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

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Response to the NHS Chief Executive Innovation Review

Introduction

Thames Valley HIEC is pleased to respond to the consultation into the future of innovation in the NHS. Having now been in operation for over a year, we are replying with the benefit of inputs from patients and our many partners – Trusts, universities, local authorities, charities and the private sector. We are also signatories to the national response on behalf of all HIECs – this document therefore is concentrating on what we believe we know in Thames Valley specifically, because of the local conditions for innovation in our region.

Learning from elsewhere about adoption and spread

A number of our partners are interested in the factors which enhance or inhibit the spread of innovation. For example, Professor Sue Dopson of Said Business School is working in this area and will present to the Thames Valley HIEC partnership later in the year. Similarly, Unipart Expert Practices are working with us to support the spread of lessons that worked in redesigning a global logistics business into end-to-end pathway change, working with GPs in Buckinghamshire.

A critical factor for us is the ways in which patient safety (which is a core interest of Thames Valley HIEC) and clinical governance concerns are balanced against a culture of innovation which involves the taking of managed risks, by trying something new and risking failure. This is associated with clinical power and the uses of evidence. An effective way of blocking change is to refuse to do anything which does not have a robust evidence base. And yet, by the time a new technology or process has a sound evidence base, it does not represent true innovation. We need to learn from others about the treatment of emergent evidence. Within Trusts, clinical governance teams should be encouraged to take a proactive stance to innovation, supporting new approaches which balance risk and patient safety, through active feedback and early data collection. This would help create organisations which are positively orientated to working in new ways.

A good example of this is our Inhaler Technique Improvement Programme which we are carrying out with Wessex HIEC. This is spreading the use of an inhaler developed locally on the Isle of Wight which aims to reduce unscheduled admissions of hospital by up to 25%, by improving the efficacy of the medication. In our HIEC, we have worked with five different PCTs, adapting our approach to their local conditions and working within the distinctive cultures of the different organisations. The speed of local spread varies with the attitude of local clinicians both to risk and to quality improvement measures.

In order for clinicians to experiment more, their work needs to be embedded within a general organisational climate that does not see the failure of a specific innovation as a failure in terms of a clinical service. Rather, there should be a clear expectation that a high proportion of innovations will have little or no real benefit, but are still part of the learning process and may in turn lead to change which is lasting and sustainable. There are clear transferable lessons here from innovative private sector companies.
Unipart Expert Practices distinguish themselves as a global leading company by building employee engagement at every level through their organisation, to engender a culture of continuous quality improvement. In partnership with South Central SHA, Buckinghamshire PCT and the Thames Valley HIEC, Unipart will be looking to transfer their “Unipart Way” into primary care across the county, to support the QIPP agenda and large scale system change. Their approach goes beyond cost reduction programmes to looking systematically at the relationship between customers (patients) and the different levels of the organisation, relationships along the whole of the supply chain and effective delivery at the point of service. Our conservative estimate of the RoI of this work is at least five to one.

In too many places still, innovation refers to new technologies rather than to new practices. The balance between technological and people change needs to be reassessed. Many technological innovations fail because insufficient care is given to the associated changes in ways of working, and resistance from both staff and patients to something unfamiliar. More time and trouble needs to be given to an active marketing of new approaches, both inside and outside organisations. This has not traditionally been seen as the work of NHS organisations, but is emerging as one of the functions of the relatively new HIECs. If they are to be encouraged to do this work, they need to be better supported to be seen as part of the new landscape of the NHS.

In a new development, Thames Valley HIEC is supporting one of our CCGs with an innovative approach to education programmes, to develop clinical engagement with the QIPP agenda, particularly among salaried GPs. The consortium concerned believes that it is more effective to engage their local doctors through concrete improvements to patient services, than by the more abstracted debates over the potential of the new structures to deliver whole system change. It is through doing that this particular group of practitioners is coming to full understanding and participation. The first project, on dermatology, has significantly reduced inappropriate referrals and now needs a full evaluation.

Such marketing activity is different to the development of a robust evidence base, which happens at a later stage in the adoption and spread process, where a new practice has been around for a sufficiently long period for there to be a sufficient level of data from which sound conclusions can be drawn. Nonetheless, the marketing, spread and evaluation of promising new ideas should be seen as a part of the development of evidence, and the HIECs should be helped to work more closely with those bodies charged with the formal validation of new forms of knowledge.

Thames Valley HIEC is supporting the local implementation of the National Dementia strategy by working on earlier diagnosis by the GP community. It is trialing locally the Evi-Dem approach developed in London by Professor Steve Iliffe of UCL. If this is successful in Thames Valley, our work will be examined by the national team for possible spread elsewhere. This shows how the HIEC can contribute to the development of an evidence base by locating our own work within a national framework.

**Actions at national level in the NHS**

When the SHAs change their form, their current statutory duty must pass in a timely way to a new body. If this is a serious commitment to continuing an active support of innovation, the most appropriate body will be the National Commissioning Board. However, following the principles of localization, there need to be a clear articulation of the ways that the National Commissioning Board will stimulate innovation at a regional and local level, and the bodies through which they will do so.
The National Commissioning Board has the power to facilitate system incentives to change such as price bundling and promoting shares in risk and reward (currently, the perception is that gains realized from new ways of working are lost through reductions in commissions).

Despite the financial pressures in the NHS, the National Commissioning Board needs to take a more long-term view of sustainable innovation. In order to move from adoption (trying something new out on a limited scale through a pilot or evaluation) to spread (wide take-up across a service that spans both early adopters and laggards), the National Commissioning Board will need to take a more long-term perspective than has hitherto been the case.

Equally, the National Commissioning Board can support the adaptation of new ideas to the local context. Although such an adaptation may appear unnecessary and to slow down spread, it can result in a more sustained change through allowing local “communities of practice” to feel they have worked through the implications of the new approach in some detail in their own localities and with their own patient groups.

With Buckinghamshire New University, we are currently evaluating a number of local pilots which offer psychological interventions to patients with long-term conditions. The outcome of the project will be a recommended best practice guide for commissioners of mental health services. It will take time for the lessons learned from these local pilots, which span both the LTC and the mental health commissioning teams across a number of PCT areas, to change the ways services are commissioned. However, the active engagement of so many different kinds of professionals in these new ways of delivering services is a part of what will make these changes more sustainable in the medium term.

There is a practical problem with the move from adoption of a new approach, to spread at pace and scale. This is to do with the balance between NHS support for innovation, and the need for a disinterested approach to procurement. Although the NHS may have worked in partnership to develop a solution to a particular problem, and have provided pump-priming support which leads to the development of an effective technology or process, it is none the less constrained in the extent to which it may actively promote the widespread uptake of such a solution by competition legislation. There is the need for a national level set of guidelines for “intelligent procurement” which helps the bodies which promote innovation to continue to work on its widespread adoption across the system.

**Actions at local level in the NHS**

At a local level, there should be financial rewards for both innovation, and also for the development of an innovative organisation which is orientated to working differently, at all levels within its organisational culture.

A part of doing that is to develop “communities of interest” within patients and the public, which is something that Thames Valley HIEC are working on now. We believe that such patient communities need to evolve locally, rather than come together with a special interest, which may be to resist a change which is not fully explained or owned. Such communities can be greatly supportive of innovation, if innovation of clinical services is seen as a part of the wider development of the locality.

Thames Valley HIEC has worked with healthtalkonline (University of Oxford) to develop resources in shared decision making. A good example of how patients can help the evolution of clinical services can be found on their website (MND section/coordination of care/one stop service/ambulance).

Finally, much can be done locally to support staff to become aware of new ways of working, to visit others who are working on the same problems as themselves, and to cross-fertilise beyond their organisations. This is one of the success stories of the early days of the HIECs and, if the HIECs continue, should be built on, with the support of all the provider organisations. With the changes in
structure in the NHS at regional level, there is a risk that many flourishing local networks will disappear or become dormant. These networks are very supportive of local innovation, and the adoption and spread of good ideas, and need to be actively encouraged to survive.

Thames Valley HIEC, the Biomedical Research Centre at the Oxford Radcliffe Hospitals and Oxford Brookes University have been working for some months now on the career development, and appropriate support networks, for research nurses. Such research nurses are an overlooked group of innovators, at the forefront of involving patients in clinical research, and yet sometimes overlooked as the powerful agents of change that they can potentially be.

**Actions by NHS partners**

In the current climate, it is difficult to make the financial case for a serious and sustained commitment to investing in innovation. Nonetheless, it must be recognised that the NHS is in a unique moment in its history. As the NHS faces the QIPP challenge, its partner universities and colleges are facing unprecedented cuts and upheaval. The NHS supply chain is being disrupted as the private sector reengines its business and reaches out to new markets. Charities, at both local and national level, are rethinking their core purposes with the cuts in public service provision. All this could have a major unanticipated consequence of the NHS, as the partners with which it has previously innovated turn their own innovative capacity inwards.

The NHS therefore needs to respond positively both by continuing to prioritize resources for innovation, and by targeting those resources to partnerships for innovation that are currently in place and working. Thames Valley HIEC joins the other HIECs by saying that such locally based partnerships are, we think, our strongest contribution to the field of innovation, and need to be encouraged. It takes time to develop relationships across organisations, and the work that has been done to date since the HIEC came into being has the potential to become an even greater catalyst for change in the future. Our partners need the support of the NHS nationally to realize these benefits in full.

**Conclusion**

The invitation to respond to the consultation refers to the interaction of three forces - *bottom up* cultures (patient pressure and professional enthusiasm) - *horizontal* pressures and support (peer influence and cooperation, competition and support) - *top down* pressures and support (incentives, regulation, targets and training).

HIECs contribute at all three levels, but it is in the middle set of horizontal activities that our most distinct contribution lies. It is unlikely that there will be a significant response to any generally framed national edict to “be innovative”; as the capacity to be innovative is something that needs to be built and developed in individuals, teams and organizations in a systematic way. Similarly, although the NHS is full of innovative clinicians, their work rarely has major impact beyond their organizations as, individually, they lack the resources or the know-how to generate formal learning that can easily be transmitted beyond the boundaries of their organizations.

If the NHS is to achieve the kinds of innovative practices it needs to generate savings on the scale required by the QIPP programme, it will need to invest in lateral relationships across a wide body of partner organizations that can see the need to work together in the long-term. Developing such relationships, which will include education and research organizations, as well as clinical networks, takes time as much as money. It requires leadership at a local level, to develop the capacity and capability to innovate, as well as examples of innovation in practice. Thames Valley HIEC has demonstrated that there is such a commitment in this region, which we ask to have supported into the future.