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

Respondent ID: 209

Organisation name: Young Foundation

Type of response: Document
Spreading Innovation in the NHS: call for evidence and ideas - Young Foundation response

- The databases that exist to provide information, evidence and tools on innovation need to be improved, made more accessible and mainstreamed. The current sources of information such as NHS Evidence, and NHSI websites are not easy to navigate making it difficult and time consuming to find relevant innovation information linked to specific topics. The BMJ best practice website may now be known to, or accessible to, managerial staff. The NIHR web-site could be improved. Commissioners need to easily access information on best practice and innovations in specific areas so mainstreaming, simplifying and linking existing information sources would help.

- Ensuring that benchmarking against best in class becomes the norm in terms of practice, and that this process also engages commissioners to drive the requirements for new innovative practice. This is only possible with data sharing and may need to be individual clinician specific as well as at a provider or service level. Also transparency is an important spur – public mortality data by surgeon etc.

- Making the adoption of innovation from elsewhere as easy as possible, by ensuring templates, documents and ‘how to’ guides are accessible and readily available for each specific innovation which has been shown to work and is ready to diffuse. Creating programmes which help either in a locally devolved networked way of from central support such as the DH Care Services Efficiency Delivery Programme which implemented home care re-ablement and is now taken up by 90% of councils. This programme created in depth tools and then marketed the programme everywhere.

- By having widespread seed funding available for diffusion and adoption perhaps 80% of innovation funding for this rather than ‘new’ ideas. Also to stage-gate funding for ‘new’ innovation and include the requirement to diffuse to get later stages of funding; NHS London are using this approach. Also potentially fund innovation scholarships, as part of an innovation development programme.

- Create a group of clinical champions who are proud to copy, perhaps creating a local panel who may influence diffusion but who also have the skill and ability to ADAPT to local circumstances as well as adopt. Ideally these should be supported by people with service design expertise. Also potentially some high profile recognition or award for those that adopt from elsewhere in the early stages.

- Ensuring that general budgeting/tariff/funding streams both within organisations and between them can be adapted to support rather than block innovation. The blockages may be internal budget silos, across health economies or between health and social care. A large proportion of community innovation requires money to be released from acute settings, so hospital reconfiguration has to be on the agenda. Pooled budgets are required across critical areas e.g. Dementia, which could be considered Mental Health or Social Car.
• Developing capacity within both provider organisations and commissioners to understand the innovation process and to develop skills and capability in this area. It is helpful for key strategic innovation goals to be set, to focus horizon scanning and adoption. These could be set by commissioners, by providers or ideally across health economy and commissioners.

• There is a need to educate clinical staff involved in commissioning in every aspect of the commissioning cycle, from understanding their community through engagement with public health and the community itself, through to mapping needs using the right tools, through to co-designing a service improvement, modelling and proto-typing through to evaluation and impact.

• By supporting networking between similar projects which are adopting the same or similar innovation, ideally through face to face contact but also through IT platforms. An innovation buddying system could be implemented – i.e. to remove the ‘not invented here’ blockages could two PCTs swap innovations – so that everyone gains, benefits from learning and innovations can actually scale.

• By working with the initiating successful projects to ensure they have effective mechanisms to ‘push’ their innovation. This could be a requirement of their funding at certain stages, but it is also important to ensure if they are a clinician that they are able to be released and backfilled so that they have the time to work with others to help them adopt the innovation. In our experience they need help with methods of achieving diffusion – this could include:
  - Support with appropriate communication material
  - Ways that they can ensure innovations are easy to trial and easy to observe – use of workshops, visits, video, new media
  - Engaging different clinical groups through the identification and involvement of a respected clinical leader
  - Use of journal articles and conferences
  - Helping them set up a learning network for new adopters and having some mechanism of keeping track of these (again linked to funding)

• Develop greater expertise and awareness of proto-typing so things have been properly tested and refined before piloting and roll-out is attempted

• By widening the understanding in the NHS that a large percentage of attempts at innovation will fail and only rolling out those that have succeeded. The NHS needs to legitimatise failure and communicate that for services to innovation and improve failure is an integral factor (removing public sector staffs barriers of risk aversion) – for this to succeed the legitimacy needs to be communicated internally to NHS staff and externally with politicians, patients, the press and partners
• Diffusion is social. We’ve know for 50 years that incontrovertible evidence is not enough to change behaviour. No company would launch a new product by releasing evidence of its efficacy, and waiting for the phone to ring. Innovations need to be supported by campaign, networks, advertising and marketing. This costs, but ...

• We need to be careful about the mode of diffusion funding. Almost any improvement plan within the NHS can be seen as the diffusion of innovation, especially when we are talking about taken an established idea to a new geography. What the NHS typically does at the moment is diffusion by bribery, which just isn't sustainable. (Here is a bunch of money to do something you should be doing anyway). We should only be funding the innovator to diffuse, rather than the site where they are going. We need to be looking for self diffusing ideas, and should be giving initial funding to new sustainable models of diffusion, rather than to a hospital to do a specific thing. For example internal nhs franchising, better use of professional networks and on-going professional training.

• The architecture and resources of the NHS are mis-configured for the health problems of the population; a system designed for curable infectious disease is being applied to incurable long term conditions. Patient empowerment must now be both the objective and the means of effective care: the NHS has to be about supporting patients to live as independent a life as possible out in the community. Lip service is paid to this concept, but the mindset of the NHS is about admission, treatment and discharge. Promoting patient independence its often no one’s job, and its much harder to innovation here than in more traditional forms of delivery that the NHS understands. But this is just where modern tech such as social networks and rich data feeds can make the greatest difference. Patients like me, patients know best, MyDex. To make this happen will require a better NHS IT platform, as well as sorting out privacy and data. Also more community based real social networks.

• Outside of the hospital sector, data is weak. Doctors often don't know the effect of the treatment they provide. Better data can be important here, including patient entered data.

• Change is disruptive, and will always be resisted. There are ways to make this easier, around the tariff system in particular, using new incentives. Outcome based incentives, rather than ones that assume and entrench a particular architecture, are particularly valuable here.

• However professional roles, institutional traditions, working practices, modes of performance measurement, and political constituencies all remain as serious barriers. Even in the private sector, where incentives are clear, large companies fail to adapt to adopt disruptive innovations, and typically do not survive a transition. Its naïve to expect a public sector leviathan to somehow be able to do things that the private sector has never been able to manage. The NHS must have a mechanism for new entrants, and for successful operations to grow. For this to happen it must also have a mechanism for unsuccessful institutions to close. Doing this for hospitals will be hard, but
GPs and community healthcare are perfectly possible areas. The role of social enterprises here could be critical.

- Evidentiary standards are a problem. Service innovations are hard to evidence, as services are part of an interdependent system, and causation is structurally difficult to establish. Not sure what to do about this, but richer data can help. Furthermore, the incumbent service or provider should be subject to the same levels of scrutiny and efficacy/ROI as new or innovative services.

In summary innovation doesn’t just happen, not even when regulation is relaxed - a favourite route for policy makers. It requires active stimulation of the market, including the various factors that make up the dynamic between supply and demand. On the side of the providers (push) this means active support for understanding needs, design, prototyping and development of services, coaching of individuals underpinned with a transparent mechanism for measuring impact. Funding streams and incubators can play a vital role here. On the purchaser/commissioner side (pull) intelligent commissioning can stimulate, create and then establish services and partnerships currently only found in small pockets of excellence. Between the two a brokering function is needed matching provision with requirements in a landscape where currently both frequently exist, but rarely match.

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August 2011