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

Respondent ID: 203

Organisation name: The Health Foundation

Type of response: Document
The Health Foundation submission of evidence to the NHS Chief Executive Innovation Review

31 August 2011

1. ABOUT THE HEALTH FOUNDATION

1.1 The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK. We are here to inspire and create the space for people to make lasting improvements to health services. Working at every level of the system, we aim to develop the technical skills, leadership, capacity and knowledge, and build the will for change, to secure lasting improvements to healthcare.

1.2 In our response to this call for evidence and ideas we are drawing on our extensive learning about how to implement quality improvement programmes in the NHS as well as our commissioned R&D to understand best practice in the adoption and spread of innovative approaches.

2. DEFINING INNOVATION

2.1 The NHS Chief Executive Innovation Review, call for evidence and ideas defines innovation as “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”.1

2.2 In the Health Foundation’s experience, NHS teams experience innovation in a subjective rather than objective sense. While innovation can be seen by people outside the health system as being about introducing new ideas and technologies, if something is new to a team in a particular setting, they may view it as innovation regardless of whether it is routine practice elsewhere. Thus the innovation challenge is as much to embed in routine care existing pockets of innovation as to introduce further new developments.

2.3 We should recognise that the implementation of ideas proven in one place can often in itself require innovation. There may not be a single, one-size-fits-all approach to putting

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innovation into practice. Learning about how to effectively implement innovation should be shared across the NHS.

3. LEARNING ABOUT ADOPTION AND SPREAD

3.1 In 2010 the Health Foundation commissioned a rapid evidence assessment to identify methods that were successful at scaling up or spreading innovation in healthcare, education and other areas of the public sector. The references identified in the study are listed at Annex 2.

3.2 The key findings were:

- Successful and widespread scaling up of innovation to improve the quality of practice requires both the top-down support by management and/or government or regulatory bodies for the innovation, with adaptation by practitioners within their local organisation to make it relevant to the local context.

- Methods that have been used with apparent success in a range of contexts and settings include: practical support from external facilitators; theoretical support from internal leadership and opinion leaders; resource support from management; communication between professionals via networks or other knowledge-sharing; training on use of the innovation for staff; and ensuring that the change aligns with organisational and national strategies.

- Similar methods have been used to scale up innovations that have originated within NHS organisations, led by individual practitioners and those developed externally to the NHS, which are then diffused nationally across NHS organisations. There is insufficient evidence to know which methods are the most effective or cost-effective, but most studies have reported on programmes that have combined one or more bottom-up and top-down strategies.

- Scaling up innovation can take considerable time and resources. These should be minimised by piloting the innovation to determine whether its benefits and cost-effectiveness mean it should be adopted widely, and minimising the level of change so that only the key aspects that lead to improved practice are adopted.

- Scale up of innovation is a cycle rather than a one-off process. The effects of the change should be measured and monitored and repeated innovation encouraged to ensure that practice remains high quality as the external environment changes.

3.2 We identified several studies which include guidance on how best to scale up innovation, with considerable overlap in what they suggest:

3.3 Bradley et al. (2004) evaluated the factors associated with the diffusion and adoption of evidence-based innovations in healthcare from research into practice, and concluded that best practices to speed adoption of evidence-based innovations into clinical practice include:
• Targeting diffusion efforts towards organisations with a strong senior management support for the innovation;
• Identifying and supporting clinical champions in the adopter organisation to enhance buy-in from clinicians;
• Developing simple methods of collecting and reporting data that are credible to the organisation and demonstrating that the program is meeting its strategic goals;
• Expecting the diffusion to take longer if it involves changes to the organisational culture or needs extensive interdepartmental collaboration;
• Planning for sustainability at inception and invest in the infrastructure to manage the dissemination and diffusion process; and
• Anticipating changes in the external environment and demonstrating how the innovation can help the organisation adapt to market and regulatory pressures.

3.4 Southwell et al. (2010) reviewed the processes by which higher education institutes can disseminate the outcomes of projects aimed at achieving large-scale change in teaching and learning. Their literature review found that conditions for successful dissemination included:
• Effective, multi-level leadership and management;
• A climate of readiness for change;
• Available resources; and
• Administrative systems to support active dissemination of innovations.

3.5 The Health Foundation has synthesised the learning from its evaluations of its improvement programmes. This is set in the context of the broader academic literature, seeking to draw out lessons for those engaged in improvement activities in the NHS and other health systems. We have learnt that sustainability and spread of improvement initiatives are key challenges. Improvement is vulnerable to an ‘evaporation effect’, particularly once projects have been completed.

3.6 We also have specific learning from our work on improving safety through the Safer Patients Initiative. This showed that implementation at scale across an organisation of some approaches that were already in limited use in certain areas was innovative in itself and needed local testing and adaptation. The other key findings were that organisations need to be in a state of ‘readiness’ to implement and embed new ways of working – have the leadership, commitment and resources to support the introduction and spread of innovations and that timescales for embedding innovation need to be realistic. Further details on this work are available in annex 1.

3.7 It is therefore important to:
• Seek to institutionalise improvement activities, so that they become part of routine activities, through, for example, alignment with wider performance management

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2 Social Science Applied to Healthcare Research Group, University of Leicester (not yet published). Barriers and facilitators to improving quality in healthcare: a review of the evidence and experience from the Health Foundation’s programmes, The Health Foundation.

3 Further information about the Safer Patients Initiative can be read at: http://www.health.org.uk/areas-of-work/programmes/safer-patients-initiative/.
systems, ongoing audit, or integration of quality indicators into existing IT systems and routine practices.

- Avoid relying on key individuals, whose tenure within organisations may be time-limited, and instead seek to engage a breadth of stakeholders at multiple levels within organisations.
- Ensure the resources necessary to the continuation of the project (e.g. clerical support) remain in place.
- Seek to ensure fit of improvement efforts with existing professional roles, so that these become seen as part of ongoing professional activity rather than a temporary ‘project’.
- Account for the importance of organisational context: if an intervention has worked in one place, it will not necessarily automatically spread to or work in another place, even within the same organisation. Organisational subcultures, differences between clinical groups, and shifting financial pressures, policies and priorities mean that adaptation is always likely to be required in transferring improvement interventions.

4. ACTIONS AT NATIONAL LEVEL IN THE NHS

4.1 The vast majority of innovation (particularly new technology) occurs outside the NHS, but the NHS through its innovation hubs, academic health science centres, and other infrastructure to support innovation can generate many innovations for itself, particularly those related to service design, rather than new technology. However, to get these ideas implemented in practice at large scale there is a need for specialist technical support to NHS management. Our review of the evidence for quality improvement saving money (Øvretveit, 2009) found that while there is strong evidence that simple and small scale clinical changes can be effectively introduced at local level, the effect is often likely to be small. Innovations which involve more complex organisation changes have a greater potential for reducing waste, improving quality, and making savings, but they come with bigger risks. For these changes, there is less evidence of effectiveness. It is possible that, the more professions and organisational units involved, the higher the risk of failure due to challenges in coordination and reaching agreement.

4.2 It is clear that large scale implementation of innovations will not happen of its own accord and needs the appropriate capacity and capability to deliver. Yet, as part of the NHS reforms we see a significant shedding of such capacity as SHAs are merged, the NPSA abolished, the DH downsized and NIII with an uncertain future.

4.3 There is a wealth of information available through existing collections and databases, most notably NHS Evidence but it is optimistic to suggest that this is “at the fingertips of all 1.3 million NHS staff” (page 6, NHS Chief Executive Innovation Review), as most frontline staff do not have access to online resources in the course of their day to day work. There is much to be done at a national level in the NHS to raise awareness of the existing information on innovations that have proved successful.

4.4 The experience of the Health Foundation in seeking to fund the pilot implementation of innovative ideas, is that clinical teams are not aware of innovative practice that has been
implemented elsewhere, proposals are put forward as ‘innovation’ that are already routine practice in other healthcare organisations.

4.5 National bodies, such as the National Commissioning Board can play an important role in providing central support to scale up an innovation from a local setting and encouraging widespread adoption (Petrova et al., 2009).

4.6 Such adoption could be formally recognised through a national award scheme, similar to current incentives to support innovation but one which recognises the achievements of those who have successfully implemented ideas that have been tested and developed elsewhere. All current approaches give recognition to the innovator – but not those who later successfully take up the ideas.

4.7 In deciding which innovations to promote at a national level it is essential that this is based on:

- Sound data from pilots undertaken in a range of different organisations that demonstrate through robust measures how quality of practice has improved.
- Cost data that shows that the innovation is likely to be a more cost-effective approach to managing care before. The full costs of implementing the change should be estimated and appropriate outcomes identified and measured to evaluate the effect of the change.

4.8 The development of ideas into effective innovations usually depends on more people becoming engaged. How well an innovation spreads through networks depends in part on the characteristics of the innovation itself, therefore a national ‘push’ should only be directed towards innovations which demonstrate:

- Relative advantage – the innovation has to be demonstrably superior to alternatives.
- Trialability – the innovation will be more acceptable if a small scale test can be made in each healthcare setting before full implementation.
- Observability – the extent to which potential adopters can see the innovation in practice, this is much easier with an innovation in equipment than new approaches to service design.
- Compatibility and complementary conditions – the innovation should be consistent with existing values, experience, external drivers and the needs of potential adopters.
- Simplicity – the degree to which an innovation is perceived as being difficult to understand or use, it is more likely to be taken up if it does not require intensive staff training or adaptation of facilities to be implemented.
- Cheapness and value for money – innovations that are costly or capital intensive will spread slowly. The more radical and systemic the innovation, the harder it will be to implement.

5. ACTIONS AT LOCAL LEVEL IN THE NHS

5.1 The Health Foundation’s Shine programme aims to support local teams in implanting innovative ideas that raise the quality of healthcare. Our experience of running this
programme is that there is little support for innovation within local systems. Ideas that would appear to be possible to implement on the basis of a business case, showing how a small investment would result in increased quality and reduced cost, were submitted for a competitive award because there appears to be no local mechanisms to fund such investments.

5.2 Furthermore, the Health Foundation often see ideas being put forward which we know have already become mainstream elsewhere. We would expect middle managers to be supporting and indeed driving their adoption rather than clinical teams feeling they need to come to a third party to support the idea. This raises issues about the extent to which middle managers see their roles as supporting adoption of new ideas and the extent to which budgets allow for the ‘invest to save’ often necessary to pump-prime new ideas.

5.3 Our experience of working with Shine local innovation teams has been that:

- For innovations in healthcare delivery to be accepted, it is vital that there is committed clinical leadership, as without it attempts to introduce new ways of working have no traction. These leaders make the case for the advantages of the innovation using local data to convince their peers to be part of the change process.

- Innovations are much more likely to be adopted and sustained where there is a culture than supports some flexibility around roles and workforce. Some of the most promising innovations are around changes that ensure that expensive and scarce resources, such as consultant time, are used most efficiently to deliver care. This may be achieved through enabling nurses to take on a wider scope of practice, such as minor surgical procedures, or through better use of IT to reduce to a minimum any time clinical staff spent on clerking patients, as information is entered into the system once and then available to all members of the care team.

- Implementation of innovations is often left to the enthusiasts with little support from divisional or board level directors. This can mean that the implementation is not explicitly aligned to the organisation’s overall strategy and is not linked into larger plans for service development.

- Even where innovations are successfully introduced, there is still a major challenge in ensuring that new ways of working are sustained. This is where engagement and support from top management are crucial to support new ways of working by building these into service plans so that a proven innovation becomes ‘business as usual’.

5.4 The findings from the rapid evidence assessment in relation to local actions were:

- Scale up should involve local practitioners adapting the innovation to suit their specific context in a bottom-up approach, with support, guidance and funding as appropriate coming top-down from the organisation and/or higher bodies.

- Top-down managerial support within the participating organisation is crucial if the innovation is to succeed. Local NHS organisations will more readily adopt innovations that reflect their own stated priorities and strategic direction.
Successful initiation and scale up of innovation requires a bottom-up process with somebody leading the project on the ground. This person needs enthusiasm and credibility and the ability to carry the majority of the relevant staff members with them. External facilitators with these characteristics may be effective, but support from local opinion leaders will also be needed.

Training is necessary, so that practitioners can deliver the innovation correctly and so that the end users benefit as much as possible. However, training need not be extensive and exhaustive. One two-hour session was found to be as effective as three sessions for training doctors on new assessment processes (Jippes et al., 2010).

Organisations can best support innovation by giving staff the time, funding and support they need in order to be innovative. Where funding levels make this difficult to achieve, the core aspects of the innovation that lead to improvements should be identified so that no resources are wasted in implementing additional changes that are less effective at improving the quality of practice.

Organisations can support adoption of innovations by developing a framework for educational leadership development aimed at senior and middle level leaders and project managers; encouraging knowledge, vision and awareness building and a culture of reflective practice; providing adequate human, financial and infrastructure resources (Southwell et al., 2010).

In general, if individuals are to adopt an innovation, they need to perceive a benefit to them or their patients to justify the extra effort involved in making a change to established practice. They need to feel a personal responsibility to make the change, to agree with the proposed change, to have the skills, knowledge, time and funding to carry out and sustain the change, and they need to share ideas and experiences with their colleagues and social contacts to reassure themselves that they are doing the right thing in the right way.

At a local level NHS organisations need to consider what support they can provide to encourage innovation. This might include training, formal structures such as an ‘innovation forum’ or local awards to enable innovative ideas to be put into practice. In addition to support for innovation, formal support and recognition should be given at a local level to those who manage to spread innovative ideas across the organisation or who adopt proven practice from elsewhere.

6. ACTIONS BY NHS PARTNERS

The Health Foundation will continue to encourage innovation through various initiatives, principally our annual Shine programme which make awards of up to £75,000 to support healthcare organisations to test out innovative ideas that will improve quality. It gives teams the space and encouragement to try out, develop and evaluate new ideas. By gathering evidence of improvement, and gaining the backing of leaders and frontline
staff, Shine aims to gain support for, implement and sustain improvement. The Health Foundation provides advice on issues such as project management and appropriate measures for quality. The award requirements include regular reporting against quality and cost metrics to ensure that sufficient and appropriate data are collected to measure progress and provide evidence of the changes attributable to the innovation. After 12 – 15 months of the implementation phase, the Foundation then works with award holders to disseminate the results of their innovation pilot.

6.2 The evidence shows that social and professional networks are highly influential in encouraging the adoption of innovations (West et al., 1999), (SDO, 2009). Formalising networks through inter-organisational collaborations has been a particularly common strategy in the healthcare field – particularly for quality improvements, rather than technology diffusion. In this respect, Royal Colleges, professional associations and the burgeoning area of web-based interest groups of healthcare professionals are vital in promoting innovations, particularly through the involvement of key opinion leaders to champion the innovations.

6.3 The Health Foundation is developing networks of improvement practitioners (clinicians, health service managers, service users and researchers) to encourage transfer of ideas and innovative approaches that are developed through our work in improvement programmes and research.

7. ROLE OF PATIENTS

7.1 It needs to be acknowledged that patients have a role in the adoption of innovation and that essentially all innovation adoption should aim to lead to improved patient outcomes. Patients are often the keenest advocates of innovations which enable easier, more convenient access to services, such as ‘virtual’ consultations, conducted from home via a webcam.

7.2 The Health Foundation supports programmes which work jointly with patients and service users in the implementation of innovative approaches to care provision.

- Engaging with Quality Primary Care (2007-2010) supported nine clinical teams to understand and apply quality improvement techniques and measure the results. The projects involved healthcare professionals including GPs, nurses and allied health professionals, as well as commissioners, patients and patient representatives. The health issues addressed by the projects range from the management of back pain to tackling domestic violence and reducing health


inequalities. Each project team included at least one patient representative and the evaluation of the programme found early service user involvement to be of considerable importance. For example, service users reported better focused, more patient-oriented outcome measures and more effective liaison with service user communities.

- **Co-creating Health** (2007-present) aims to embed self management support within mainstream health services across the UK and equip individuals and clinicians to work in partnership to achieve better outcomes. It focuses on developing the skills and attitudes of both people with long term conditions and their clinicians, while also ensuring systems and services are designed to support and facilitate self management. Patients are actively engaged through participating in Co-creating Health’s self management programme and also through acting as lay tutors in patient and clinician training.

- **Making Good Decisions in Collaboration** or MAGIC (2010-present) is exploring how shared decision making can be embedded in the core clinical practice of mainstream health services. The participating clinical teams are focusing on raising awareness of proven effective decision-support tools and concentrating on the behavioural shift needed to roll out their use.

- **Shine** (2010-present) aims to stimulate thinking, activity and the development of innovative approaches that will improve healthcare quality. Shine projects to support innovation include: web-based virtual consultations; text messaging support for people in alcohol recovery; access to electronic records to enable better responsiveness to symptoms for people with inflammatory bowel disease. Many of the teams involve patients in the development of the ideas through focus groups and interviews with patients to develop and refine ideas for service innovations. As part of the evaluation of the projects patient surveys have been carried out to gain feedback on the service changes. Patients have reported:
  - Preference for routine consultations for diabetes (those involving no tests or treatment) to be held via webcam, which the patient can access from home (or from their workplace during lunch break) rather than by the patient attending a clinic.
  - Preference for accessing cardiac rehabilitation via an interactive web-based programme that can be accessed from home at any time suitable to the patient, rather than having to attend a fixed time regular session at a community gym or physiotherapy department.

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7 Ling T et al, (not yet published). *An evaluation of the Health Foundation’s Engaging with Quality in Primary Care programme*, The Health Foundation.


Benefits in being able to manage the symptoms of inflammatory bowel disease through access to electronic records including case history and care plan.

Clients in an alcohol relapse programme are delighted with an innovative text messaging service that provides extra support between formal sessions and have engaged with focus groups to design improvements to the service.

8. RECOMMENDATIONS

8.1 Choosing which innovation to scale-up

- All innovation should aim to lead to improved patient clinical and experiential outcomes, and this should be an essential criterion for decisions about which innovation to scale-up.
- Innovation should be piloted to identify the key aspects that will lead to improved practice and determine whether they should be adopted widely.
- Pilots should involve patients and service users from the very earliest planning stages.
- Decisions about which innovation to promote at a national level should be based on sound data from pilots, cost data that shows that the innovation is likely to be a more cost-effective approach than current practice.
- A national ‘push’ to promote adoption of an innovation should only be focused on those which demonstrate: relative advantage, trialability, observability, compatibility, simplicity and value for money.
- At national level the NHS should both raise awareness of the existing information on innovations that have proved successful but also consider how best to engage NHS staff with how to effectively implement innovation.

8.2 Scaling up innovation effectively

- A cyclical process of scaling up innovation should be supported with monitoring and measurement of the effects of change and encouragement of repeated innovation.
- The NHS must account for the importance of organisational context. If an intervention has worked in one place, it will not necessarily automatically spread to or work in another place, even within the same organisation.
- Funding mechanisms should be put in place to support development, implementation and spread of innovation within local systems.
- Formal recognition should be developed for those who successfully take up and apply innovations, as well as those who develop the initial innovation.
- Social and professional networks are highly influential in encouraging the adoption of innovations and should be encouraged and supported.
- The NHS must acknowledge the essential role of patients in the adoption of innovation and encourage patient involvement in shaping services.
- The NHS must encourage both top-down support by management with grassroots local adaptation to ensure innovation is relevant to the local context.
• The NHS should avoid relying on key individuals, whose tenure within organisations may be time-limited, and instead seek to engage a breadth of stakeholders at multiple levels within organisations.
• The NHS must provide training and some infrastructure for technical support to support practitioners in implementing innovation correctly.
• The NHS must support a cyclical process of both engaging staff in learning about innovation in healthcare but also in learning about how to effectively implement innovation and scale it up. New learning from local experience of putting this learning into practice should be fed into this cycle and be shared across the NHS.

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ANNEX 1

Learning from the Health Foundation’s Safer Patients Initiative

The Safer Patients Initiative set out to implement a series of evidence based intervention to improve patient safety in first four and then a further 20 organisations across the UK. Many of these interventions – eg safety briefings, executive walkrounds, ‘bundles’ – are now applied widely across healthcare in the UK. Through this work and the subsequent nationally led initiatives in the four UK countries, including Patient Safety First in England, the Health Foundation has been able to observe and learn about the diffusion and adoption of innovation.

We found the following:

- While the approaches were already in use in other industries and some healthcare settings, implementation at scale across an organisation was innovative in itself and needed local testing and adaptation.

- Organisations need to be in a state of ‘readiness’ to implement and embed new ways of working – they need to have the leadership, commitment and resources to support the introduction and spread of innovations. Timescales for embedding innovation need to be realistic. Even once the wider contextual factors have been taken into account, where change needs to be embedded into mainstream structures, processes can and often do take time.

- Widespread adoption requires action at several points within the system:
  - Developing awareness of the issue (safety) and commitment to the changes at all levels of the organisation from frontline to Board helped build a sense of urgency and momentum. This approach is often referred to as an ‘innovation movement’, a movement that wants to introduce or change particular norms and values.
  - Alignment with external drivers reinforces adoption. The second phase of the Safer Patients Initiative overlapped with wider national safety campaigns which supported its principles and helped it to be embedded within local organisations.
  - The experience from the Safer Patients Initiative and Patient Safety First reiterated the importance of early engagement of clinicians, front line staff and managers to achieve buy-in to the new ideas. Clinician engagement was identified as a key success factor.
  - A core team of frontline clinicians and senior managers were used to exert peer to peer influence in Patient Safety First. This was a major success factor for sign-up and engagement.

- A simple and practical approach helps implementation. Focusing on a limited number of interventions with practical ‘How to’ guides was instrumental in the Patient Safety First campaign in helping demonstrate how changes in patient safety could be made simply and easily.
ANNEX 2

Studies included in Health Foundation rapid evidence assessment:
‘Spread and scale up of innovations in healthcare and other fields’


