Response to NHS Chief Executive’s Open Call for Evidence and Ideas

Respondent ID: 117

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Innovation Review

Call for evidence and ideas

Organisation: South Central SHA

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Do you want to be kept in touch with the next steps in this process? Yes

Do you want to be included in a wider community of interest? Yes

Introduction

This paper responds specifically to the questions asked on pages 13 and 14 of the call for Evidence and Ideas Document (gateway Ref 16219)

It is noted that the definition given of innovation on page 5 of the document:

‘For the purposes of this call, innovation is an idea, service or product new to the NHS, or applied in a way that is new to healthcare, which significantly improves the quality of health and care wherever it is applied.’

Is not one that we would support locally. It could be changed as follows:

Innovation is an idea, service or product locally new to the NHS, or applied in a way that is locally new, which when applied improves the quality of health and care’

This change allows innovation to be viewed at local or national scale and acknowledges the significance of adopting and disseminating innovation to maximise the impact upon improving the patient experience. What is important is that the cost (not only financial) vs. benefit (again not only financial) equation favours local implementation.

It is also noted that innovations in other sectors can offer considerable returns to health – for example innovations in reablement in social care can greatly diminish the consumption of health services. In future it would be wise to be receptive to and be supportive of innovation in the whole care sector where there is a demonstrable return for health. This will require the forging of new relationship and new financial arrangements and agreements.

Overall we would support and agree with comments made in the document on pages 7 and 8 and our comments below should be seen as embracing and endorsing those comments rather than replicating them.
Responses to the Questions

**Question 1. Learning from elsewhere about adoption and spread**

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?

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<tr>
<th>Barriers to adoption and spread</th>
<th>NHS / NCB learning</th>
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| **Cost**                        | • Support the development of costing tools to ensure cost is fully understood.  
                                 | • Procure at scale  
                                 | • Dedicated pump priming funding – particularly to support the cost of making a change rather than the cost of the change itself (which should be met from financial benefits once delivered)  
                                 | • It should be the norm that external costs (payment to industry etc) are deferred until savings are realised – exemplar contracts would be helpful and contracting / procurement support is essential. |
| **Perceived risk – Clinical**   | • Ensure the clinical evidence base is fully explored, articulated and is robust – role for NIHCE and NTAC and NHS evidence  
                                 | • Contrary to the ‘do once and share’ ideal be prepared to support phased implementation of proven innovations to allow the building of local evidence – notwithstanding the argument that evidence should be transferable experience demonstrates that local evidence is the most compelling (and can create local peer to peer transfer and spread) |
| **Perceived risk – Financial.** | • Support the building of approaches and tools to capture RoI  
                                 | • Build systems that allow RoI to be delivered over 3-5 years not one  
                                 | • Ensure that the care economy can share cost and benefits across the system  
                                 | • Stimulate collaborative working across sectors with mutual benefits realisation |
| **Return on investment unclear or deferred** | • Reward entrepreneurship in the NHS  
                                 | • Reward and incentivise copying of successes from elsewhere (current focus tends to be on rewarding invention or totally new to the NHS)  
                                 | • Allow informed financial risk taking and remove reputational risk by acknowledging learning gained from well conducted but failed trials.  
                                 | • Provide a supportive environment in which new products services and technologies can be tested locally |
| **Benefits dislocated from costs** | • Accelerate processes |
| **Perceived risk – Reputational** | • Risks need to be shared – too much of the risk is currently with service.  
                                 | • New procurement practices – Need to revisit codes of practice (ABHI / ABPI) to promote true partnerships and cost recovery from successful implementation (as opposed |
Question 2. Actions at national level in the NHS

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?

Suggested actions are:

- Clarify who in new architecture has legal duty to innovate (commissioners or providers or both) and be clear about role of NHSCB and HEE
- Ensure that innovation is integrated into the drive for improvement – innovation as a solution to delivering challenging standards with respect to clinical outcomes – ‘This is upper quartile performance and here are some new approaches proven to support delivery of this standard’
- With respect to upper quartile or decile performance develop a ‘deliver or explain regime’ that requires organisations the explain their failure to adopt effective practices if they have below median performance (this will continually raise median performance)
• Ring fenced dedicated funding – there can be no doubt that the very small RIFs have stimulated uptake of innovations.
• Create Innovation leadership roles in all organisations – provide leaders with training in innovation and improvement
• Create managed innovation networks who should create and be accountable for delivering an innovation work programme (both locally developed and derived from national programmes). These networks to work alongside clinical networks / programmes to offer real expertise in identifying, developing and delivering new ways of working. They would facilitate joint working across the care sector.
• Incentivise the system with rewards for adoption and spread
• Ensure that there is a clear demarcation of roles between NTAC and NIHCE and that their respective programmes focus on building and displaying the evidence base for the most relevant innovations
• Create new specimen procurement strategies and contracts to support new ways of engaging with industry
• Include training and education in innovation improvement in basic and post basic education and training
• Ensure Innovation is owned by providers and seen core business of Local Education and Training Boards

Question 3. Actions at local level in the NHS

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?

Suggested actions are:
• Support the localisation of items for questions 1 and questions 2
• Ensure that a local innovation and improvement culture develops
• Develop local process that systematise the assessment, localisation, delivery and evaluation of innovation locally with an outcomes focus
• Bring together the local innovation landscape via Innovation Networks under the auspices of the LETBs (who being neither commissioners nor providers of health care sit in a useful strategic position within the local landscape). The innovation networks could include HIECs, clinical networks and improvement and innovation teams. Local Education and Training Boards could host these innovation and improvement networks and offer a powerful vehicle for alignment of innovation with local and national priorities and ensure that workforce / practice change is supported and delivered when necessary. The networks would offer local ‘innovation consultancy’ as expert advice and support to the local health economy and to innovation leads across the economy and would become the local ‘doing arm’ of the NCB with respect to innovation. LETBs would need to have this expectation placed upon them early so they would be sufficiently capable to receive a hand-over of local responsibility for innovation from SHAs in 2013.
• Use systems to capture and progress good ideas from the ground floor (such as Ideas Street)
• Identify and broadcast local successes and create local drive for spread on a ‘comply or explain’ basis with respect to upper quartile outcomes.
• Use system incentives (contracts and CQUIN) to stimulate new practice through contracting for and rewarding of upper quartile performance
• Set aside an innovation fund locally explicitly for innovation and delivery of returns across two or more financial years.
**Question 4. Actions by NHS partners**

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?

The relationship between the NHS industry and academia needs to change from the NHS simply being a provider to patients and a market place for industry and academia to one where responsibilities and risks are shared as are benefits and returns on investment. The NHS needs to create pull from industry and academia so that responses to NHS needs are rapidly developed and deployed. The SBRI process has proven locally that true partnerships with industry can rapidly create new cost effective solutions that are responsive to NHS needs and provide a route to market to industry.

This requires a radical rethink of the relationships, the creation of new financial instruments, a willingness to enter in to risk sharing agreements and the creation of new partnerships.

There needs to be recognition of the value and resources that users bring to the service and well as the resources they consume. Experience based design using the experience of service users to create new service innovations also needs to be developed.

To support this the DH and others will need to support the development of new financial flows that overcome disincentives or perverse incentives in the current system. These new arrangements will need to support financial risk and rewards sharing.

HEIs need to develop a focus on innovation as a means to achieving service excellence and education commissioners could stimulate this with contracts that specify the appropriate content. That content would include basic business management skills so that staff are equipped to frame proposed improvements in the context of improved business as well as improved quality.

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