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

Respondent ID: 166

Organisation name: Advancing Quality Alliance (AQuA)

Type of response: Letter
31st August 2011

Dear Sir Ian,

**NHS Chief Executive Innovation Review**

Thank you for the opportunity to contribute your call for evidence on how adoption and diffusion of innovations can be accelerated across the NHS. We agree that innovation demands excellent people and excellent ideas but that we also need to spread their new ideas at pace and scale.

This letter sets out the response from the Advancing Quality Alliance (AQuA) to your call for evidence for the NHS Chief Executive’s Innovation Review. AQuA’s vision is to improve healthcare services across our membership by stimulating innovation and supporting scale and spread. We work with a range of regional, national and international bodies to introduce new ideas and to support their implementation across the North West. We are hosted by Salford Royal NHSFT on behalf of healthcare organisations across the North West of England and operates on a not for profit basis.

**The lessons we have learnt**

In developing our own scale and spread strategy we have looked at the lessons that can be learnt from other sectors and other countries at local, regional, national and international best practice. A list of the documents that we consider particularly relevant is provided listed at Appendix A.

Our conclusion is that successful scale and spread requires the following components:

- Evidenced based intelligence to provide a robust case for change underpinned by recognised improvement methodologies.
  - The buy in from the target audience at all levels of the system. Our membership model encourages a sense of ‘done with’ rather than ‘done to’ by having:
  - Commitment from CEOs and Boards to support the programmes and to making AQuA a successful enterprise.
- Products that are co-designed with local leading experts through our AQuA Associates scheme.
- Implementation strategies that are created and tested out in collaboration with the people who will lead the implementation backed up by regular supportive communications to share concerns and to tackle knotty issues.
- A joint ownership of success across commissioner and provider systems and across healthcare sectors.
- The use of formal and informal methods of peer to peer spread including breakthrough collaboratives, action learning sets, and committees of practice.

- Programmes that are aligned to a small number of priorities that are viewed as important and highly relevant to the membership community and that are aligned to system and local incentives. The nature of these incentives varies across our portfolio depending on the target audience. For instance, some relate to reputational (i.e. awards and published results) whereas others relates to financial incentives (e.g. tariff, CQUINS and productivity) and/or delivery of mandatory obligations (e.g. Monitor or CQC compliance).

- An appreciation that to gain ownership local organisations do need to ‘reinvent the wheel’ but we need to help them to this more quickly. In AQuA we call this ‘Accelerated Wheel Reinvention’ (AWR). (Figure 1).

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Figure 1: AQuA’s concept of ‘accelerated wheel reinvention’ (AWR)

Examples of our approach in practice

An example of this in action is provided by our Advancing Quality Programme. Supported by all commissioners and implemented in all providers in the North West of England the Advancing Quality programme has successfully improved clinical care by reducing variation in 5 clinical areas. The five clinical areas are: acute myocardial infarction; coronary artery bypass grafts; heart failure; hip and knee...
replacement and community acquired pneumonia. It has now been extended to encompass stroke, psychosis and dementia.

Our learning and knowledge sharing events have helped member organisations to bring both clinical and non-clinical colleagues together to share best practice and learn from each other.

This ‘pay per performance’ scheme brings together:

- People with the capacity and capability to promote change. A key element in the success of the Advancing Quality programme has been clinical ownership. Led by clinical champions and supported by managers in provider and commissioning organisations the AQ programme has enabled the development of strong and effective clinical coalitions which have delivered short and long terms wins in a way that provides sustainable improvements.
- A common language and metrics. We develop, collect and report data against clinician agreed quality measures, patient reported outcome measures and patient reported experience measures. This means we have public facing data which is transparent, meaningful and useful.
- Effective data. We utilise the data and the information to determine opportunities to improve quality. This means that participating Trusts are able to report at trust, ward, focus area and clinician level compliance with effective care and improved outcomes from a patient and clinical perspective and to use the data to focus improvement activities.
- Rewards. Achievement of the AQ programme for part of the regional CQUIN scheme so providers and commissioners have vested interested in delivery.

As figure 2 shows the AQ programme has seen consistent quarter on quarter improvements in the quality of care delivered
Figure 2: Results of the Advancing Quality Programme between Q4 2008/09 and Q3 2010/11.

Other examples that have also had success include our:

*Stroke 90:10 programme.*

The Stroke 90:10 Programme has seen significant improvements in the quality of care for stroke patients across the region in a number of the stroke sentinel audit markers. Over the last two years AQuA has supported the clinical and managerial leaders in the 26 participating acute providers to deliver a shared ambition to deliver significant improvements in stroke care. As well as delivering impressive results the Stroke 90:10 has also demonstrated that the NHS can self organise to independently improve healthcare.

Much of what was accomplished in Stroke 90:10 was not reflected in numbers alone. We have observed the emergence of new behaviours which are of note and are being summarised through qualitative interviews including:

- A stronger emphasis on accountability.
- Recognition of the benefits of creating a different dynamic between patients and professionals.
- A stronger sense of responsibility for the ways the wider health system works.
- An acceptance of change as an asset and not a threat.
A range of new approaches to supplement the evidence base and an emphasis on the importance of clinicians working across organisational boundaries.

Stroke 90:10 was shortlisted at the BMJ Group Awards for Best Improvement in Quality & Safety (May 2011) and has also featured at the International Forum for Quality in Healthcare in Amsterdam this April.

Reducing Mortality Collaborative.

Our Reducing Mortality Collaborative has worked with nine Trusts with high Hospital Standardised Mortality Rates (HSMR). Supported by AQuA, their aim was to reduce mortality rates in each of the participating providers by at least ten points between 1 April 2010 and 31 March 2011.

By concentrating on the areas they considered would make the greatest contribution to a reduction in hospital mortality rates they achieved their aim and thereby reduced mortality from avoidable deaths faster than all other providers in the North West using either the Dr Foster methodology or the CHKS RAMI.

The learning from this work is now being rolled out to all AQuA members so that those organisations that didn’t initially participate in the Reducing Mortality Collaborative can also benefit. The package should enable other provider organisations to rapidly improve patient outcomes by reducing avoidable deaths through the delivery of even safer patient care.

Safety Nodes

Our Developing Safety Networks Programme aimed to test out a new approach to scale a spread. The programme aimed to build improvement capability in a group of organisations who would then go on to run three safety improvement collaboratives of their own. As a result AQuA has developed and now recommends this nodal network model. Our belief is that this approach creates knowledge transfer whilst also building a strong improvement capability within the host organisations. This work was sponsored by the Heath Foundation and will be showcased at an international conference in April 2011.

Pointers for a national strategy

Defining expectations.

The NHS Commissioning board and the Department of Health now have a role in more clearly defining the areas in which innovations should be quickly adopted. In recent years there have been a number of initiatives aimed at improving translational research capacity and capability. These include, but are not limited to, the outputs from: BioMedical Research Units and Centres, the Academic Health Science
Centres, the Health Innovation and Education Clusters (HIEC), the NIHR Collaboration for Leadership in Applied health Research and Care (CLAHRC), initiatives like Science City as well as more generally the areas of knowledge transfer being sponsored by the Technology Strategy Board and the development of the health related Technology and Innovation Centre.

The recent DH paper, *Research and Development Work Relating to Assistive Technology*, also illustrates the vast array of innovative and practical ideas that potentially could if adopted quickly and at scale help transform the NHS.

Therefore our suggestion is that the NHS Commissioning Board, in collaboration with the DH, should:

- **Identify a small number of well-defined system innovation aims and initiatives** which underpinned by a case for change that is evidence-based, can clearly demonstrate a quality and productivity benefits to clinicians, managers and the public and supported by targeted marketing campaigns. The FAST campaign, launched as part of the National Stroke Strategy, possibly gives some pointers for how this might be achieved.

- **Make a clear connection between local benefit and national imperatives** i.e. having identifiable links to the outcome framework and the actions that need to taken to deliver them in a way that is easy to demonstrate (i.e. measure and monitor).

- **Make the link to financial and non financial system levers** i.e. make use of the existing system levers such as CQUINs, quality accounts, CQC registration, contracts and the NHSFT Terms of Authorisation to reinforce the need to demonstrate the success of implementation strategies to the commissioners, the NHS commissioning Board, Monitor and to the public.

- **Support the bold system aims by providing ring fenced implementation incentives and rewards.** Ring fenced implementation support funds would allow for local adoption of evidenced based good ideas and reward schemes to incentivise the implementation and take up of peer reviewed translational research. These could be potentially linked to the Quality Premium and Health Premium envisioned to the Clinical Commissioning Groups & Health & Well Being Boards.

- **Create a robust and accessible implementation knowledge base.** The NHS Commissioning Board should consider creating a central knowledge base of innovation schemes that can demonstrate quantified clinical quality and productivity gains. Linked to this more rigorous and realistic models of evaluation of successful interventions to enable them to be better understood and replicated in other settings is required. However, to achieve this there needs to be more emphasis on publishing material on the process that was used to implement
innovations and as part of that greater acceptance that we can learn as much, if not more, from what didn’t work as we can from what did. It may be that there could be a key role for a reshaped NHS Institute for Innovation and Improvement.

- **Develop a network of national and local adoption champions** who are experts in diffusion. This includes both managerial and clinical champions that can foster networks and build good relationships to win hearts and minds. This needs to go much wider than simply asking for organisations to nominate knowledge managers and needs to allow organisations to:
  - Secure the implementation support that allows for local adoption and ownership.
  - Acknowledge their organisational readiness, and therefore willingness, to adopt new initiatives.
  - Recognise that they need to change rather than being told that they have to change.

- **Fund, but not necessarily provide, training.** A major gap is the translation from innovation to full implementation and the recognition that the process and skill set are different. Investment is required in many areas including:
  - Improvement methodologies at all levels in the system across all professional disciplines in how to adopt and implement new idea is required. This training needs to recognise that there is no one size fits all. Staff needs to be offered tailored yet multi-faceted approaches to implementation.
  - The development of an NHS analytical capacity and capability that can measure, monitor and analyse improvements. The Government OR Service, the Government Statistical Service and the Government Economic Service might provide models for this and how a career development structure might be created.

**Conclusion**

Thank you for the opportunity to contribute your call for evidence on how adoption and diffusion of innovations can be accelerated across the NHS.

We agree that much has already been achieved but there is still more to do to encourage the NHS to spread their use at pace and scale. Our response sets out our thoughts in three areas: the insight we gained in developing our share and spread model; our experiences in sharing and spreading good practice and our suggestions for inclusion in a national policy.

Our conclusion is that the NHS Commissioning Board has an important role in supporting adoption and diffusion. In particular, consideration needs to be given to how the system levers and incentives can be used in a way that helps to create a
local ‘pull’ from patients and the public and for that to be supported by access to targeted implementation funds.

We look forward to reading your report in November 2011 and in the meantime would be delighted to provide any follow up material.

Julia Hickling
Director
Advancing Quality Alliance
AQuA's spread model

Evidence and Intelligence

Robust Improvement Methods

Incentives

Change Champions and Communities of Practice

Peer to Peer Learning

All underpinned by a campaigning approach drawing on learning from

5th Floor, St James’s House, Pendleton Way, Salford, M6 5FW
Appendix A: List of relevant documents


Morrow E, Robert G, Maben J, Griffiths P. Facilitating the Spread of the Productive Ward. Final report (Study 420), National Nursing Research Unit. June 2010


Spreading Improvement and Innovation: A guide for CLAHRC. Professor Ruth Boaden, Manchester Business School, May 2010

Diagnostic Innovation in the NHS. Angela Douglas, lead Scientist NHSNW. How can we build skills to transform the healthcare system? Helen Bevan

The NIHR Collaboration for Leadership in Applied health Research and Care (CLAHRC) for Greater Manchester: Combining empirical, theoretical and experimental evidence to design and evaluate a large-scale implementation strategy. Gill Harvey, Louise Fitzgerald, Sandra Fielden, Anne McBride, Heather Waterman, David Bamford, Roman Kislov and Ruth Boaden.