new forms of care and services can be co-designed and tested with service users and the wider population, and policy research (e.g. why the power and influence of acute care and hospitals nearly always trumps primary care services and professions when political realities hit, and what needs and could be done to counter this, for example through much more collaborative research with and in primary care as well as with hospitals).

- Success in shifting care depends on staff and ability to adapt to new ways of working. HSR has contributed to understanding of the complex trade-offs and ways to optimise deployment of staff such as
    - Work on new roles such as physician associates
    - Upskilling support staff e.g. assistant workforce in diagnostic imaging
    - Role substitution and shifting professional boundaries such as in maternity care
    - As well as wider work on staff wellbeing and resilience

- A lot of the evidence about this shift already exists, and there is a lot to learn from where this has been achieved, in the UK and overseas, to inform wider policy measures and plans to make it happen at a much wider scale, and in a way that is acceptable to patients, communities, staff and NHS leaders. Some existing research in this area includes evidence relating to:
    - Trial of hospital at home to avoid admission
    - Shifting diagnostic services to community
    - 10 year review of integrated care pilots

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

- One of the biggest challenges for this priority is how to bring high quality evidence to bear on what can be the 'shiny new' which is sometimes over-promoted by commercial and other interests, before sufficient piloting and evaluation has taken place in the complex context of health and care services and the ways in which users, patients, staff and professionals work and interact.

- The HSR community studies the role and implementation of technology within health and care in the round, enabling services to obtain best value from technological investments. For example, studying how and why the implementation of remote consulting has worked (or not), for whom, when and where, and all that is needed to enable its benefits to be realised plus potential risks of exacerbating inequalities and adversely impacting patient experience.

- The nature of HSR in being cross-disciplinary and mixed methods approaches have a key enabling role to play here, for example in understanding why some technology is not implemented and spread as expected, what needs to be done to address this, and how the studies themselves can form a part of service and organisational development when 'alongside'. Ongoing studies whose results can support this understanding include:
    - The role of AI in healthcare eg in primary care triage
    - Evaluating the implementation of AI in chest diagnostics
    - AI enabled tele-dermatology skin cancer triage and diagnosis
    - Evaluation of live streaming between 999 callers and emergency services

    - Evaluation of the use of virtual consultations in people with learning disabilities

- HSR is effective at undertaking pragmatic, mixed methods studies that can build on/complement trial findings and do in-depth analysis of how a proven clinical/service intervention will work in context and practice, and what needs to be in place to enable this.

- HSR, when including high-quality economic analysis and workforce research, can offer important insights into the wider investment and service development that is needed to enable new technology to be embedded into service organisation and delivery.

- HSR can also enable a broader look at how technology is facilitating care rather than focusing on medtech innovations in isolation; so much technology in the NHS is supporting care rather than replacing care. Work in this area includes understanding the impact of new technologies on staff roles and training, professional behaviour and practice, what patients expect and experience, and what it might mean for other sectors such as community pharmacy, general practice and diagnostic services.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

- There is a wide body of HSR, and particularly public health research, about this. Evidence should be drawn from the existing body of research created by the NIHR School for Public Health Research, Public Health Interventions Research Studies Teams, and other such centres and groups.

- The rapidly increasing local and national collaborations in studies across health, care and wider local government and civil society is particularly important and exciting in respect of this NHS Plan priority. Of particular importance will be the outputs from the NIHR-funded Health Determinants Research Collaborations which integrate health with wider determinants of health across the government's other missions.

- Using HSR skills to identify those at risk and provide earlier identification, treatment, and prevention of avoidable disease – from child dental problems to kidney disease

- As ever, HSR brings the perspective of getting proven innovations into wider health and care practice, exploring the how, when, and why of implementing associated change, and then evaluating and studying what is working (or not) and why.

- It is typically particularly difficult for public health and preventative services to be implemented and spread, as they are complex, often cross many services and sectors, local government is more diverse and (rightly) independent as a sector, and a very wide range of stakeholders and roles are involved.

- In the area of prevention, the interaction of clinically proven interventions (e.g. a new vaccine) and the need for evidence to enable equitable and effective roll out and sustained implementation is often critical. Similarly, there can be a risk of diffuse roll-out and a real struggle to develop evidence about and understand implementation and impact. These evidence gaps can be addressed via the HSR community such as building the evidence base for social prescribing. However, results from research into the impact of such interventions on health outcomes in real world practice, such as the limitations of NHS health checks, need to be translated into policy and practice.

- There are many media stories about new ways of detecting ill-health and illness, but many fewer accounts of when and how these are implemented in a sustained manner, and what outcomes result. Evidence is vital here, for as with technology theme above, the 'shiny new' may promise long and deliver short, when the opposite is needed.

- In addition, attention needs to be paid to the dangers of overdiagnosis and overtreatment, with policy makers equipped to better understand the wider evidence relating to innovations which are pushed by lobby groups. Prostate cancer screening is a good example of this, with popular media pushing an approach which is potentially unsupported by evidence.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- Quick to do, that is in the next year or so
- In the middle, that is in the next 2 to 5 years

- Long term change, that will take more than 5 years

Short term

- Prioritise accelerating access to routine NHS and care data to support research across care pathways and priorities in the 10-year plan. Without this access, timely HSR, evaluations and policy research to underpin the plan will be impossible.
- Further improve access to data to facilitate evaluations by building data into innovations. Good existing examples are the datasets built into the Diabetes Prevention Programme and NHS Talking Therapies.
- Systematically commission HSR evaluation alongside putting innovations into practice – pilot, learn and implement with close consideration to access, workforce, equity, safety and patient experience. Use evidence to understand what policy decisions are helping, and what are hindering, the NHS.
- Work with the HRA to simplify and centralise research approvals for low-risk HSR studies and evaluations undertaken within the NHS to facilitate faster understanding of what works and doesn't in the 10-year plan.

Middle term

- It is not possible to deliver change and improve the population health without data. Despite progress within the NHS, there still exists challenges within and outside the organisation (e.g., inadequate infrastructures, barriers to data sharing between stakeholders, data not sufficiently representative of the population the NHS cater for making some groups invisible and hindering the research and practice communities' ability to efficiently assess population needs, and monitor and evaluate policies, services, and interventions).
- Therefore, the plan, to be successful, requires a commitment to improve interoperable electronic records, ensure data is representative, dataset completeness (e.g., improving data validation checks, enforcement through data collection protocols, data governance policies, data monitoring processes), effective health information exchange between organisations, and strengthen digital health data infrastructure and health care analytics.

Long term change

- Long-term progress cannot be achieved with short-term research funding. Therefore, a robust and sustainable long-term plan to support research and development and to ensure England is a global leader in healthcare research is fundamental for the plan to be successful.

- Similarly, long-term progress cannot be achieved without a skilled and motivated workforce. Despite the efforts to roll out a major retention programme, there is need to attract people into the healthcare services and offer high quality training. To achieve this goal, the plan should include a robust and sustainable strategy to support universities and academic staff to educate the existing and future generations that will deliver the NHS 10 Year Health Plan.
- Workforce strategies may include reviewing fees or student loan amnesties for priority professions such as nursing and midwifery, return of no fees (potentially tied to a period of work for the NHS post-graduation) for these professions, and review incentives such as the ability of overseas registered health staff to bring their families to the UK when they come to work for the NHS and in social care.
- In addition, there should be a commitment to develop a credible and sustainable plan that allows the NHS and HSR UK workforce to contribute to healthcare research. This could be achieved by establishing a practical and rewarding mechanisms for harnessing expertise and interest in evidence-based practice; create clinical academic posts and research fellowships and equal opportunities for all staff members; create a research culture and establish clear and transparent governance, management, and infrastructure (e.g., integration of research within clinical practice, in job description and appraisals, well-designed time-management systems that recognise activities of NHS staff).
- Work with medical schools to develop their curricula so that medical students are exposed to health services research methods and approaches alongside their exposure to clinical research. Understanding evidence-based approaches must also include evidence to support approaches to service change.
- There is an urgent need to increase diversity both in research and the healthcare system to help building and rebuilding trust with communities and reduce inequalities in knowledge and innovations. A successful plan needs to reflect a credible strategy to diversify the academic and healthcare workforce at all levels, to engage and increase participation of minoritised groups in research, and to prioritise research and development of innovations and treatments that reflects the needs of diverse populations.
- Co-production and co-creation of research and services are fundamental to influencing ownership and improving research engagement and uptake of services, retaining staff, improving patient experience, and achieving better health outcomes for all, and reduce inequalities. Therefore, for the plan to be successful it must include a credible, funded, and sustainable EDI (Equality, Diversity and inclusion) and Patient and Public Involvement and Engagement (PPIE) strategy that is not

tokenistic but guarantee meaningful, impactful, and true collaboration with communities and third sector organisations.

- It is fundamental that the plan commits to challenging silo working and enable realistic and feasible partnerships across organisations by incentivising research collaborations – for example, between HSR UK, NHS Integrated Care Boards, local government and academics.
- To bridge the research-policy gap, the plan should include a robust and sustainable strategy to accelerate knowledge translation and implementation of innovation using evidence-based approaches.