Accenture submission to the NHS Chief Executive Innovation Review

Accenture welcomes the opportunity to contribute to the NHS Chief Executive Innovation Review. In responding to this review, we have drawn on our experience working across the NHS and broader health system, with smaller and third sector organisations, to suggest ways of increasing innovation to enhance quality of service and patient experience, improve safety and reduce cost. We recognise that there are other steps the NHS could take to improve the adoption and diffusion of innovation that are beyond our area of expertise.

Overarching perspective

We welcome the review into how to accelerate the pace and scale of adoption of innovations in the NHS. Without innovating and adapting services, the NHS will struggle to face the challenges that lie ahead – the immediate requirement for £20bn of efficiency savings along with the longer-term need for service redesign in order to meet future demographic trends. The NHS was designed originally as a treatment service for patients to receive medical advice and services, delivered face-to-face. Today, however, it is required a more holistic health service, with ever-more sophisticated treatments in an environment where citizens expect multi-channel, 24/7 customer service; and are becoming active shapers of those services.

Adapting to this transformation – and taking advantage of its potential – requires significant innovation in terms of service delivery. In this context, we welcome the review’s broad definition of innovation rather than the more narrow focus of developing a new drug or clinical technique. Innovation is a broad concept that includes improvements to existing business processes, clinical practices, and the technologies that support healthcare. It can lead to commercialisation, intellectual property and revenue streams for the NHS. Innovation is not always radical or disruptive. Some of the greatest improvements to patients’ experience come from the simplest things – such as the 24 hour Urine Collection Device as developed by the North West NHS Innovation Hub. Or inventive approaches – such as moving breast cancer screening units into car parks – have brought low-demand services to a wider group. These innovations, spread through the NHS, have high impact, but are not high cost.

In our experience the health system (of public, private and third sector organisations) generates innovative ideas effectively but innovation alone will not transform patients’ experience. It needs to be exploited, adopted and spread through the health system and so the Review is right to highlight the issues around adoption and diffusion and to seek ideas about how these processes could be improved.

In order to improve the adoption and diffusion of innovative ideas, processes and technologies, we think the NHS should take these critical steps (as outlined in figure 1):

- **Champion an open and collaborative culture** to ensure that the innovations are relevant: bringing the best of the public, private and third sectors in true partnership will develop innovative solutions that respond to real challenges.

- **“Think big, start small, scale fast”** rather than the current system where piloting risks losing the momentum of innovation. Too often, only after extensive evaluation of the pilots will resources be devoted to scaling the pilot. We have found the most effective approach is a complete change of mindset: working with early-adopter trusts we assume that a new technology or process will be rolled out unless it is proved not to work. We give significant consideration at the outset to how the successful small-scale projects may be effectively scaled once we have proof-of-concept. (This is an approach we used with Accenture PACS Connect which is explored in question 1).

- **“Commission and procure for innovation”**: a principle which should lie at the heart of the Any Qualified Provider policy. In order to take advantage of some of the most innovative new ideas, the NHS will have to work with third and private sector organisations, some of which will lack scale or experience of working in

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1 Accenture is a global management consulting, technology services and outsourcing company, with around 223,000 people serving clients in more than 120 countries. The company generated net revenues of US $21.6 billion for the fiscal year ended 31 August 2010. We employ c.9,000 people in the UK.

the NHS before. Commissioners should be empowered to take calculated risks in pursuit of innovations that will lead to improved service and patient experience, increased safety and reduced costs. (We explore this in our answers to questions 2 and 3).

- **Invest in change management**: effective implementation is necessary to ensure the innovation is adopted rather than ignored or “worked around”. (We explore this in our answer to question 4).
- **Build and empower clinical networks**: effective adoption which delivers results will make the case for further diffusion through the NHS – innovations need advocates who spread the new ideas both within their organisation and in the wider health system. Peer-to-peer networks should be facilitated and promoted.

**Figure 1: Key stages in the innovation, adoption and diffusion cycle**

**Review questions**

1. What can the NHS and NHS Commissioning Board learn from local, national and international best practice to accelerate the pace and scale of adoption of innovations in the NHS? [Please include relevant examples, published papers or other evidence you have found useful.]

From our experience of working globally across public and private sectors, including in healthcare, we think that:

- **Creating the right culture of innovation and empowerment is critical**: several innovative private sector firms, such as Google and 3M have dedicated “innovation time” where employees are encouraged to work on their own innovative projects and ideas often working in small, cross-cutting teams. This creates an expectation of innovation and embeds it throughout the organisation.

- **Powerful clinical networks and effective change management are key to adoption**: One recent example is that of Accenture PACS Connect (APC) - a system that offers secure and near-instant clinician-to-clinician image sharing which dramatically decreases the time taken to make referrals. Where it has worked most effectively and clinicians and patients are experiencing the benefits, common steps were taken:
  - True collaboration led to a relevant solution by bringing the best of the public and private sector together: APC was developed in conjunction with clinicians to address a specific challenge.

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3 Ideas for Google News, Gmail and the “Post It” all emerged during these sessions.
4 APC is an innovative solution to the challenge that large Picture Archiving and Communications Systems (PACS) images created previously to share these images across different trusts meant the local PACS team sending the image via the network (using considerable bandwidth) or burning the image onto a CD for physical transportation, a process that could take days.
Our philosophy was "think big, start small, scale fast": Early-adopter trusts that allowed us to prove the concept of APC worked provided extremely useful feedback, which was used to feed in to further development.

Implementation was coupled with significant focus on change management and active stakeholder engagement. In our experience the need for investment in change management can be significantly underestimated; we would recommend that a high proportion of the budget for implementation should be allocated to change management (depending on the case this could be around 50 per cent of the cost of the programme). We explore effective change management in more detail in our answer to question 4.

Effective clinical networks were critically important in building the right support: our experience across the NHS has led us to believe that powerful clinical networks can be the single most important factor in the adoption of innovation.

**“Chief Clinical Information Officers” can be lynchpins in innovation:** they provide greater senior clinical involvement (at board level) leading to more effective project design and implementation. This post is well-established in the United States (where they are known as Chief Medical Information Officers) and evolved in recognition of the growing role that IT has in supporting clinical outcomes. Accenture’s research into innovation in the private sector\(^5\) has shown that organisations with a dedicated innovation executive consider themselves significantly more innovative than their closest competitors:

- 31 per cent of organisations with a dedicated innovation executive think they are better able to change course than their competitors (compared with 12 per cent who lack an innovation executive);
- 27 per cent think they innovate faster (compared with 7 per cent).

We believe that CCIOs have the potential to be a focus point for the adoption of innovations by encouraging multi-disciplinary collaboration within organisations – and could be a helpful network to support the diffusion of innovation across the NHS.

2. What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?

The NHS Commissioning Board will have a crucial role providing an appropriate vision for innovation in the NHS: setting the tone and narrative, particularly about creating an expectation of innovation, will be critical to success. In order to stimulate the rapid and successful adoption of innovation, the NHS Commissioning Board should help develop and support a system throughout the NHS of commissioning and procuring for innovation. A truly innovative service that delivers the right outcomes for patients may not resemble commissioners’ expectations, based on their current experience. This is because, in some settings, developments in technology and mobile workforces have rendered the concept of a fixed, permanent infrastructure obsolete (this is particularly true of community and specialist services). Commissioners should be sufficiently flexible to recognise this and thus give due consideration to innovative approaches, focussed on outcomes rather than the familiar, traditional, constituent building blocks of a service. They should commission for outcomes, not processes.

Successful innovation requires Commissioners to work closely with innovators and, in the process, to embrace risk, perhaps more than they have done in the past when working with traditional or incumbent providers. Many third and new private sector organisations encounter challenges when seeking to provide services to the NHS and it is important that Commissioners work with providers to address them: smaller and third sector organisations in particular may lack scale; the length of the procurement cycle can result in prohibitive costs; and commissioners frequently require references of similar work for similar clients – all of which favour incumbent suppliers rather than new entrants. The Any Qualified Provider (AQP) policy has the potential to address these challenges.

To make commissioning for innovation a reality, the NHS Commissioning Board should focus on four key enablers:

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\(^5\) Accenture/Economist Intelligence Unit research 2008

[http://www.accenture.com/SiteCollectionDocuments/PDF/OutlookPDF_Innovation_03.pdf](http://www.accenture.com/SiteCollectionDocuments/PDF/OutlookPDF_Innovation_03.pdf)
1. **Create an open, empowering and collaborative culture:** Leaders, at all levels, should create an expectation of innovation; commissioners should feel empowered to choose the innovative approach; and providers should work with customers (commissioners and clinical and non-clinical staff) to develop solutions to the NHS’s challenges that are both relevant and appropriate. In particular, the Commissioning Board has an important role in giving commissioners the confidence to take calculated risks – currently, concerns about potential litigation may stifle innovation by encouraging commissioners to take the “tried and tested” approach.

2. **Share good practice and identify “best in class”**. By identifying the outcomes associated with good practice (improved service and patient experience, safety and reduced cost), the Commissioning Board would take a helpful step towards resetting expectations; ideally, the NHS should be able to achieve “best in class” outcomes across the service it commissions within the existing funding envelope. This would help change behaviour and allow commissioners to commission for innovation. Publicising information about “best in class” practice in an accessible and standardised format would enable patient groups to compare with commissioning in their area, and if necessary to put pressure on commissioners to ensure that the best outcomes are being achieved within the funding envelope. Sharing good practice would also help to raise awareness, and build the profile, of small and third sector organisations who may encounter difficulties in reaching a large number of commissioners.

3. **Ensure “Any Qualified Provider” delivers a fair and equitable market**. Genuine competition will play a positive role in increasing standards. High-performing organisations relish competition – and, both within the NHS and outside it, are already working to differentiate themselves as they compete for contracts, which should result in greater value for money for the NHS. Commissioners (at all levels) and Monitor will have an important role ensuring a level playing field and making a reality of “Any Qualified Provider” if the NHS is to take advantage of the innovations in the private and third sectors. A helpful step would be greater transparency in the tendering process (perhaps around reasons for awarding contracts) - giving increased confidence to those bidding. It is worth noting that as techniques and technologies develop, that AQP should also evolve. The standards, expectations and requirements should adapt so that the threshold is regularly raised ensure better outcomes by favouring dynamic, innovative organisations over complacent, incumbent providers.

4. **Encourage the sharing of ideas and information across boundaries.** In our experience, evidence generates confidence and so spreading good practice, information about clinical effectiveness and evaluation of cost-effectiveness will help to underpin innovation. Currently the NHS is a data-rich organisation but marshalling the different data sets to create usable, analytical intelligence to provide valuable insights can be challenging. Widespread adoption of analytic and predictive modelling techniques would strengthen commissioners’ decision-making capabilities and give them the confidence to commission innovative services. The NHS Commissioning Board has an important role to play in encouraging the sharing of patient-specific and anonymised, aggregated information to provide local and national intelligence to support innovative commissioning. This can be done by building on the significant investment already made, and increasing interoperability and adoption of practical standards to create a ‘system of systems’.

The Commissioning Board could work with SHA clusters to promote powerful clinical networks. Research should be undertaken to understand the current geographic and specialism coverage of the networks and to evaluate their effectiveness (we believe that mapping effective networks and innovation will reveal a strong correlation). The findings can then inform the promotion and supportive of effective networks - and if necessary stimulate networks in areas where coverage is limited.

3. **What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**
As outlined in our answer to question 2, the role of the NHS Commissioning Board will be critical. In addition, however, making a reality of commissioning and procuring for innovation will require local organisations to consider their role in relation to the four key enablers:

1. **Creating an open, empowering and collaborative culture:** Local leaders will have a critical role setting the tone in each trust and Clinical Commissioning Consortia (CCG), creating an environment where individuals are supported, and rewarded, for innovating. Leaders should promote a culture of true collaboration that will bring together the best of the public, private and third sectors to solve real problems with relevant solutions. True joint-working will require the removal of barriers – an important step will be for all partners to understand and accept the objectives of each sector (for example that the private sector must make a profit, that the NHS is accountable to the public).

   Trusts and CCGs should ensure that employees have the skills to write effective business cases and to assess the benefits of the innovation. Early adopters (opinion leaders amongst their peers – clinical and non-clinical) should be encouraged and supported. Part of this will include consideration of the method for scaling from the outset (the “think big, start small, scale fast” approach we outlined in our answer to question 1) in order for momentum not to be lost.

   If the NHS is to identify increased innovation as a priority, it is important to make sure that the approach to culture, talent and organisational structure are aligned to this objective. This will include ensuring the right incentives and enabling support are in place – which may differ for different members of the workforce, including new entrants such as Generation Y. A culture that promotes an entrepreneurial mindset and allows employees the time to think innovatively will challenge resistance to change often described as “not invented here”.

   In our experience across the private and public sectors, successful and innovative organisations have been those who constantly question their approach – seeking to learn from peers.

2. **Sharing good practice and identify “best in class”:** The NHS reform programme should stimulate innovation at a local level by devolving power and responsibility – but this needs to be done in a manner that avoids creating disjointed silos. Neither extreme (either letting “a thousand flowers bloom” or centrally-driven top-down approach to innovation) is right. We believe an important middle ground can be found – where the SHA and PCT clusters have a filtering and coordinating role. This would enable them to work with the NHS Commissioning Board to identify, evaluate and share good practice quickly across localities and regions.

   It is worth noting that one reason behind the success of the Spanish healthcare system in reducing costs has been strong, regional governance spreading good practice.

   It is worth noting that no innovation or development is “future proof”. The definition of innovation and “best in class” must be dynamic and adapt to developments in technology, processes and drugs.

3. **Ensuring “Any Qualified Provider” delivers a fair and equitable market:** as outlined in our answer to question 2, commissioners at all levels will have to demonstrate vigilant commitment to the principles of AQP which represents an excellent opportunity and mechanism for bringing together the best of the public, private and third sectors.

4. **Encouraging the sharing of ideas and information across boundaries.** Clinical Commissioning Group commissioners have a responsibility to keep informed about innovative approaches and technologies that may help them treat patients more effectively. Indeed, powerful clinical networks can be the most important factor in promoting the adoption and diffusion of innovation. PCT and SHA Clusters may have a role to play in facilitating the development of cross-organisation, cross-silo networks – at both a geographic (ie regional or local) level but also a thematic one (ie specialisms or diseases) – to ensure all can achieve the efficacy of the best.
In addition, as mentioned in our response to question 2, patient groups have an opportunity to put pressure on commissioners in order to ensure that “best in class” providers are selected in order to improve outcomes across the NHS.

4. What specific actions do you believe others, such as industry, academia, patient groups or local authorities, could take to accelerate adoption and spread, and what might encourage them to do so?

In our experience, innovation works most successfully when providers respond to (and even anticipate) an organisation’s needs. A collaborative relationship, working in partnership with clinical and non-clinical staff, helps develop an innovative technology or process that is a good “fit” for the organisation. However, it need to be used effectively in order to reach its full potential – failure to do so results in missed opportunities to make significant improvements in quality and productivity. Providers should support organisations to understand, use and modify the technology or process – such “change management” (with effective communication and planning) will ensure the full benefit is realised, rather than the undesirable scenario where a new process or technology is commissioned but not adopted on the ground. Both the NHS and external providers should work at creating a relationship that is open, consensual and collaborative in order to achieve this. From our experience supporting NHS organisations with change management we think the following steps are important for implementing innovative processes or technologies effectively:

- **Build support for innovation and make it sustainable**: a critical step is building a network of advocates in each area, comprising of the key clinical and non-clinical staff who play an important role highlighting to their peers and colleagues the case for change and the advantages the innovation has over existing options. Chief Clinical Information Officers (as discussed in our answer to question 1) have the potential to be a focus point for the adoption of innovations by encouraging multi-disciplinary collaboration within organisations – and could be a helpful network to diffuse innovation across the NHS. The wider stakeholder group of those affected by the change should be identified and their level of commitment to the project should be evaluated in order to get a good understanding of their motivations. This should be supported by effective communication. Implementation of the innovation should be done in partnership – so they do not feel change is done to them, but rather with them. It is important to recognise that individuals who feel threatened by new techniques and processes may effectively “opt out” and undermine the process. Investing time in supporting these individuals is critical. Of related importance is the need to “decommission” the previous process or technology rapidly to enable benefit realisation.

- **“Change” should be the responsibility of everybody at every level within the organisation**: High level accountability for innovation and change is essential as it embeds commitment through the rest of the organisation and ensures that the innovation is effectively adopted and diffused. Dedicated change management teams with specifically-skilled professionals can offer clear project management support to larger trusts. But individuals throughout the organisation should take responsibility for change – which should be embedded into every day working practices. Change perceived as top-down imposition might have very damaging effects on morale and implementation, particularly if it is perceived to come in to conflict with the clinical culture. In order to make innovation sustainable (and perhaps more relevant for new processes rather than products), its adoption should be written into business and personal objectives. This would encourage employees to develop “change” skills, creating a culture in which innovation can flourish – for some this will be specific project management skills but for many it will be “soft skills” such as flexibility, adaptability, collaboration and team-work.

- **Information-sharing and collaboration is key**: Innovative techniques and processes frequently require individuals to work outside established team structures, for example on different patient pathways. An approach that has worked successfully in other organisations is to develop “communities of practice” – interest groups of key individuals who share knowledge and experience informally. Creating a collaborative relationship within NHS organisations and also with the private and third sector providers bringing the innovation is vital.

- **Measure the benefits**: Data on the impact of the innovation should be collected and shared to ensure effective implementation and to feedback into further development of the product or process (and indeed
how its adoption has been managed). This information can also be shared to highlight good practice and “best in class” performance.

- **Coordinate consistent implementation**: High level accountability within the organizations and strategic coordination will help ensure the innovation delivers its full benefits. The emerging SHA and PCT clusters may have may have a high-level coordinating role, particularly supporting smaller trusts and organisations for which it may be impractical to sustain their own change management teams. Implementation of innovative new technologies or processes should also be coordinated with the wider service transformation agenda in the rest of the organisation rather than being seen in isolation.

5. **Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?**

In addition to the comments above, we think that:

- The best practice tariff has real potential to be a mechanism for reducing cost (whilst maintaining quality) particularly in areas where costs can be managed effectively through standardisation. As noted in our answer to question 2, the definition of “best in class” should underpin the best practice tariff must be dynamic and adapt to innovations in technology, techniques, processes and drugs.

- Analysis and measurement is an important aspect of benefit realisation. But targets can be an unhelpful distraction when they force individuals to report on, and document, processes rather than outcomes. We think that the development of the Outcomes Framework could helpfully underpin a more innovative culture – where the improvement in outcome is required, but the process or method for achieving the improvement is left to the discretion of the clinician.

- It may be helpful to prioritise areas for promoting innovation. Given the huge proportion of NHS spending devoted to the treatment of long-term conditions, we think steps to innovate in the management of these conditions should be an important priority. Telehealth technologies have the potential to transform long-term care in the UK – the key is now to build on the Whole Systems Demonstrator Pilots and bring the successful innovations rapidly to scale rather than lose momentum. A “think big, start small, scale fast” approach should be adopted as a priority.