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

Respondent ID: 167

Organisation name: Leeds Community Healthcare NHS Trust

Type of response: Letter, document and presentation
Dear Sir Ian

Re: NHS Chief Executive Innovation Review - Call for Evidence

Thanks for the opportunity to provide evidence for the review. I believe that there is significant good practice in the NHS in terms of innovation. We now need to ensure that the system ruthlessly exploits this innovation to ensure that we deliver high quality care in a difficult environment. This is a logistical and cultural challenge and our submission covers some of this ground.

I look forward to seeing the results of the Review.

Best wishes

Rob Webster
Chief Executive
Leeds Community Healthcare NHS Trust

Enc.
1. Learning re Adoption and Spread: Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust is passionate about building an organisation where improvement and innovation are key drivers for delivery of excellent care to our service users.

LCH has established an ambitious programme of improvement, known as the Leeds Approach which will over time encompass all of our teams and services (65 services, 3,500 staff). The Leeds Approach embraces a Microsystems model of improvement and incorporates evidence based improvement methodologies:

- Productive Community Services is being implemented extensively across our services
- We are also an early implementer of the Safety Express programme and exploring the connections between these frameworks to provide a comprehensive improvement framework for services
- We are exploring the development of a Productive Pathway to support discharge processes with partner organisations

Our improvement and innovation work organisationally have enabled the following:

- 5,000 hours per annum of released time (April 2011), projected to reach 15,000 at October 2012 [around 400 WTEs]
- delivery of 5% CIP Targets 2010/11, and projected 2011/12
- 93% patient satisfaction levels across the organisation
- Good levels of staff engagement, using tools such as Survey Monkey to regularly measure staff awareness and engagement with the programme

We are continually refining our approach through research and exploration of international models of system improvement. The Jonkoping County Council (Sweden) model of improvement has been particularly influential, particularly in the following areas:

- Redesigning pathways from the perspective of the patient
- Measurement of value through service delivery
- Developing the improvement capability of staff
- Skilled, coordinated resource to support improvement
- Linking improvement and innovation to research programmes
Our Chief Executive recently shared learning on this with the York health system and a presentation is attached that describes this learning.

The following reflections are based on our experiences and learning of implementing a large scale improvement and innovation programme and set out what we believe is required at local level to deliver a culture of innovation and improvement.

2. Actions at Local Level in the NHS

2.1 Innovation and improvement as a culture

- Staff are resourceful, creative and have the ability to find their own solutions
- The organisation should be structured to allow this creativity to flourish, setting out clear expected standards of excellence in service delivery, improvement and innovation
- Leadership at every level in the organisation underpins this commitment and consistently demonstrates adherence to this in practice by supporting and encouraging staff to work in this way

2.2 Embedding the culture of innovation and improvement through organisational structure and resource

- Director / senior level responsibility for innovation & improvement to ensure it underpins strategic decision-making
- Recognition of the balance required at service level between delivery and innovation (doing the job and improving the way the job is done). The resource required to support this (time, headspace, training, support) needs to be planned for within the business planning process.
- The nature of innovation is such that the organisation needs to recognise the need to test / PDSA new ideas in the knowledge that some will be discarded – this needs to be built into assumptions around return on investment
- CFT surplus could fund the resource to support the improvement and innovation work undertaken by teams
- Innovation and improvement is underpinned by a sound basis of audit and measurement – staff need to be trained / skilled in their use
- Innovation can be linked to strategic and service priorities – facilitated through the business planning process. However there is also a need for freedom to test good ideas – through the establishment of an Ideas Channel, supported by a central funding stream either organisationally or at health community level (see Risk-sharing below)

2.3 Adoption and diffusion of innovations / best practice

- All clinical services should be aware of and working towards implementing best practice in their field. This could be supported by best practice champions / clinical leaders in each service area with an explicit responsibility for keeping up to date with best practice
The Improvement and innovation support resource will systematically **horizon scan** and establish user-friendly, accessible communications to best practice champions / clinical leaders about new approaches / developments. Cross-service and cross-organisation innovations such as mobile technology, telecare should be managed as innovation programmes.

Use of **NHS Evidence** and Institute for Improvement and Innovation and other resource bank websites will be actively promoted across the organisation.

Exploration of the role of **partner university** organisations to support adoption & diffusion should be pursued.

An annual innovation and improvement **share & learn event** should be established either at organisational, health & social care community or regional level.

### 2.4 Reward & Recognition

- Individual or service innovators / improvers should be rewarded and **recognised for effective ideas** contributed through the Ideas Channel and / or tested service innovations. Publication and promotion of good ideas and innovations will be supported at local and national level.

### 2.5 Risk Sharing

- The burden of non-return on investment may be too great for individual organisations / services to create the environment for innovation.
- **Collaborative funding arrangements** with commissioners – clinical commissioning groups and partner organisations to support innovation could be established e.g. Leeds Health & Social Care Innovation Fund.
- This could be **targeted around strategic priorities** or open to good ideas which fulfil agreed criteria / principles.

### 3. Actions at National Level

- **The NHS Commissioning Board** should have a key role to play in promoting the adoption and spread of innovations, learning from and disseminating best practice, both at a national and international level.

- **The NHS Institute for Innovation and Improvement (NHS III)** should continue to have a pivotal role in the future, particularly as an expert resource on innovation and change, and providing a platform for sharing best practice nationally. However, it is acknowledged that there are an ever increasing number of sources of information and guidance on innovation and change in the NHS, and it may now be helpful to have a **national kite marking system for best practice**. This would
help to better coordinate resources, and make them more easily accessible for staff. The NHS III would be ideally placed to lead and coordinate this area of work.

- There should be a clear mechanism, both at national and regional level, to enable a coordinated and simple process for organisations to access the multiple funding streams available for innovation work and research.
- **Research activity** needs to be a balance between developmental, action research and empirical research, and the dissemination of outcomes needs to be well coordinated locally, nationally and internationally.
- Both at a national and local level, we need **dynamic leadership** that encourages and supports innovation at all levels, and across all activities. This will help establish innovation, and promote thought leadership, as everyone’s responsibility, and part of everyday work, rather than just as an ‘add-on’.

4. Actions by NHS partners

- We need to ensure all our partner agencies share our commitment to the adoption and spread of innovation and change
- **Partnership working** should ensure the multiple boards e.g. Health and Wellbeing Board, Health and Social Care Partnership Board, Protection Board and Innovation Board, all work together to a common innovation agenda, which has a clear thread to National best practice.
- **The QIPP programme** should be system wide, and owned by the local Health and Wellbeing Board, providing a common agenda for all partners.
- We need **local governance and clinical commissioning tools** in place that incorporate QIPP. This will provide a common framework for providers, commissioners and emergent Clinical Commissioning Groups to work together. This will also help ensure consistent, best practice at local, regional and national level.
- Our **involvement in national initiatives, such as Safety Express**, will help support this. This will provide high level scrutiny of our processes and systems, including our work with partners in key areas.
- **Work around co-production** in Leeds (funded and supported by NESTA and the Innovation Fund), will focus on risk stratification, promotion of self care, and the integration of Health and Social Care teams. This work could provide a framework for co-production applicable across all services and partners, with innovation at its core.
Impressions from Jonkoping

Rob Webster
Chief Executive
Leeds Community Healthcare NHS Trust

With thanks to Goran Hendricks ©
Leeds Community Healthcare NHS Trust

We provide the best possible care in every community

We will do this by:

• Working with children, adults and families to deliver high quality care
• Being a good partner
• Developing and valuing our staff
• Using our resources wisely and efficiently
Where?
Why are we interested?
Three healthcare districts
51 primary care centres and three hospitals
Jonkoping: The Official Line

- Jonkoping County Council
- Commissioning and provision of health and social care
- 340,000 population
- Leadership focus on quality improvement, married with financial discipline
- Focus on systems thinking to produce results – the person/measurement / performance
Jonkoping: The Bottom Line

• Highest Quality
• Third lowest costs [last time I looked]

=QIPP
Outcomes

- Financial savings through efficiency – 2% of net costs (c. £8mn)
- Reduced infection rates
- Improved long term condition management
- Reduced staff absenteeism
- Reduced staff turnover
1. Focus on Value
Value = 
(technical quality + service quality) / resources

• Best fit
• Value chains – map processes from the patient’s perspective
• Value shops – simplify and standardize
• Value development by networking
Simple Tests: Esther
2. It’s a world of integration
Clinical Microsystems

A microsystem is the small group of healthcare staff who regularly work together with the patient to achieve the best possible care.

Microsystems are the value creating elements of healthcare and the ambition is that the entire organisation is built for and supports the microsystem.
Micro System

Service Plans & Frameworks: Quality, PPI, Productivity

Organisational Priorities: Quality, Innovation, Productivity, Improvement Culture

Integrated teams
3. Aim for the best possible
Benchmarking

Jönköping        Sweden        World
Best in the world?
Best possible
4. Give everyone two jobs....and the support to do them
Everyone has two jobs

1. To do your job

2. To improve your job
Professional knowledge
- Education
- Personal skills
- Values, Ethics

Profound knowledge
- Understanding of system
- Variation
- Change psychology
- Learning based improvement work

Improve diagnosis and treatments + Improvement of processes and systems → Increased value
And the support to do them

All staff
access
4,000
Trained
Improvement
tools
Common
language
5. Manage and Measure Performance
6. Manage the system
Low Value

Problems we face Every Day

High Cost
- New drugs and tech ≠ outcomes
- No mechanism to control cost at the population level
- Supply-Driven Demand

Low Quality
- Over-Reliance On Doctors
- Insignificant role for individuals and families
- Under-valuing “system” design

Ref. Tom Nolan
1. Primary Care: redefined, higher capacity
   - General medical practice connected to other resources
   - Self-care designed by “lead patients and families”

2. Reverse the cost-flow gradient
   - GP - specialist compacts
   - Make the expensive places the bottlenecks

3. Reclaim wasted hospital capacity
   - Flow optimization
   - Chronic disease care

4. Patient goals at least total cost
   - Patient reported outcomes
   - Decision aids and peer to peer support

5. Focused segment: High cost, socially or medically complex

6. Integration of regional resources
   - Negotiate fair arrangements
   - Ostrom’s design concepts

Primary Drivers

“More Is Better” Culture
Mitigated by: 1, 2, 4

Supply Driven Demand
Mitigated by: 2, 3, 6

No Mechanism to Control Cost at the Population Level
Mitigated by: 3, 5, 6

Over-Reliance on Doctors
Mitigated by: 1, 4, 5

Lack of Appreciation for a System
Mitigated by: 1, 2, 6

Goran Hendricks ©
7. It’s all about leadership and culture
1. Individuals – consistency, continuity
2. Processes
**Improvement culture**

1. Reduce waste
2. Reduce costs with increased quality
3. New services/design to meet patient expectation and need

From “1 : 1” to “many : 1”
From “mono-diagnoses” to “illness burden”
From “cost - focus” to “value - focus”
8. We are not Swedish, this is not Sweden
My Aims for Leeds
The Leeds Approach

Supporting teams to deliver the best possible care in every community

Embedding service improvement into the culture of the organisation

Jönköping News
No Money No New Resources

Patient at the centre of everything
Define measures through patients eyes not systems

QULTURUM

Staff are the biggest asset to the organisation

A copy of Goran's presentation, a summary of the event and all the photos are all available on the T drive:
T:\Care Services\Service Improvement\Leeds Approach\Programme Management\Communication\Jönköping

COMING SOON...the video of the event will be available via the Intranet (Leeds Approach pages)
Next Steps in Leeds [1]

- We set the organisation up to deliver value
- We measure this at an organisational and individual level
- Every person has 2 jobs - do your job and improve your job
- We use the Leeds Approach to support this
Next Steps in Leeds [2]

• Teams direct the Leeds Approach at their chosen issue
• We link this to feedback from staff listening events and address issues such as duplication, bureaucracy and too much paperwork … this adds value
• To ensure all engaged we need visible symbols of change
• These symbols could be giving money to teams from non recurrent monies to support improvement or the integration of universal services
Next Steps in Leeds [3]

• As this matures we must shift decision making and resources closer to patients
• We will develop balanced scorecards and indicators
• We need to ensure that there is an ideas channel to get big ideas to top team
• We will draw on clinical voices or network or groups
• Underpinning this will be Associate Director of Innovation and their team- our Qulturum
Questions?