Introduction
The institute’s response is in two parts; the first response details a clinically focused approach whereas the second approach is from a more financial management perspective.

We have kept our comments on the side of brevity but would be more than happy to provide more in-depth evidence to support the Institute’s views and statements.

Part I Clinical perspective
Our comments are in three inter-linked areas namely contextual, operational and strategic. It is clear from our work with the Thames Valley HIEC that there is as yet no single, clear definition of innovation in the NHS; we are not short of definitions but we do not have a clear, simplified working definition.

Whatever strategy you do have in the NHS, for it to be of any real use, it has to be understood and ‘operationalised’ by the staff; “your innovation strategy is your staff” to paraphrase an oft quoted saying.

At operational level our work with one of the leading NHS Innovation Hubs demonstrated that whilst the idea of innovation scouts was accepted as a ‘positive step’, the capacity and capabilities of such scouts needed to be strengthened significantly. One of the other recommendations was to simplify the advice and support mechanisms by way of an innovation route map.

At a strategic level, the regional innovation infrastructure needs to be clarified and streamlined. Our work with two other HIECs (Yorkshire & Humber and Cambridgeshire & Peterborough) has emphasised three important elements, a) the relationship between the HIECs, NHS Innovation Hubs and university KTDs needs to be streamlined (an innovation route map would help here!), b) entrepreneurship in the NHS needs to be promoted – but promoted well. By entrepreneurship we do not primarily mean creating a business to make lots of money – it is more to do with following your interest to add value to the overall service that an organisation provides; it is to do with coming up with ideas – the majority of which will not come to fruition but a significant number will which in turn will ‘add value’ to the overall experience and outcome of patients, and c) for these changes to be sustained there needs to be effective leadership skills in innovation & development- a parallel stream
of work to R&D that has its emphasis in service development. Each NHS organisation has to take seriously the ‘job’ of innovation and development – if we are truly looking for cultural change then staff need to be convinced that I&D is not simply a fashion or rhetoric but a necessity.

The three elements of context, operation and strategy are depicted and summarised in Figure 1 below.

**Figure 1** Change at clinical level

<table>
<thead>
<tr>
<th>Strategic</th>
<th>Operational</th>
<th>Contextual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify regional innovation infrastructure</td>
<td>Strengthen capacity and capabilities of innovation scouts</td>
<td>Simplify what innovation means in the NHS</td>
</tr>
<tr>
<td>Leadership skills in innovation development (I&amp;D)</td>
<td>Provide an Innovation Route Map</td>
<td>‘NHS Innovation strategy is its staff’</td>
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<td>Promote entrepreneurship in the NHS</td>
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**Part II**
The second part of our submission is focused on a financial management perspective

Innovation is about making good, evidence based practice commonplace. This requires, inter alia, changes in behaviour - not just clinical and educational but also managerially at a system level.

It is accepted that HIEC's will lead on be tackling the clinical and educational dimensions of innovation. The risk is that the impact will still be a long way short of optimal if the managerial dimensions aren't also addressed.

To illustrate this, consider the many evidence based practices that can both improve quality and release financial resources. However, there is a risk that these changes will be resisted by Provider senior managers and finance staff who see their tariff based income reducing on a full cost basis whilst the savings they can make are only in marginal costs - the latter being typically 15-20% of the former.
To overcome this, several things need to happen:

- DH needs to promote leadership on innovation and give 'guidance' to commissioners as to what is expected;
- Need to look at the flexibility commissioners have (or could be given) at local level to vary tariff prices;
- Commissioners then need to agree with Providers the types and volumes of innovative practice that are expected;
- Commissioners need to give income guarantees based on pre-innovation practice where this would historically have led to higher income levels than post-innovation; and
- This arrangement should be time limited - to say three years.

The above arrangement should be conditional on two things, a) the Provider supplying evidence as to implementation of agreed innovations at the levels specified and b) an 'open book policy' so that Commissioners and Providers alike can see how costs have changed.

Lastly, towards the end of the three years there should be a review with the intention of making any permanent changes. These should reflect the learning in the first three years as to the feasibility of practice of the agreed innovations and as to the 'real' changes in cost structures.

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