It’s become a truism to say that for every problem the NHS also has a solution – it’s just that the two have not yet been joined up.

That’s particularly true of innovation in healthcare: there is plenty of great work going on, often involving NHS organisations working closely with partners, which could offer benefits across the system. However, this work often remains siloed, with limited spread to other organisations.

An HSJ roundtable tried to understand why this should happen, what could be learned from success stories where innovations had spread successfully, and what factors had enabled this to happen at scale.

Chair and HSJ editor Alastair McLellan started the debate by stressing it was about how innovation could be spread at scale rather than simply about innovation. He asked the participants if they could give examples – whether in the NHS, the wider healthcare sector or other parts of the economy – of where spread at scale had happened successfully, and what factors had enabled this to happen.

Chair and HSJ editor Alastair McLellan started the debate by stressing it was about how innovation could be spread at scale rather than simply about innovation. He asked the participants if they could give examples – whether in the NHS, the wider healthcare sector or other parts of the economy – of where spread at scale had happened successfully, and what factors had enabled this to happen.

An HSJ roundtable tried to understand why this should happen, what could be learned from success stories where innovations had spread successfully, and what factors had enabled this to happen at scale.

Managing director of the Greater Manchester Academic Healthcare Science Network Mike Burrows spoke about improving anticoagulation in atrial fibrillation patients where some areas in Greater Manchester had been more successful than others.

There had been a number of factors which had been important in determining the level of success. First, there was a collaborative approach, involving GPs rather than clinical commissioning groups, being seen as issuing instructions. Different tactics had been used in different parts of the GP community. Data was used to not just measure progress, but to show practices where they were compared with their peers.

“There is nothing like that to create an incentive for certain GPs and practices not to be in the remedial group,” he said. There had also been investment in the capacity needed to make the change. This could be time limited on the back of benefits realisation.

Capacity to change

Another success story was the uptake of insulin pumps for diabetes sufferers in south London, where the UK lagged other developed health systems. Tara Donnelly, chief executive of the Health Innovation Network, the AHSN for the area, said that although more expensive for the NHS to start off with, they paid off over time through better blood sugar control.

“We did a piece of work across seven hospital providers and set up a collaborative, including manufacturers and people with diabetes,” she said. “We have managed to make a huge change in the update – it was just under nine per cent and now it is twelve per cent.”

Key factors had been recognising there was a need for skills and capacity to change; a very specific focus; and credible leadership and buy-in.
This meeting was organised and funded by Pfizer Ltd and this report has been developed by HSJ based on discussions resulting from the roundtable meeting. Pfizer has had no editorial control, but has approved the final report in line with the ABPI Code of Practice.

This is a summary of the discussion from the roundtable meeting held on 20 June 2016 with representatives from the healthcare sector, including NHS chief executives, patient organisations, the charities, pharmaceutical and clinical research organisations.

However brilliant innovation is it is not going to spread itself,” said Will Warburton, director of improvement at the Health Foundation. “It needs skills and energy and capacity.”

But the NHS may be able to learn from other health economies which have brought in changes successfully. In the US, central line acquired blood stream infections had been reduced by 80 per cent over 15 years, said Will Warburton, director of improvement at the Health Foundation. However, this had been preceded by many years of standardising measurement and establishing a clinical evidence base, followed by the production of guidelines in the 1990s.

The reduction in cases through the 2000s had been helped by clinical engagement utilising quality improvement and collaborative methods. Information on “what to do” had been important but so was giving people permission to challenge practice in intensive care units.

In the UK, there has been a revolution in the use of primary care navigators or community health champion with rapid spread, said Dr Nav Chana, chair of the National Association of Primary Care. These signposted patients to community resources around lifestyle changes.

Collaborative networks around community pharmacies and general practices had been set up but the role of “word of mouth” among patients had also been a powerful enabler. Capacity and a little bit of funding to allow headspace had also helped, he said.

Pfizer was involved in an innovative partnership with hospitals in Leicester aimed at reducing junior doctors’ prescribing mistakes. Pfizer’s UK managing director Erik Nordkamp said: “It was a big success and was picked up by other trusts but it is an example of how if it was done slightly differently it could have been scaled even further.”

The project reduced the number of mistakes made by junior doctors by half and saved the NHS £300,000 in that trust alone, together with better outcomes and satisfaction among patients.

“However brilliant innovation is it is not going to spread itself. It needs skills and energy and capacity”
colleagues and also commissioners. Data and measurement were also crucial in demonstrating outcomes and giving confidence that it could be scaled up.

Tony Young, national clinical director for innovation, put forward the National Innovation Accelerator as an example of a change in policy at the centre which was rapidly making a difference in uptake and scaling at the frontline.

The NIA tried to “incubate” proven solutions and provide support for them for spread: he cited the example of a COPD project where up to 90 per cent of COPD patients were not using their inhalers correctly.

A web-based training programme had seen that reduce to just 2 per cent. This intervention, which cost just £20 per patient – a fraction of face-to-face training – would benefit them for the rest of their lives but also enabled far more patients to be reached for the same overall cost. This had now been taken up by 10 CCGs, he added.

Such examples proved that innovation at scale was possible in the NHS, said Mr McLellan. He had been told for many years that there was a problem with spread of innovation in the NHS compared with other sectors but asked whether there was anything distinct about the challenges in the NHS which underlay this.

Ms Donnelly said its devolved nature meant “It’s more of an art to get spread”. Professor Young suggested what could be done was determined in part by patient safety. “Patient safety is the key, the heart, of what we do. We can only take forward something new and innovative with the appropriate safeguards,” he said.

However, some of the issues about spread may be because the right factors are not being addressed. Mr Nordkamp pointed out: “We know 70 per cent of transformations fail because they don’t address behavioural change. The NHS is not one culture, it is many mini cultures. We look a lot at performance metrics, processes, but not at the behavioural change that is required to make things happen.

“You make sure you measure the engagement of your organisation. You need to define the elements you want to change. If you have a culture very focused on not following the rules, you want to change that and say this is an important change I want to make. You can put some process elements in that, such as in how many cases you have followed them.”

Ms Donnelly said it was necessary to fail sometimes but it could be hard to do that in the context of the NHS. She said that they were trying to get junior doctors with great ideas a way to take them forward so they could develop skills in leadership and management.

Dr Chana said: “For me the definition of success is improving population health outcomes.” He suggested one of the great successes of the changes going on in Greater Manchester was that it was configuring services around populations of 30,000 to 50,000 people.

Virtuous circle
He said what people felt was important to them around healthcare was crucial in talking about success. Concentrating on this could lead to, for example, fewer medications for some people with long term conditions who might feel unwell on multiple medications.

Developing metrics around this – such as measuring people’s activation – would be one way of driving behaviour change in how healthcare professionals work.

Mr Burrows said one of the constraints on the NHS compared with other sectors was the yearly planning round. “It does not give them the flexibility that other industries have to invest in innovation. Some of these decisions are five to 10 year ones. The really successful leaders are those who can reconcile the operational here and now with that ability to invest.”

Even in the current economic situation, there were leaders who were managing to do this. This can be a virtuous circle as it allows organisations which are ahead of the pack to stay in front, suggested Mr McLellan. “You get ahead on all the year-to-year, day-to-day stuff and the centre leaves you alone. The regulators are knocking on your door and that gives you the headspace to push things forward. But it is increasingly challenging to do that right now.”

Sometimes innovation can align with the direction of travel of other parts of health policy and can be financially incentivised. Ms Donnelly said her organisation had been running an exercise programme called “escape pain” for patients with joint pain.

However, joint pain was also an issue for many NHS staff and helping them would align with the recently introduced CQUIN around staff health. Mr Burrows said the tariff incentives announced by NHS England in June were an opportunity to encourage spread. “It is a great way to create a new system that incentivises adoption and uptake,” he said.

However, Mr Warburton said financial incentives could sometimes have unexpected results: for example, fines for late pick-ups at daycare centres in Israel had been associated with soaring number of parents arriving late – paying fines had changed attitudes towards something which was previously seen as unacceptable.

Mr McLellan said: “It seems to me that the financial incentives have to be there and there are good short term incentives to push someone over the line but if we rely on them you end up with something like the quality and outcomes framework, which does not necessarily produce what you wanted.”

But many of the incentives for adopting innovation are likely to be non-financial. They could help make clinicians lives easier, said Dr Chana, while Professor Young said: “We all went into medicine to make a difference and we are still there to make a difference – that is the key driver for clinicians.”

Ms Ravenscroft said non-financial incentives for staff could help. “One thing that the NHS could do which would cost no money is just celebrating the spread of innovation,” she added.

One of the issues for Ms Donnelly was that while many programmes saved money, they
Professor Young suggested this as a way for the NHS to spread best practice or not. “minds” and making clear what was acceptable penalty; it was more a matter of “hearts and more widely adopted without a draconian be affected. Professor Young said the World regulation in cases where patient safety could required, he said.

There are also “sticks” for clinicians around innovation, what are the sticks which should be used alongside them, asked Mr McLellan. Mr Burrows said that small penalties might be all that was needed – such as comparative data involving peers. Sometimes realising that you do not follow the evidence is all the stick that is required, he said.

If accountable care organisations were to be developed in the NHS, it would be helpful to partner with organisations which could help with some of the skills needed around public health management, said Dr Chana. But Mr Warburton warned about the capacity to take part in partnerships. “Partnership takes time, building trust takes time, building relationships takes time,” he said. Managers found it hard to make this time when they were in firefighting mode in the NHS.

Sustainability and transformation plans may offer a way of spreading best practice. Mr Nordkamp said he hoped it would provide a way ahead but had concerns that it was a centralised solution and there was limited capacity for transformation across a system, especially if those involved in transformation already had a big remit within their own organisations.

Ms Ravenscroft said there was hope that the STP approach to looking across an area could be a game changer and overcome some of the issues, releasing savings. But what support would there be for those who were lagging behind for whatever reason, she asked.

This inequality also concerned Mr McLellan: “The good areas of the NHS are always able to look after themselves, regardless of the central constructions,” he said. But the areas which were weakest also tended to have the weakest STPs – despite often being the ones which would benefit most from the spread of best practice.

did not always save money in the same pocket as it was spent. “If there was more of a place based capitation funding for those things, it might incentivise the right thing.”

Where does innovation fit into the drive towards standardising processes across the NHS or groups of hospitals? Mr McLellan said that the hospitals joining with Salford Foundation Trust in a chain were looking at standardisation of processes to improve care and this was common in other industries.

Getting clinical buy-in to change, however, can be a challenge in even well-regarded organisations. Approaches needed to be nuanced, Mr Warburton suggested, to avoid provoking negative reactions in a culture of autonomy. Ms Ravenscroft suggested “knowledge management” might be a less threatening term than standardisation to describe what was needed.

Who is – or isn’t – taking responsibility for widescale change management across a fragmented NHS concerned Mr Nordkamp. “This is one of the main issues the NHS needs to fix. If no one focuses on it then we are back in the position where 70 per cent of change fails,” he said.

If incentives are the carrots to drive spread of innovation, what are the sticks which should be used alongside them, asked Mr McLellan. Mr Burrows said that small penalties might be all that was needed – such as comparative data involving peers. Sometimes realising that you do not follow the evidence is all the stick that is required, he said.

There are also “sticks” for clinicians around regulation in cases where patient safety could be affected. Professor Young said the World Health Organisation surgical checklist had been more widely adopted without a draconian penalty; it was more a matter of “hearts and minds” and making clear what was acceptable or not.

Partnership with other organisations may be a way for the NHS to spread best practice quickly. Professor Young suggested this underlay the Five Year Forward. Ms Donnelly said the AHSNs were the first organisations to work with many partners, including industry. Mr Burrows said there was sometimes a reluctance to work with industry but it had the skills which was needed and was a “no brainer”. Mr Nordkamp said: “When I look at partnerships, one of the key ingredients of success is trust. That is not always there and we need to really work on it from all sides to ensure we build that trust.”

To help this process it needed everyone to declare at the start why they were there and what they wanted to get out of it. The other thing that would help was partnerships at various levels.

He would like to partner with NHS England around scaling up some innovations. “Let’s talk about areas where that could happen – whether it is standardisation or taking cost out of the system,” he said.

Game changer There was pressure to come together with other pharmaceutical organisations – and they were perusing this, for example, around Alzheimer’s. “We are living in a complex world with complex problems that need different solutions to solve them,” he said: it needed partnership to tackle them.

Mr McLellan asked where the NHS was not partnering and what sort of organisations did it need to partner with. Mr Donnelly said her AHSN had learnt the universities it works with were concerned about graduate employment. An internship, allowing graduates to get valuable experience in non-clinical roles, had been developed – and was encouraging graduates to think about careers in the NHS.