Spread and adoption of national priority innovations

Insight project with Hampshire Hospitals NHS Foundation Trust

Case study

March 2019

This is a short version of the project report produced for and approved by Hampshire Hospitals NHS Foundation Trust.

1. Introduction

There is an increasing national emphasis on improving the spread and adoption of innovations that have demonstrated that they can improve the quality and economy of care and are ready to be used at scale. The Academic Health Science Networks (AHSNs) have an important role to support their member organisations and local delivery systems to achieve the spread and uptake of these nationally prioritised innovations (NPIs)[1].

The NHS doesn't have a good track record of adopting innovations and delivering them at scale. This isn't new and reflects a growing recognition that the process of adoption (identify, deciding and implementing an innovation) is not straight forward – and that approaches based on central direction haven't worked[2].

Recognising this, Wessex AHSN is working on a best practice model that draws on the evidence of how innovations spread and how this could be applied in Wessex. This Insight project with Hampshire Hospitals NHS FT (HHFT) was an important part of this work.

The project had **two aims**:

a) To give HHFT the opportunity to review their current roles and processes in support of innovation with colleagues in the WAHSN to identify areas of best practice and improvement.

b) For WAHSN to increase its understanding of the identification, decision making and implementation roles and processes for innovation in HHFT - and for this to inform the methodology it is developing for spread and adoption in Wessex.

It focused on clinical technological innovations being adopted by the Trust's clinicians – not information or process innovations being implemented by through the digital exemplar programme or the Trust's quality improvement process.

2. Methodology

The project has explored three key stages in the adoption of an innovation in HHFT – how it is **identified**; how a **decision** is made as to whether to adopt it; and how it is **implemented.** These have been explored by:

[1] A summary of the NPIs can be found at https://wessexahsn.org.uk/programmes/10/nationally-prioritised-innovations. See for example the ITT/ ITP and AAC products.

[2] For example, 'Spread and adoption of innovation in the NHS', King's Fund, January 2018

- A series of semi-structured interviews to map and describe how the Trust expects innovations to be identified, decided and implemented – and understand people's views on how this is working.
- Using case studies to explore how this has happened in practice.

The project reported to the Chief Operating Officer, who identified the following people to **interview**:

- Chief Operating Officer
- Company Secretary and General Legal Counsel
- Director of R&D
- Gastroenterology lead
- Director of Surgical Services
- Operational Director of Surgical Services
- Director of Family and Clinical Support Services
- Urology lead
- Clinical Director for Critical Care and Anaesthetics
- Operational Manager, Surgery (on secondment to CCG)
- Chief Financial Officer
- Programme Manager, Without Walls
- Associate Director of Contracts

Through these interviews, the following **case studies** were identified to help illustrate and understand how innovation is adopted within the Trust in practice:

- Point of care testing for flu and respiratory syncytial virus (RSV)
- Accelerate Pheno TM Rapid Blood Culture Analyser
- Urological treatments for benign prostatic hyperplasia (HBP) – Urolift and REZUM
- Intrabeam
- Sysmex magnetic lymph node localisation
- WireSafe
- SpyGlass

3. Mapping and describing how innovations are adopted in HHFT

3.1 Identifying innovations

All of the people interviewed said that they would expect the majority of innovations to be identified bottom up by clinicians though their speciality and professional networks. This is in-line with the evidence base for diffusion – that most innovations spread through peer networks.

A number of people described issues with how this is working in practice. Relying on personal interest (in innovation) can mean that there are some parts of the Trust where a lot of innovations are identified and others where there aren't. Taking time to explore innovation opportunities isn't a formal part of people's role and some feel isn't recognised for its contribution to the organisation compared with other activities. In microbiology a clinical scientist has been deliberately developed to be outward looking, evaluating the costs and benefits of innovations with good effect (two of the case studies reviewed). The evidence base suggests that organisations that encourage and invest in people to be outward looking adopt more innovations.

No-one felt that there was currently a Trust level responsibility or process for identifying innovations. It wasn't clear how the nationally prioritised innovations communicated by the AHSN were being received, communicated and reviewed within the Trust – although some people had heard about them, most hadn't. Similarly, there isn't a way of taking an overview of where innovation is and isn't happening in the Trust and the potential to expand or accelerate it.

3.2 Deciding whether to adopt the innovation at HHFT

All of the people interviewed said that they would expect that the process of deciding whether to adopt an innovation would be led by Divisions. The governance processes in place to support this are:

- Standing financial instructions delegate investments decisions of up to £100,000 to Divisional level. The AHSN's experience of the nationally prioritised innovations are that the vast majority would be within this limit.
- There is a business case process setting out 3 levels of case depending on its size and complexity, supported by standard templates.
- Each Division has a formal monthly Governance Board meeting that brings all of their key people together to review performance and progress and make decisions. A Trust Accountability Framework sets out its responsibilities and accountabilities.

From the outside this looks clear. However, from the interviews, people weren't always clear about when the Division and when the Executive should make the decision. We have mapped the value of the innovations prioritised by NHS England for accelerated spread and the innovations identified through this review from within HHFT against the trusts standing financial instructions. In all cases, the innovations have 1 year costs that are less than £100,000 and all were within the authorisation limits of Divisions.

People weren't always sighted on the business case process and which level template they should complete – and from the case studies, a number of innovations have been implemented without a business case. There was confusion about whether and when to engage the CCG in the business case for an innovation. The CFO expressed a concern that the business case process was developed at a time when increasing activity would increase income and that would pay for the innovation – but that this is changing – and the Trust needs a greater emphasis on how innovations can support the local health system.

The role and recognition of the Divisions as being central to innovation is a strength for HHFT. The evidence base suggests that organisations that have effective devolved decision making adopt more innovations.

3.3 Implementing innovation

The Divisions have their own planning and development managers and they described these as being the people who work with the relevant specialities and clinicians to implement an innovation when a decision has been made to adopt it. The people interviewed didn't describe any particular issues with how this was working.

Some people felt that the Trust can find it hard to implement change – or that some change projects don't get completed but are over taken by another change. This isn't uncommon - change management is a key organisational competency and capacity that all Trusts have to continually work

at. People described a number of other teams within the Trust that work on implementing change, including the Transformation Team, Global Digital Exemplar and the Quality Improvement Academy.

The aim is to not just implement an innovation – but to deliver the benefits that led to it being adopted – and to sustain this over time. The evidence suggests that innovations are more likely to be sustained when they network with other sites that have also adopted it and when there is ongoing feedback of the benefit that the innovation is delivering.

People felt that the Trust could improve its review of innovations after they have been implemented to understand if they have delivered their benefits. The case studies identified that some innovations are implemented at one of the Trust's hospitals but not the other.

4. Recommendations

The following recommendations have been accepted by the Trust.

4.1 Redesign the **business case process for clinical innovation**. This should describe when a business case is required (expected to be when investment over the Division's current run rate; causes a change in Trust policy, and when the innovation has implications on other services and departments). The process should give sufficient detail to support a decision, balanced with the need to not create unnecessary delay. It is expected that the majority of clinical innovation business cases will be approved by Divisional Governance Boards.

4.2 The design of **a new process for monitoring the implementation of clinical innovations** and the benefits they deliver over time. This should include ensuring the benefits are available at both hospitals.

4.3 The design of a **process for receiving, reviewing and implementing Nationally Prioritised Innovations**. This could take the form of an annual or bi-annual session with the Executive Committee to receive NPIs and allocate them to Divisions for review. The assumption is that the Trust will benefit from adopting these innovations – and that if following review, the decision is to 'opt-out', the reasons why it is not right for HHFT will be set out.

4.4 The **Quality Improvement Strategy should have a focus of encouraging the identification** of innovation and supporting the people in the Trust with an interest and talent for innovation. This could include introducing an innovation fund for staff to bid against to pump prime or trial clinical innovations. It could also work with the Divisions to identify and develop the Trust's innovators.

4.5 Discussion with each CCG about developing a set of **joint innovations at system level**.

5. Next steps

The Trust has formed a task and finish group to implement these recommendations and the AHSN is part of this. This will include bi-annual presentations of the latest nationally prioritised innovations to the Trust's Senior Management Team.