The AHSN Network

NIHR | National Institute for Health Research

SURVEY OF LOCAL INNOVATION AND RESEARCH NEEDS OF THE NHS

REGIONAL REPORT FOR WESSEX AHSN

APRIL 2019

NHS England

REPORT OF FINDINGS

INTRODUCTION

In November 2017, NHS England and the National Institute for Health Research (NIHR) published the paper "Twelve actions to support and apply research in the NHS". This document requested that, in order to articulate regional NHS needs, the 15 Academic Health Science Networks (AHSNs), working with their regional NIHR infrastructure each produce a statement of regional NHS innovation and research needs on behalf of their regional Sustainability and Transformation Partnership (STPs).

Accordingly, the AHSN Network commissioned an independent research consultancy, ComRes, to design, implement and deliver a survey that provides a robust and detailed understanding of the innovation and research needs at regional level and across all AHSNs. The project gathered the views of regional health and social care applied research stakeholders between June and October 2018, with a total of 61 telephone interviews conducted, followed by a survey of 257 stakeholders. This exercise focused on the views of clinicians and managers rather than researchers and short to medium term priorities, so as to complement the recent *Future of Health* survey commissioned by NIHR (RAND 2017).

This report is for the use of Wessex AHSN stakeholders, to support the drafting of the statement of innovation and research priorities, and is not intended to be published. It summarises the key findings from the interviews and online survey, first at national level[1] for context and then in relation to the data generated by Wessex AHSN's stakeholders. It also includes a methodology note as well as tables of the key survey questions in an appendix. Since the findings are based on a small sample size, they should be treated as indicative (see the methodology section on p. 11 for more).

The report provides an outline of the priority areas for innovation and research; however, these will require further refinement through consultation with stakeholders in order to develop specific innovation opportunities or research questions that are relevant to Wessex AHSN.

NATIONAL FINDINGS

Stakeholders were surveyed about priorities for innovation and research under three headings: system-level topics[2], medical treatment areas and specific patient groups. Each had between 11 and 14 options for them to choose from. The answers to these survey questions have been analysed alongside the topics that arose during the telephone interviews with stakeholders, and summarised in the table below. This sets out the themes around innovation and research and the specific priorities for each one.

Innovation and research theme	Specific priorities for innovation and research
Workforce	• Recruitment and retention of staff; • How staff perceive their roles and providing training and opportunities; • Use of alternative roles within the health service.
Mental Illness	• Mental health issues in children and young people; • Parity between mental and physical health; • Understanding and treating co-morbidities; • Diagnosis and treatment of dementia; • Community based support for those with mental illness.

[1] In this report, the term "national" is used to refer to the total population of stakeholders who participated in this project on the invitation of all AHSNs involved. This group incorporated the stakeholders of 14 AHSNs who completed the online survey and the stakeholders from 15 AHSNs who took part in a telephone interview.

[2] System-level priorities refer to any aspect of the processes, infrastructure and resources used in the delivery of public health services and care. By system-level we did not mean specific conditions/ diseases, or the functionality of individual organisations and practices.

Older People	• Care in the home and community support; • The social needs of the elderly population, and tackling social isolation; • Multi-morbidities within this demographic; • Frailty within this demographic.
Frailty	• Alternative integrated models of care; • Community care solutions; • Technology to support independent living.
Multi-morbidities	• Polypharmacy; • Parity between mental and physical health; • Integrated care pathways that promote holistic views of the patient.

When questioned about existing innovation and research, seven in ten (72%) stakeholders say that innovation and research taking place in their region at least partially addresses the areas they consider a priority and one in ten (11%) say it at least mostly addresses the areas they consider a priority. Just over half (55%) are at least reasonably confident in their ability to access current research and innovation, compared to three in ten (30%) who are at least reasonably confident about implementation of available research and innovation.

Stakeholders also emphasised the distinction between research and innovation, with research evidence published and then often left unapplied and unimplemented. In the course of the interviews and surveys, national stakeholders also made a number of suggestions to improve awareness and application of research and innovation. These included improving communications about it and increasing its profile, as well as turning research and innovation into part of day-to-day working.

REGIONAL PRIORITIES

OVERVIEW

This section presents the evidence from the survey responses and interviews with Wessex AHSN stakeholders. The survey was structured around asking stakeholders to identify their priority areas in terms of system-level topics or challenges; medical treatment areas; and specific patient groups. This section provides further detail around some of the key themes that came up across these areas, including: workforce issues, primary care, mental health, frailty and multi-morbidities. It also includes analysis of stakeholders' views about existing innovation and research in the Wessex AHSN region, including suggestions to increase awareness and implementation of innovation and research.

HOW DID THE WESSEX AHSN PRIORITIES ALIGN WITH THE NATIONAL RESPONSES?

In line with the national findings, workforce issues, such as recruitment, retention and skills were a high priority for Wessex AHSN stakeholders. However, stakeholders in Wessex were more likely than national stakeholders to identify primary care, including capacity and capability of GP services in their top three highest priorities, compared with national stakeholders. While integrated care for those with multi-morbidity and/or complex social care needs emerged as a high priority for AHSN stakeholders overall, it was less important for Wessex AHSN stakeholders.

The medical treatment areas identified as priorities were broadly similar in the Wessex AHSN region to the national results, with mental illness, frailty and multi-morbidities as top three priority areas.

Of specific patient groups whose care could benefit from innovation and research, Wessex AHSN stakeholders identified people with mental health conditions, older people and socially-isolated people as groups to focus on. This pattern reflects the national-level findings where the same three groups were prioritised at an overall level.

DETAILED FINDINGS

WORKFORCE ISSUES

Workforce issues, such as recruitment, retention and skills, were prioritised by Wessex respondents in their top three topics which could benefit from innovation and research, although they were not frequently discussed in the qualitative interviews or open-ended comments. Where workforce was commented on, stakeholders were interested in research about staffing structures: how staff could be "shared" across healthcare settings or their roles changed to incorporate new aspects of care, how they might be supplemented effectively by a non-registered workforce and the effectiveness of new innovations in workforce. They also suggested building evidence around barriers to recruitment in the health service. One stakeholder singled out the primary care workforce as a group requiring research and innovation.

> *"Challenge of ageing and disengaged primary care workforce. Requirement for new models of primary and community care that change the way that GPs will have to contract and engage with the system. The impact of all of this on training, recruitment and retention of GPs and wider primary care workforce."*
>
> **Online survey respondent**

> *"I would like to see more conclusive evidence that new roles do indeed improve the efficiency of a system (as well as the quality of service provided). There is limited evidence about the effectiveness of some of the new roles working in novel settings - for instance the impact of paramedics working within primary care. There seems to be very little evidence around the impact and effectiveness of formal clinical networks across providers, with a high degree of scepticism from clinicians that this would work (particularly thinking about some of the issues that we are tackling around lack of consultants in some areas and the need to share on-call between Solent partners)."*
>
> **Online survey respondent**

PRIMARY CARE

Several Wessex AHSN stakeholders identified primary care, including capacity and capability of GP services, as a topic within their list of top three research and innovation priorities. In discussion around this topic, they proposed several questions that innovation and research might tackle. These included exploring why example patients were treated as acute admissions rather than at primary care level; understanding the effectiveness of interventions that are meant to avoid patients being treated outside primary care; and evaluation of extended primary care teams. Stakeholders also mentioned the need to examine how primary care could be made more accessible to the patients it serves, with patient experience at the heart of new innovations.

> *"We've got a real need to look at how we interact with people… 'Let's start with the patient experience or the personal experience, and then how do we weave the services around?' as opposed to, 'Let's talk about what suits the doctor or nurse, or organisation process, and then work all the people activity around that.'"*
>
> **ICS Director of Transformation (STP)[3]**

[3] Stakeholders fell into 11 broad categories based on the stakeholder's job title, organisation and specialisation: Acute, Clinical Commissioning Group (CCG), commissioner, community, Independent Clinical Services (ICS), mental health, NHSE, primary care, public health, social care and Sustainability and Transformation Partnerships (STP). Throughout the report, quotations are presented with the job title and role category of the stakeholder they belong to.

"Evidence gaps relate to various interventions that promise to 'keep people out of hospital' but in reality may well be a small part of a more complex solution."

Online survey respondent

MENTAL ILLNESS

Mental illness was identified by stakeholders both as a priority medical treatment area and in terms of specific patient groups who might benefit from innovation and research. Stakeholders suggested innovation or research to analyse the effectiveness and timing of community interventions for mental health problems, using examples including peer support, the work of non-mental health specialist frontline staff and Mental Health First Aid. Other stakeholders suggested that genomics and digital approaches might hold potential to innovate around mental health in a way that has not yet been attempted or successful. Stakeholders also saw potential in research that explores the connection between physical and mental health, including the impact of increasing low-level mental health problems on overall health and wellbeing.

"Genomics and MH [mental health] "So, of the 30% of people who commit suicide who haven't had any contact with mental health care or services prior to their death, is there a predictability about that? How can we predict individuals?'"

STP Lead (STP)

"I think mental health has definitely fallen behind the curve in terms of research and resource and innovation. I think there's an awful lot that, certainly, digital can offer, in terms of mental health and support. I don't think it gets as much airtime as other, more physical health does."

STP Clinical Lead (STP)

Stakeholders also highlighted that people with mental health conditions were a specific patient group who could benefit from innovation and research. Stakeholders identified several other groups who were priority subsets of those with mental ill health, such as children and young people, those with substance abuse issues or homeless people. Other innovation and research priorities suggested by stakeholders included exploration of how self-care might be used by individuals, how they might take advantage of community support, and how their experiences of mental health affect others around them.

"We are struggling now, or beginning to struggle with, effects of socialising mental health, particularly in young people. Self-harming I've seen go through the roof. More people seem to be adopting that and taking risk behaviours, which is actually leading, I think, to suicidal attempts where I wouldn't have seen it before."

STP Clinical Lead (STP)

"I think probably the biggest challenge is the overlap between mental health and physical health, and how we manage it as a person as opposed to how we manage it as a disease. So, we've got some good examples where we've made some changes in our system to put in front rooms, which are very friendly, community-based places that people can go to when they're in crisis. Which gives us a much better way of understanding what the crisis is before we then move on to deal with the physical health."

ICS Director of Transformation (STP)

"There is a link between people with mental health conditions, substance abuse and homelessness – are there ways of supporting people with mental health problems to help stop them becoming victims of the other two issues?"

Online survey respondent

FRAILTY

Among Wessex AHSN stakeholders, frailty was ranked as a high priority alongside mental illness and multi-morbidities. Stakeholders proffered ideas for innovation and research that covered frailty in the round: its prevention, prediction and management. Some stakeholders suggested research to identify the greatest contributors to frailty, for example diet or social conditions. Other topics included innovation or research around the general management of frailty and the interventions that slow down frailty decline and support quality of life and patient priorities. Non-medical interventions, community support and self-monitoring polypharmacy were specific topics that stakeholders suggested. Planning for forecasted higher levels of frailty was also suggested, in the expectation that an ageing population would lead to increased frailty. Another stakeholder was keen to point out that innovation and research should "take care that frailty is not used as a blanket term for older people". Finally, several stakeholders were interested in how different sectors and agencies could better coordinate and pool resources to support frail patients.

"We don't have the resources to identify frail people before they get frail. Once people have been identified, they need a treatment plan. People tend to get worse rather than better after interventions."

STP Clinical Lead (STP)

"We've seen an awful lot of research, currently, into frailty and long-term condition management. I think we're almost overdoing the research and exploration of innovation around long-term condition management now…other than the two areas around behavioural and data science, that needs to be strengthened in that area. I think the area that we struggle with is around tech… They've not really applied much research and innovation into the use of technology in supporting people living independently in a home or community setting. It's a big, big opportunity."

STP Lead (STP)

MULTI-MORBIDITIES

In Wessex AHSN, many stakeholders agreed that multi-morbidities were a priority on a par with frailty and mental illness. Once again, the relationship between physical and mental health was raised as a topic to better understand. Stakeholders also suggested that there was potential to research or develop new applications and interventions around prevention and self-management so that people with multi-morbidities can better support themselves. Wessex AHSN stakeholders were also interested in new models or pathways to treat complex multi-morbidities associated with conditions such as diabetes. As with frailty, there was an expectation from at least one stakeholder that an elderly population is likely to be equated with higher levels of multi-morbidities, although the two topics are distinct.

> *"For me, I'd be saying if we're looking at anything around research in diabetes, it's really trying to get under the concept of, 'What is a new care model for diabetes,' or anyone with a complex co-morbidity, and that ought to be-, there should be research going into that."*
>
> **STP Clinical Lead (STP)**

> *"Could greater use of lifestyle apps and support groups enable patients with multi-morbidities reduce the severity of their conditions and enhance quality of life for less cost to mainstream health care."*
>
> **Online survey respondent**

OLDER PEOPLE

Several Wessex AHSN stakeholders emphasised that their region should prioritise innovation and research that pertained to an older population. Dorset and Hampshire were two relevant areas referred to by name in the qualitative interviews. As noted in the previous sections, while topics in their own right, frailty and multi-morbidities were often brought up in the context of ageing. However, stakeholders also suggested that innovation and research should tackle how best to join up services for and meet the demands of an ageing population; one also suggested evaluating more closely how technology could support older populations and the issues that affect them.

> *"One is about understanding how a population which is more heavily distributed to the ageing end-, so, we tend to have an older population in the main. So, it is how are we going to deal with, in the future, a population that's growing probably faster than the UK average and certainly has some pockets which are the oldest in the country? We've as yet no experience in dealing with a population that's aged, that's living that long with those type of complex comorbidities. So, in terms of our position, we are pretty much experiencing what other systems are going to experience in ten years' time."*
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> **ICS Director of Transformation (STP)**

EXISTING INNOVATION AND RESEARCH

Several stakeholders for Wessex AHSN said that existing innovation and research in their region partially addressed the areas they considered a priority, with a much smaller proportion saying it mostly addressed their priority areas and none saying that it did so fully. Nonetheless, a substantial proportion of the stakeholders said that they were not aware of existing innovation or research activity taking place in their region. Therefore, these results suggest that there is potential for Wessex AHSN and others to do more to address stakeholders' priority areas and publicise the innovation and research that is already taking place in the region.

Some Wessex AHSN stakeholders were at least reasonably confident that they could access innovation and research in their region and even fewer were at least reasonably confident that they could implement available innovation and research in the region.

When asked what existing innovation or research could be curtailed to make way for other priorities, stakeholders suggested fewer large observational studies, projects in acute settings, and research around costly "medicalised" interventions; instead they suggested switching attention to "messier" topics and applied research about care at community level. Some stakeholders also highlighted their perception that academic interests tended to drive research to the detriment of the issues facing local health systems. One suggested that processes need to be curtailed to make room for other work.

> *"The thing to curtail is the level of waste in the research system. NIHR's processes are incredibly excessive and slow. For example, why have a 100+ page form to answer what is effectively 4 questions: Is the new knowledge needed? Is it a good approach to answering the question(s)? Is the team capable of delivering? Is it good value?"*
>
> **Online survey respondent**

Wessex AHSN stakeholders were able to provide examples of successful use or application of innovation and research in their regions. One stakeholder had been involved in an initiative to improve the connection between research, its application and innovation, bringing researchers together with CCG staff. He had found it to be a positive experience. Meanwhile, another had an example of innovation that was being undertaken in his region in the social care sector that he thought was promising.

> *"Then, having the university, the academic and science network, clinical research network and the clinicians from the CCG in the same room as the research groups, where they're much, much better placed, for example, to look at how can we work at scale, how can we get more patients involved in research and how can we improve our quality? So, all good things have come from that."*
>
> **ICS Director of Transformation (STP)**

> *"For example, if we're talking about social care and carers, they know they've got a workforce problem. They're looking at exoskeleton technology, so that a carer can go in by themselves. You don't need to have two carers going in full-time. One carer can go in, put on their exoskeleton, and do the lifting and manual handling completely safely, and you retain that hands-on feeling, rather than hoists and lifts and everything else."*
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> **STP Clinical Lead (STP)**

Stakeholders had a number of other suggestions to improve awareness of innovation and research. These included introducing organisational change that named innovation and research at a strategic level and allowed for more profile raising and outreach at local level. Stakeholders also suggested embedding it in the everyday work of a wider range of clinicians and frontline staff, and disseminating research framed to be relevant to practitioners and formatted in easy-to-read layouts, such as infographics.

> *"Through embedding research and improvement in to every day practice. It should be in job descriptions and appraisals. People should be improving what they do and able to point to the latest evidence to say why. And that's everyone regardless of them being a prof, doctor, nurse, support staff, cleaner, manager, CEO."*
>
> **Online survey respondent**

> *"We don't have clever systems in place that would flag something, much the way Amazon would flag 'you might also be interested in this'. I think that's our opportunity, to do that. So, I think there's a disconnect between how people work and how much time they've got to look for things, their specialist area, and then the overwhelming amount of information available. In a way, it becomes a barrier to accessing any of it."*
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> **ICS Director of Transformation (STP)**

In terms of improving application of evidence and adoption of innovation, some stakeholders traced this back to research or innovation design itself, suggesting that research questions should be more relevant and practical to the frontline of the health and social care system or should align with commissioning priorities. They also thought that frontline implementers could be engaged in the research process from an early stage or throughout, as well as through timely dissemination. Funding models were also mentioned by several stakeholders with one recommending that research funding should cover implementation of innovations as well as research and evaluation and that funding should be at system or CCG-level. Another stakeholder considered adoption and implementation to depend on the individuals driving it forward.

> *"…if you look at the acute sector, stuff that comes out of the clinical networks, strategic clinical networks, that says, 'This is best practice,' just doesn't get then adopted by some consultants in some trusts, but it is adopted by other consultants in other trusts. I think it's because it's-, no one's really driving it from either a patient or community perspective, and there's no moral authority to try and get the buy-in. I'm very much a 'culture eats strategy for breakfast' sort of person. I think you can do the research, you can get the innovation, but actually it's people that you have to change."*
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> **STP Clinical Lead (STP)**

> *"So, for me, the three things that are really important for me would be, one, is that we deal with a needs-led research approach, as opposed to an academic-led research approach. Two, is we fund at a system-level, not an individual provider level. The third thing is we look at systems research, as opposed to a list of disease areas."*
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> **ICS Director of Transformation (STP)**

METHODOLOGY

The project was designed with the intention of capturing the views of senior health and social care stakeholders who work in a range of roles and practice areas, allowing for the variation in views to be observed while also arriving at an overview of the top priority innovation and research needs of a robust sample of regional stakeholders. The project consisted of two stages, a programme of qualitative telephone interviews with senior health and social care stakeholders followed by an online quantitative survey amongst a broader range of regional stakeholders.

The project was conducted with NHS stakeholders from all 15 AHSN regions. Where 'national' findings are referred to in this report and in the individual AHSN statements this refers to the results of the survey of 14 sets of AHSN regions' stakeholders and evidence from interviews for all 15 AHSNs.

STAGE 1: QUALITATIVE TELEPHONE INTERVIEWS

61 regional healthcare stakeholders were recruited to take part in semi-structured audio-recorded interviews. Each in-depth interview lasted 45 minutes and was conducted over the telephone. Stakeholders were identified by individual AHSNs based on a set of criteria determined by the project governance group. All stakeholders were required to be key systems leaders who could provide insight into regional innovation and research needs, but without responsibility for research in their role, and with a range of knowledge to reflect the diversity of the medical practices areas covered by the NHS. All stakeholders submitted by the individual AHSN regions were reviewed and approved by the governance group before being formally invited for interview.

Stakeholders held a range of job titles, including Chief Executives, Directors of Strategy, Medical Directors and other senior stakeholders across health and social care systems. Stakeholders fell into 11 broad categories based on the stakeholder's job title, organisation and specialisation: Acute, Clinical Commissioning Group (CCG), commissioner, community, Independent Clinical Services (ICS), mental health, NHSE, primary care, public health, social care and Sustainability and Transformation Partnerships (STP).

Role category	All AHSNs
Sustainability and Transformation Partnerships (STP)	20 (33%)
Acute	15 (25%)
Social Care	7 (11%)
Primary Care	1 (2%)
NHS England	1 (2%)
Mental Health	7 (11%)
Clinical Commissioning Group (CCG)	1 (2%)
Public Health	2 (3%)
Commissioner	6 (10%)
Community	1 (2%)

Independent Clinical Services (ICS)	1 (2%)

Table 1: Role category of stakeholders taking part in interviews

For Wessex AHSN, three stakeholders agreed to take part in a 45 minute telephone interview. These stakeholders all agreed to waive their anonymity and have their comments attributed to them in the report. Their role titles were: STP Lead (STP), STP Clinical Lead (STP) and ICS Director of Transformation (STP).

All interviews were conducted by members of the core project team, and before each interview consultants ensured they were familiar with the context of the interview and the stakeholder being interviewed, and were aware of the most relevant parts of the interview to the project objectives. The interviews followed a discussion guide which was developed in collaboration with the governance group and had an open format to allow for stakeholders to answer priority questions while also having the opportunity to express unprompted views on NHS innovations and research needs. The interviews covered three key topic areas:

- Uncertainties and challenges in health and social care at a regional level, including around national priorities, clinical practice, commissioning and organisation of services;
- What innovation and research is required to address these challenges;
- Opportunities and ideas for approaches to innovation and research in the future.

In terms of the analysis of data, each interview was transcribed, with the permission of the stakeholder, and was then reviewed by a member of the project team, other than the moderator. Members of the project team then met to discuss the research findings, analysis and direction of the report, identifying themes within regions and across them. All qualitative reports were proofed and checked by a ComRes consultant not involved in the project to provide a fresh perspective and objective point of view.

ComRes used the data from the qualitative interviews to develop an online survey for stakeholders. Throughout this report, quotations and key points from the interviews have also been used alongside the evidence from the online survey to illustrate or contextualise commonly-held opinions.

STAGE 2: ONLINE SURVEY

Using the emerging findings from the telephone interviews, a survey was designed to test the views of a wider set of stakeholders from across AHSNs, but within similar roles within the NHS. This survey was conducted throughout September and October 2018. 1240 stakeholders were approached to complete the survey and 257 completed it, resulting in a response rate of 21%. The survey consisted of 22 questions in total, and a copy of the questionnaire can be found in the appendix.

As with the telephone interviews, stakeholders for the survey were identified by individual AHSNs, based on the same set of criteria provided by the project governance group, but allowing for a wider range of seniority of role to capture a broader set of views from senior health and social care stakeholders. A breakdown of the job roles can be found in Table 2 below.

Of the stakeholders who were put forward by Wessex AHSN, 21 answered the online survey, a response rate of 21% from the 99 stakeholders approached to participate. When asked to select the label that best described their current role, compared to all AHSN stakeholders a higher proportion of Wessex AHSN stakeholders selected the role of non-clinical leader/manager/director. No stakeholder – of Wessex or any other AHSN – selected the title of social care practitioner as one that best described their current role.

Role title	Wessex AHSN	All AHSNs

Clinical practitioner in the NHS	2 (10%)	43 (17%)
Clinical leader/manager/director	6 (29%)	87 (34%)
Non-clinical leader/manager/director	9 (43%)	63 (25%)
Director	2 (10%)	40 (16%)
Social care practitioner	0 (0%)	0 (0%)
Other	2 (10%)	24 (9%)

Table 2: Role titles of stakeholders responding to online survey – Wessex AHSN compared to all AHSNs

ComRes are specialists in conducting stakeholder surveys and followed a process designed to maximise response rates while guarding these stakeholder relationships and complying with ethical and GDPR survey requirements. Survey stakeholders were notified by their respective AHSN regions in advance of the survey invitations being sent. All those identified as appropriate to participate were then invited by ComRes to participate in the research, with subsequent follow-ups by individual AHSN regions, in order to encourage stakeholder support for the project. Each stakeholder was sent unique link in order for ComRes to track completes across the different AHSN regions.

PROJECT DESIGN LIMITATIONS

As with any project, a few limitations in the project design and/or process were encountered which are useful to document.

- There are relatively small sample sizes across the different regions for the quantitative survey, meaning that little regional analysis could be done, as it would not be statistically robust.
- North East and North Cumbria had fieldwork dates that were two weeks shorter than all other regions; however their response rate is still comparable to other regions.
- Some AHSNs achieved fewer interviews than others. This meant that different levels of qualitative data were available to triangulate the quantitative findings at individual AHSN-level, making detailed analysis more challenging.
- The sample was a purposive one, identified by the AHSNs themselves; therefore, in terms of interpretation, it is possible that some viewpoints may have been excluded from this research, and that some other perspectives on innovation and research may be missing.
- Whilst social care practitioners were included in the sample, none responded to the survey, resulting in their specific views not being represented across both elements of this project.
- For the quantitative survey, only 14 AHSNs have data available, as Imperial College AHSN did not have enough respondents to provide a survey list, meaning their report is based on only the qualitative data.
- Several questions on the survey were closed-answer, which may have influenced the way in which respondents answered the questions; however, an 'other' option, which asked them to specify any other priority area they had, would have helped in minimising the impact of this.
- At an overall national level, the quantitative survey findings are robust enough to be considered alone, and the qualitative survey offers an overall picture of stakeholders needs across different AHSN regions. However, deeper analysis based on crossbreaks of the data has been limited by the low sample sizes that are observed when looking in detail on this level.

A copy of the full questionnaire wording for the online survey is available as an Annex to the national report 'National Survey of Local Innovation and Research Needs of the NHS: Full Report' (January 2019).

APPENDIX: TABLES

Table 3: System-level topics

	Top 3 highest priority: Wessex	Top 3 highest priority: National
Workforce issues, such as recruitment, retention and skills	8 (38%)	106 (41%)
Primary care, including capacity and capability of GP services	8 (38%)	69 (27%)
Integrated care for those with multi-morbidity and/or complex social care needs	7 (33%)	99 (39%)
Optimising use of digital technology and Artificial Intelligence	6 (29%)	86 (33%)
Education amongst patients and the public on health conditions or encouraging healthy behaviours	6 (29%)	55 (21%)
Improving quality and efficiency within organisations	5 (24%)	64 (25%)
Evaluation of the impact of health and social care service developments and initiatives	5 (24%)	47 (18%)
Urgent and emergency care, such as demand on capacity and decision making	4 (19%)	51 (20%)
Earlier diagnosis and intervention	4 (19%)	46 (18%)
Community care, such as social prescribing and patient self-management	4 (19%)	58 (23%)
Social determinants of health and health inequalities	3 (14%)	33 (13%)
Personalising treatment and interventions	2 (10%)	26 (10%)
Demographic changes, such as an ageing population or ethnic profile of a population	1 (5%)	28 (11%)
Geographic variation such as urban and rural differences	-	3 (1%)

Q4. There are a number of challenges currently facing England's health and social care system. We are particularly interested in challenges that innovation and research could help to solve, rather than funding or resource pressures. With this in mind, of the following system-level topics listed below, which three would you prioritise for innovation and/or research in the next 3 years to address challenges in your local health and social care system? Base: all respondents for Wessex AHSN (n=21), all respondents nationally (n=257).

Table 4: Medical treatment areas

	Top 3 highest priority: Wessex	Top 3 highest priority: National
Mental illness	11 (52%)	147 (57%)
Frailty	11 (52%)	112 (44%)
Multi-morbidities	11 (52%)	118 (46%)
Palliative and end of life care	6 (29%)	46 (18%)
Obesity	5 (24%)	77 (30%)
Diabetes	5 (24%)	42 (16%)
Dementia	4 (19%)	79 (31%)
Musculoskeletal	3 (14%)	20 (8%)
Cancer	3 (14%)	30 (12%)
Maternity and peri-natal care	2 (10%)	29 (11%)
Respiratory diseases, including asthma	1 (5%)	25 (10%)
Sexual health	1 (5%)	8 (3%)
Cardiovascular and stroke	- -	38 (15%)

Q8. Of the following medical treatment areas listed below, which three would you prioritise for innovation and/or research in the next 3 years to address challenges associated with them in your local health and social care system? Base: all respondents for Wessex AHSN (n=21), all respondents nationally (n=257).

Table 5: Specific patient groups

	Top 3 highest priority: Wessex	Top 3 highest priority: National
People with mental health conditions	14 (67%)	160 (62%)
Older people	13 (62%)	129 (50%)
Socially-isolated people	10 (48%)	117 (46%)
Children and young people	9 (43%)	84 (33%)
Those from lower income backgrounds	4 (19%)	80 (31%)
Homeless people	3 (14%)	41 (16%)
People with physical disabilities	3 (14%)	18 (7%)
People with alcohol and/or substance dependency and misuse	3 (14%)	56 (22%)
Black Asian and Minority Ethnic (BAME) people	1 (5%)	31 (12%)
People with learning disabilities	1 (5%)	46 (18%)
Lesbian Gay Bisexual Trans+ (LGBT+) people	2 (10%)	9 (4%)

Q13. There may be specific challenges in providing health and social care for the groups of people listed below. Where should innovation and or/research be focused in order to address the specific challenges associated with these groups in your region? Base: all respondents for Wessex AHSN (n=21), all respondents nationally (n=257).

Table 6: Extent to which innovation and research currently addresses stakeholders' priorities

	Total: Wessex	Total: National
It fully addresses the areas I consider a priority	-	3 (1%)
It mostly addresses the areas I consider a priority	3 (14%)	24 (9%)
It partially addresses the areas I consider a priority	8 (38%)	158 (61%)
Research and innovation does not address the areas I consider a priority	4 (19%)	36 (14%)
I am not aware of the innovation and/or research activity taking place in my local area	6 (29%)	36 (14%)
NET: At least mostly addresses	**3 (14%)**	**27 (11%)**
NET: At least partially addresses	**11 (52%)**	**185 (72%)**

Q18. To what extent does the innovation and research taking place in your region currently address the areas you consider a priority, as outlined in your answers so far? Base: all respondents for Wessex AHSN (n=21), all respondents nationally (n=257).

Table 7: Confidence in ability to access and implement available innovation and research

	Access (Wessex)	Access (National)	Implement (Wessex)	Implement (National)
Very confident	1 (5%)	21 (8%)	-	7 (3%)
Reasonably confident	8 (38%)	121 (47%)	2 (10%)	70 (27%)
Slightly confident	8 (38%)	84 (33%)	10 (48%)	124 (48%)
Not at all confident	4 (19%)	31 (12%)	9 (43%)	56 (22%)
NET: At least reasonably confident	**9 (43%)**	**142 (55%)**	**2 (10%)**	**77 (30%)**
NET: At least slightly confident	**17 (81%)**	**226 (88%)**	**12 (57%)**	**201 (78%)**

Q20. How confident are you that you can access and implement available innovation and research in your region? Base: all respondents for Wessex AHSN (n=21), all respondents nationally (n=257).