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

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Background

A large number of Government initiatives, some of which I helped to introduce when employed as a Director in the DH and NHS between 2004 and 2009, have attempted to assist the spread and adoption of ideas within the NHS. The first challenge was getting some consensus on the meaning of the word innovation. The key point here is the activity of putting ideas into practice and involving the relevant players in the ownership of this activity.

What has worked well?

One major lesson I think is that success always involves “acting locally”. The NHS landscape is complex and heterogeneous and a local interpretation is essential. On occasions a central menu may be necessary but the local adoption is essential to success so “Think Centrally but Act Locally” should be the maxim.

One initiative I was responsible for was the establishment of the local Innovation Hubs around the country. In reality, I think that these have had a mixed success rate and we could have done better. The ones that have been successful have strongly embraced local partnership and have used these to drive the local NHS agenda. TrustTECH in the North West is in my opinion a success story here. There is a partnership between the local NHS Trusts, the Centre (particularly with NIHR initiatives in basic research), the local Universities, Industry, local charities and local government. Their strategy has always been on improved patient care (not accruing IP as the sole endpoint in itself) and there was a sizeable critical mass for meaningful interaction.

Other initiatives which I have seen first hand as contributing to the spread of innovative thinking include the CLAHRC activities. It is impressive that so much of their focus on clinical practice includes active participation with involving the patient in the pathway such as in the management of diabetes. The NIHR CLAHRC for North West London is an excellent exemplar of this. Effective communication with the patient is a major focus and the CLAHRCs have ably embraced this concept.

On the positioning of UK’s healthcare achievements on the international stage, I think that the AHSCs are starting to play their part here and could be encouraged to do more. They have both the calibre and stature to lead this international role and also should be able to help drive standards as well. A high degree of academic leadership and reputation is needed for this international role to compete with and be respected by the likes of the Mayo Clinic, Duke Medical Centre and others. Again, the partnership model of University, Business and NHS which AHSCs embrace should be the most effective model in both amortising costs across several fund holders and contributing most effectively to diffusing aspects of the UK’s healthcare agenda internationally.

What have we learnt?

Acting locally is an essential ingredient and leading behavioural change is a vital component to success. The much quoted comment from the SOS “No decision
about me without me” in regard to the patient perspective is very appropriate and empowered, self confident, well trained healthcare teams are an essential ingredient for success.

We know that we have severely reduced budgets, a global financial crisis, ageing demographics, a prevalence of long term conditions that require treatment and monitoring and a greater patient awareness of what treatments are available with often media hyped expectations on possible outcomes. Healthcare agendas are assuming unparalleled attention in this digital age.

In this situation what can we take as the major challenges to the NHS?

One issue has always been siloed budgets both within the NHS and between NHS and Social Care. The move to integration of some aspects of NHS and Social Care is growing. Is there any way that breakdown of some of these budget silos could accelerate? If more patients are to be treated in the community this budget issue may become a major barrier to innovation. The Future Forum recommended a strengthened role for the Health and Wellbeing Boards as a local vehicle to work with clinical commissioning groups. This may be one initiative that helps to catalyse the process.

Another challenge has been a poor IT system in the NHS. We need interoperability of IT systems which experts tell us is not a big issue to resolve. Local IT systems will need to communicate both locally and nationally. Let’s do it and gain the self confidence in this area that was lost with mega projects that were done with good intent but were not always successful.

This needs facilitating with rapid introduction and a lot of the IT architecture is already there. It is important for esr, individual staff training records, e-learning courses (which are a very cost effective part of staff training), patient records and will also allow the spread of telehealth for patient management particularly but not solely for COPD, diabetes and heart failure. The possible treatment agenda here is growing and remote monitoring of LTCs is likely to be strongly wanted when the Whole System Demonstrator (WSD) results from the ongoing pilots are reviewed in the Autumn.

For example, in parts of Spain telehealth has a growing presence particularly in the management of LTCs in ageing and often socially isolated individuals. According to WHO, Spain is 7th in the world in effectiveness of healthcare delivery and the application of telehealth may be one contributing factor to this success.

One other barrier to adoption in the NHS is culture. To build a more enabled and empowered workforce will require more visibility in behavioural training and leadership. The NHS is already well served with budgets in this area and it is perhaps time to try to constantly reinforce the need for self confidence using appropriate communication message boards in this digital age.

Embrace change and use what works well for 2011
We are being encouraged to partner where appropriate, to grow the strengths of the UK in lots of areas whether in education, local government, business, charities or healthcare.

The concept of developing clusters of expertise wherever we can is a well tried and tested approach. It works!

In high tech business and healthcare clusters, the formation of integrated networks and interdependencies has accelerated the spread of ideas and sharing of some best practices. These have often helped to encourage behaviour change, stimulate local dynamism and more importantly, local ownership. The clusters are populated by Universities, Hospitals and other health providers, companies, government organisations and other parties depending on the particular focus. The proposed merging of SHAs into Super Clusters could have an impact here in driving leadership.

There are numerous documented examples of successful clusters around a common local focus from around the world and I have visited several of these for example in Boston, North Carolina, Australia and Singapore.

The NHS has an ideal leadership opportunity given the respect of the brand, the national importance of the healthcare agenda and the diversity of players who contribute to health and well being locally. These could include hospitals, patients, staff, carers, local government, social care, Universities, pharmacies and others.

The shared agenda in the local environment could be positioned to help drive efficiency, grow team confidence and accelerate the spread of best practice in integrated networks of partners all contributing to the powerful NHS brand. Partnership in clusters is a proven and effective force with each contributing partner playing to its strengths.

This model would fit well with our global economic restraints and deliver innovation that is, putting ideas into practice, with benefits to all participants.

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