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<td>North West London HIEC and North West London CLAHRC</td>
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<td>Your name (completed by):</td>
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**What can the NHS and NHS Commissioning Board learn from national and international best practice to accelerate the pace and scale of adoption of innovations throughout the NHS?**

- **Adapt to adopt**
  Innovation will only deliver service improvement if it is supported by evidence-based implementation (Reed 2011). As it is well recognised in the literature the implementation or adoption of new technologies or evidence is highly dependent on local environment and it is necessary to adapt and ensure interventions are fit for purpose at a local level.

- **Harnessing capacity**
  A wide variety of academic disciplines and industries are able to provide insights and advice on how to adapt and optimise interventions at a local level. There is a need to facilitate translation and communication from these traditionally disparate groups.

- **Developing Networks and Dissemination Portal**
  Within the northwest London sector the CLAHRC and HIEC have been able to facilitate discussion and activities across a wide range of stakeholders. This has been recognised as essential to identify common goals, reduce duplication and share learning between different improvement approaches.
  This has been achieved at a number of levels:
  - Intra-organisational
  - Inter-organisational (northwest London)
  - Regional (pan London)
  - National (through CLAHRC and HIEC networks)

- **Coproduction**
  The engagement and buy-in of both staff and patient groups is essential to the design, development and implementation of interventions if we are to achieve sustainable improvements. Our experience has shown that patients uniquely have a holistic view of the healthcare system,
and therefore provide a valuable driving force for collaboration between different providers.

**Supportive infrastructure**

There is a growing understanding of the diverse skills and competencies needed to deliver evidence-based improvements in healthcare (Rhydderch, Elwyn et al. 2004). To deliver the above there is a need for a coordinated approach to build the necessary capacity and capability and maximise efficiency of resources (Stetler, Mittman et al. 2008).

**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?**

**Shift the focus of research funding to support implementation and sustainable improvements**

As Sir Ian has recognised that whilst the NHS excels at innovation it is the adaption and diffusion of these ideas that means great ideas fail to deliver anticipated benefits. There is a tradition of significant investment in innovation within the DH but only a small fraction of this funding (1% (Eccles, Armstrong et al. 2009)) is spent on research to explore how to facilitate and accelerate the adaption and adoption of innovations to deliver consistent improvements in real world settings.

Furthermore, our approach within northwest London has highlighted the need to invest funding and support at the point of care for successful adoption and sustained improvement. Until the need for this local level of support is recognised and addressed we will not fully realise the benefits of innovation.

**Review the innovation landscape to ensure cohesion between organisations**

Within northwest London we have generated close working relationships between CLAHRC and HIEC and the local healthcare community to form a synergistic alignment of our innovation and implementation strategies and resources. The HIEC and CLAHRC both partner with all provider and commissioner organisations within northwest London and have developed innovative partnerships with industry and HEIs. Further we have engaged with other research organisations including the BRC, BRUs, TfI and AHSC to ensure a development pipeline is cohesive from laboratory work to patient bedside.

It is our recommendation that this is a model that should be endorsed at a national policy level to support replication within other local healthcare economies.

**Social Care/Local Authorities**

Identifying innovations that transcend traditional working boundaries to develop an integrated approach across care pathways.

**Academia**

To support the NHS, academic researchers need to increase their awareness of the contextual issues and day-to-day challenges faced by staff working at the front line to ensure research is relevant and practical. The CLAHRC and HIEC currently act as “translators” and “communicators” across traditionally disparate groups of academics and healthcare workers and believe that this role needs to be formally recognised and supported if we are to harness the power of academia. Examples include collaboration between computing, mathematics and healthcare experts to develop data collection tools and user-friendly display of complex information.

**Industry**

The CLAHRC and HIEC have established working relationships with industrial partners including GE, McKinsey and GSK. These bring the best of their business acumen and operational experience to our partnership. Industry need to share their expertise on a broader platform. Examples include developing leadership and change management expertise.
Third Sector
We have found that the third sector bring resources, expertise and a coherent patient perspective and have added a driving force to accelerate the up-take of innovation and ensure it is fit for purpose. Examples include joint working with Macmillan Cancer Support to deliver training for acute oncology care in emergency departments and with National Sickle Cell Society to improve GP understanding and treatment of stable sickle cell patients. The third sector needs to align their efforts with NHS priorities but it is important that we enable this to happen at a strategic level.

Patients and communities
Engaging patients and communities can provide a shared improvement aim to unite diverse healthcare professional and academics. CLAHRC have utilised patient engagement in all of their improvement work to support agreement of common aims. Patients need to be aware of the opportunities to engage and the important contribution they can make individually and collectively to improvement efforts. However, to support patients achieve this goal it is important that we create a receptive environment and training and guidance as necessary. To this effect CLAHRC have developed an effective patient and community representative course that supports patients to engage with healthcare improvements.

Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?

n/a
We would like to be able to follow up interesting comments and case studies. Can we contact you for this purpose?

Yes
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

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?

If we are to deliver the recent Health and Social Care Bill’s commitment to continuous improvement in healthcare we must develop local infrastructures to embed an evidence-based systematic approach to “doing”, thus supporting the implementation of policy, research and innovation to improve everyday care (Reed, Marshall et al. 2011). The CLAHRC and HIEC in northwest London have been leading the way in developing a supportive infrastructure and believe that the main roles that need to be adopted a local level are:

1. Work within the local health economy with a shared commitment to deliver better patient care. Such an infrastructure should work within the local health economy with a shared commitment to deliver tangible and sustained improvements at the point of care. The infrastructure would provide expert advice and directly support the delivery of national and local priorities through utilizing real-world research and improvement science to inform and drive innovation and implementation.
2. Provide an integrated structure for collaboration within the local health and research community;
The infrastructure needs to be inclusive of all healthcare organizations, higher education institutes, the local community and patients plus relevant industry partners within the network. A key role would be to coordinate a whole systems approach to innovation and adoption to ensure sustainable improvements are achieved that deliver the needs of its patients. In turn this will reduce duplication of effort and increase knowledge sharing and mobilisation.

3. Build capacity and promote learning within and between local NHS organisations and academia;
To sustain improvements and maximize effectiveness it is essential to build staff capacity and capability across the interface between the NHS and academia, recognizing that managers, clinicians and frontline staff are key actors in affecting large-scale change and implementing evidence-based medicine.

4. Develop Improvement Science as a systematic approach to “doing”.
It is crucial that a systematic and scientific approach to “doing” is developed to support utilization of best evidence, creation and utilization of new knowledge and to underpin new developments with continuous evaluation. The creation of an evidence-based implementation framework is essential to support commissioners, providers and academics to work together to deliver better quality care (Reed 2011).