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

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<th>Organisation name: Health Innovation Education Cluster North East London, North Central London &amp; Essex (NECLES)</th>
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North East London, North Central London and Essex Health Innovation Education Cluster (NECLES HIEC)

Response to the NHS Chief Executive review

The NECLES HIEC has been operational since May 2010. There are 3 founding partners Queen Mary University London, UCL Partners and the Postgraduate Medical Institute Anglia Ruskin University. These partners bring together many University’s, NHS providers, Commissioners, commercial organisations and the third sector. All of whom strive to deliver health care to a population of 5.8million in London and Essex.

In the space of 18 months we believe we have driven the innovation and improvement agenda at pace and scale within a period of significant change and challenge for the NHS. It is our view that our HIEC has been able to achieve this due to the following factors:

1) Leadership
   We have a small core team with HIEC Fellows and HIEC Facilitators to lead and foster the development of workstreams. The Fellows are Band 6/7 (Agenda for Change) clinicians or managers who are tasked with coordinating numerous complex projects.

2) Permeate traditional organisational, professional and geographical boundaries
   We focus on improvement of patients outcomes by facilitating connection between Health Professionals across organisational, professional and geographical boundaries. In our Maternity work we have connected midwives in 12 acute sites and 2 Strategic Health Authorities through a community of practice designed to promote normal birth. This has lead to rapid exchange of ideas and practice.

3) Capacity to connect resources
   As we have diverse partners we are able to connect resources held in separate institutions to build wide-ranging programmes of work. For instance we are building an Android App focused on self-management programmes for asthma. We plan to make it freely available to children and young people. This has only been possible through collaboration between Asthma UK, App developers, clinical experts in Asthma and the energy of the HIEC. Other similar examples are found in the COPD work where the British Lung Foundation, City University, Picker Institute Europe, Royal College of Physicians have all collaborated to create a whole pathway Patient Reported Experience Measure for this population of patients. The University partners consistently bring academic rigour and robust evaluation to the workstreams.

4) Acting locally, connecting regionally
   The successful workstreams have addressed pressures such as QIPP and CQUINN targets with local teams who are then connected to other local teams. This mechanism of scaling has lead to whole regions working together. For instance North East London’s acute hospitals have all been engaged in providing uniform self-management advice and medication rescue packs to COPD patients admitted with an exacerbation. For hospitals this initiative will contribute to
reduced admissions, and together will strive to effect a whole population of people in North East London who have COPD. The notion of Acting locally and Connecting regionally has also been used to engage with challenging issues such as access by migrant people to primary care and an the need to upgrade data quality in primary care.

We believe that our HIEC has demonstrated benefit for local and regional health outcomes with a small amount of resource and we have enabled the start of real and effective innovative change in the system.

When considering what has been learnt by our HIEC and the barriers that slowed or prevented spread and development of innovation we would consider the following significant enough to need a National intervention:

1) **Access to relevant data and clarity around Information Governance**
   
   One of the most persuasive tools for uptake of innovation is relevant data that is frequently updated. At this time there is information available however it is not flexible enough to be relevant to networks of clinicians working outside of their single institution and across varying geography. It does not support integration, sharing and improvement work that aims to place patients in the centre of care.

   In addition, the variable understanding of Information Governance requirements often hinders the sharing of data between NHS Organisations.

   There is a clear desire by Government to release information more widely. This initiative must occur with speed and clarity in order to allow innovation to spread through collaborative, informal groups.

2) **Innovation and Ethical requirements**

   The need to gain Ethical approval for innovation and change work that occurs at scale is difficult to navigate for those who are not from a research background. In addition when collaborating on Health Improvement or Innovation projects the need for ethics is driven by the need to be able to meet publication criteria as much as for ethical reasons.

In summary, our experience suggests that a relatively small investment in infrastructure can catalyse cross-boundary collaboration to create a critical mass of interest and expertise. Once created, these collaborative structures can often access funding and support that might not be available to the individual collaborators working in isolation.

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Chair NECLES HIEC

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Managing Director NECLES HIEC