



# 1. Introduction

**The NHS response to Covid-19 has seen an increase in innovation. In the year preceding Covid-19, Wessex AHSN worked with five of its member acute trusts to undertake ‘Innovation Adoption Reviews’. These aimed to help the trusts understand their current practice and experience of adopting innovation, what they do well and how they might improve. The key themes and findings from these reviews have been used to identify a set of positive influences on innovation in trusts – things that can help them identify and adopt more innovation, across more services and help deliver their priorities. These are described in section 5.**

Semi-structured interviews were held with a cross section of people in each Trust – covering the Executive and corporate team, divisional leadership teams and front-line innovative staff. Case studies of recent innovations were also developed. Across the five trusts, 100 people were interviewed, and 21 case studies developed.

**The reviews explored three key stages in the adoption of innovation in the trusts:**



The reviews took a wide view of what an innovation could be – including medtech, digital products, processes, pathways or new care models. The focus has been on the adoption of existing innovations from elsewhere rather than invention. The reviews included exploration of the adoption of the nationally prioritised innovations such as the NHS England Innovation Technology Payment (ITP) products.

We produced a report for each Trust setting out the key themes and findings and agreed a set of recommendations and next steps, including further support from the AHSN.

This short paper summarises the key themes from these five reviews, pulls these together into a set of positive influences that can increase innovation in Trusts and introduces our plans for this work to develop further in 2020.



## 2. Identifying innovations

Having set the scene, a typical opening interview question would be...

**“How do you know if there is an innovation being used in other hospitals that could be an improvement on how you are currently working?”**

### 2.1 Clinicians and professionals are the main source

Everyone we interviewed agreed that the trust’s clinicians and professionals are the main source of potential innovations and that they identify these through their networks, relationships and by keeping up to date.

This is in line with the evidence that innovations most readily spread and adopt through personal and professional networks and that the more outward looking an organisation and its staff are the more innovations they adopt.<sup>1</sup>

### 2.2 Innovation happens in pockets

All trusts have good examples of services that are innovative and forward thinking, and this is usually where they have members of staff who have a personal interest in innovation. They recognised that this reliance on personal interest means that innovation happens in pockets. In discussion, people recognised the need to open up more of the organisation to innovation, rather than rely on these pockets. One clinical leader described how some specialities are ‘often knocking on our door’ to try something new, whereas others they ‘never hear from’.

A lack of time or headspace to be outward looking was also a recurrent theme. People described operational pressures, covering vacancies and having to juggle or do this in their own time. The size of this time or pressure constraint can vary across services and departments within a trust, contributing to the variation in innovation. People described how some of their most under-pressure services are the ones that need to innovate most, but who don’t have the time, experience or relationships to make progress.

### 2.3 Variation between organisations

We also identified apparent differences between trusts in the degree to which they support and encourage their staff to be outward and forward looking. In some, the message is that operational and financial pressures mean that this has to be rationed. In others, it continues to be encouraged and valued. Clinical speciality away days were seen to be an important way for teams to spend time looking forward and identifying improvements and innovations. Similarly, annual operational planning can include identification and exploration of innovations that improve delivery of the trust’s targets.

We found that the trusts that were more outward and forward looking were able to identify more examples of innovations.

It often isn’t clear where responsibility for innovation sits within a trust and who holds the ring. The Medical Director tends to be the Executive lead for innovation. Some of the trusts have re-designated their R&D departments as R&I – though only one had worked this through in practice and had incorporated innovation into its work programme, governance and resources. One implication is variable knowledge, understanding and adoption of the nationally prioritised innovations across the trusts.

## 2.4 Integrated Care Systems

Some of the trusts reviewed are members of one of the early Integrated Care Systems (ICSs) and were able to demonstrate how the system can support innovation. The system horizon scans for solutions and this has led to the trial and adoption of a number of digital innovations, including video consultations and advice and guidance. There are a number of ICS speciality networks, where they have been able to trial innovations identified by the ICS and then quickly spread them to all of the trusts.

The team at the ICS described the importance of framing innovation around the needs of the local people and populations. The engine for innovation is bringing together the communities of innovators and staff in 'super networks' to respond to these needs. The solutions are all out there, the task is to find, trial and adapt these to local needs and circumstance in a coordinated way. There is work to develop an innovation 'ecosystem' that combines and enables capability in universities, data services and the research community.

## 2.5 Quality Improvement and Dragons' Dens

One of the trusts had a well-established Quality Improvement Programme that had been running for more than five years. The staff we interviewed were positive about the programme and its team.

Looking outside for solutions and visiting other hospitals is a key part of their approach and this trust was probably the most outward looking of those we reviewed. As a result, the identification of innovation appeared more widespread than in other trusts, rather than in pockets.

There was a lot of discussion about terminology during the reviews. The view that we have formed is that identifying 'innovation' fits within wider work and ambitions to 'improve' care and services. It is a means to this end.

A number of the trusts had used pump priming funds in the past to encourage staff to come forward with their ideas and innovations for improvement - often described as 'dragons' den' processes, with a requirement for something like a 3 to 1 return on investment. Staff valued the ability to engage with senior management to share and discuss their ideas and gain support for trialling them. There is a risk that this deepens the pockets of current innovation, but it could be designed in ways to encourage and target the areas that aren't innovating. Staff felt that to encourage widespread participation, there shouldn't be too much theatre around the 'interview'. They also felt that CIPs and savings shouldn't be the only benefit or value that the fund sets out to generate.

## 2.6 Developing a narrative

A common recommendation from these reviews was that the trust develop a narrative that supports and encourages staff to identify innovations that could improve how care and services are currently delivered. The narrative could describe the benefits that the trust needs innovations to deliver (such as financial savings, safety improvements, shorter lengths of stay, time savings for staff) and the things to avoid (such as high levels of capital or long lead in times for benefits). This could be brought to life with case studies.

There was a general concern that when staff have a good idea, they don't know where to take it. This raises the importance of the devolved structure of leadership and management in trusts, which is a key part of the next section on decision making.



## 3. Deciding whether to adopt?

For this section is helpful to summarise how most acute trusts organise themselves to make decisions:

### Box 1: The ‘classic’ approach to decision making in acute trusts

Most trusts have a devolved operational structure of clinical divisions (also known as Care Groups or Directorates) with a triumvirate leadership team (a Consultant, manager and nurse/ AHP) for a group of services and specialities that will have their own local professional leads. They hold the budget for these services, are responsible for their operational performance and plan for their future and will probably have a monthly divisional Board meeting. Standing Financial Instructions (SFIs) would typically give divisions devolved accountability for decisions that incur up between £50K and £100K revenue. They may or may not have a budget and be able to make decisions requiring capital expenditure over c.£5K.

Everything else requires the case to be made to an Executive committee for decision – usually made up of the Executive Directors and the divisional leaders. Trusts have business case guidelines and proformas to support decision making for developments that require investment. They will also have an annual business planning process to set the priorities for the coming year, including budgets and capital expenditure.

There are also a set of important clinical governance processes to provide assurance for new clinical procedures and equipment.

Having set the scene, a typical opening interview question would be...

“what happens when staff come back to the trust with an innovation?”.

### 3.1 Business cases

All of the trusts had a standard business case process that covered all decisions with a capital and revenue requirement. Some were tiered, with smaller sums requiring less detail. Some had a scoping stage, ahead of developing a detailed business case. This is the main decision-making process for innovations that require resource to implement.

We heard a lot of issues about the experience of producing business cases. There can be an expectation from staff that it is going to be too difficult and is best bypassed or avoided. In practice the process isn’t well understood or followed, and decisions are made in different ways. When followed, it can easily get stuck and take a very long time to see it through. The level of detail required can be onerous and disproportionate to the resource decision. Some templates still focus on identifying additional income through PbR, which is less relevant now.

That isn’t to say that using the trust’s standard business case process for innovation doesn’t work in some places. But mostly we heard about problems.

## 3.2 Trialling

Another common issue with business cases, is that they require the benefits of the innovation to be quantified and evidenced. The existing evidence base for an innovation may not be sufficient to support this and staff describe constraints with accessing information and data to help calculate benefits. In practice the benefits an innovation delivers will be very dependent on the local situation.

This points to the importance of supporting the trialling of innovations as part of the decision-making process. One of the trusts uses this to good effect. They have a concept stage to their business case process and a review group meet each month to consider and discuss these. One of the things they will consider will be ways that the idea can be trialled, using charitable funds for example.

## 3.3 Devolved decision making

There is evidence that organisations will more readily identify and adopt innovations if they are divided into semi-autonomous departments (divisions) and have effective decentralised decision making.<sup>1</sup> Divisional teams are closer to the front-line, are more accessible, and are more likely to know and understand the areas that need to be supported and encouraged to innovate.

All of the trusts have established devolved structures similar to that described in box 1. Although they have devolved decision making accountability, there is a trend for more of this to be centralised to the Executive Committee because of financial pressures.

There were differences in the focus of the divisions in the different trusts. Some were almost entirely focused on the in-year operational and financial agenda – and this was reflected in the agenda of their divisional meetings. Others had time think longer term, to include improvement and innovation at their divisional meetings and support away days.

## 3.4 Informatics and IT departments

There is an additional set of decisions that need to be made for innovations that require additions or changes to the trust's IT or informatics systems. Assurance is required that the innovation meets information governance and interoperability requirements. The trust will have an Informatics Strategy with a prioritised set of changes and there is limited resource to work on projects beyond these.

The Chief Information Officers interviewed as part of these reviews were concerned about how bottom-up ideas for innovation were best handled. Getting the balance right between proper assurance and prioritisation and not being seen as a block is important.

## 3.5 Virtuous circles

Many of the innovators we met had identified and introduced multiple innovations in the trust. There was a sense that once you've been successful with your first one, subsequent ones are easier because you understand the decision-making process and you have a reputation for this type of thing. We heard examples where this virtuous circle can extend to a whole department, developing a national reputation for innovation and attracting high calibre trainees and staff.

This gives a sense of the importance of the interaction between the person with the idea and the organisation. There was a concern that if they are put off, they may never try again.

One of the trusts has recognised that it has a number of digital innovators among its staff, working separately to develop new digital applications. They are planning to bring them together as a 'think tank' to work together to support the priorities in the trust's new Digital Transformation Strategy.

## 3.6 Recommending a streamlined process for innovation

A common recommendation was that trusts should replace the standard business case process with a purpose built 'Innovation Adoption Process'. This could build on the narrative recommended at 2.6 and describe where staff should go with their idea for an innovation and the people that can support them to work it up. Decision making could start with a short concept paper for early discussion within their division. Pump priming or charitable funds could be used to support trials to identify the potential long-term benefits for a business case.



## 4. Implementing and sustaining innovations

### 4.1 Local or trust-wide support for implementation

All of the trusts have one or more central teams with responsibility for implementing change - covering areas like Programme Management (PMO), Cost Improvement, Transformation, Digital Transformation and Quality Improvement.

However, most of the innovation examples and case studies from these reviews were smaller and more local than the things that these trust-wide teams were working on. In the main, people felt that the best way to implement them was locally within their devolved management structure. Many of the case studies described staff motivated to implement their idea with the support of their local managers. There can be issues with local capacity to support this alongside operational pressures - but in the main enthusiasm seemed to win through.

### 4.2 Quality Improvement capability

In 2.5 we described the relationship between a well-established QI programme in one of the trusts and their identification of innovations. Their programme includes a QI Academy that has now trained more than 500 staff in improvement and change management. The programme also uses the NHS Sustainability Model to help it sustain change and improvement.

### 4.3 Little review of benefits

People described a lot of organisational effort going into business cases and decision making, but not much into the subsequent review of whether the planned benefits were delivered or sustained. Lots of people felt that this was an omission and that it should be done, but that this was one of the things that had to be de-prioritised when there is so much to be done. There is evidence that understanding the impact an innovation makes is a key contributor to it being sustained by the team and the organisation.<sup>1</sup>

# 5. Positive influences on innovation in trusts

We have brought the key themes and findings from these five innovation adoption reviews together to identify a set of positive influences on innovation in trusts. We believe that these things can help trusts identify and adopt more innovation, across more of their services and help them deliver its priorities.

Stage	Positive influences on innovation in trusts
<b>Identifying innovations</b>	<ul style="list-style-type: none"><li>· The trust has a clear narrative supporting and encouraging staff to identify innovation. This describes how innovation can help the trust deliver its priorities and the benefits it values (e.g. freeing up staff time, reducing acuity of care)</li><li>· There are clinicians/ professionals who are outward looking and have the time to do this</li><li>· This is widespread – not only in pockets</li><li>· The value of looking outwards is recognised and encouraged in the Trust</li><li>· It is common for trusts to have a ‘pump priming’ fund to encourage staff to identify innovations</li><li>· The organisation is receptive to new ideas when people identify potential innovations</li><li>· At Trust level, there is a person or process for holding the ring and acting as a conduit to nationally prioritised innovations</li><li>· There are good networks (ICS/ STP, Wessex, national) that support people to explore innovations</li><li>· The system (ICS or STP) is actively horizon scanning and identifying innovations that meet population needs and integrate care</li></ul>
<b>Deciding whether to adopt</b>	<ul style="list-style-type: none"><li>· A clear devolved decision-making structure (e.g. divisional boards) that has innovation as part of its regular agenda</li><li>· Decision making structures and processes are understood and used consistently – not bypassed.</li><li>· An annual planning process that encourages teams to take time out together to look outward and further forward than the coming year</li><li>· Support for trialling innovations to help understand more fully the benefits they can deliver before requiring a quantified business case</li><li>· Clear and proportionate decision-making processes. Taking care that the business case requirements are not onerous or complex and supporting front line staff to navigate this. This may include a dedicated “innovation adoption process”, avoiding the need for generic business case templates.</li></ul>
<b>Implementing and sustaining innovations</b>	<ul style="list-style-type: none"><li>· There is capacity and capability to implement change at speciality and divisional level. An established Quality Improvement Programme that includes training in common improvement tools and techniques is an effective way of doing this</li><li>· A culture of completing change projects and giving them time to deliver results/ benefits</li><li>· A review process to understand whether the innovation was implemented as planned and delivered the intended benefits</li><li>· Teams implementing the innovation have information on the benefits they are delivering and know that there is wider interest in what they are achieving</li></ul>

## 6. Next steps

**The review findings and recommendations were well received by the five trusts and the AHSN has been active in supporting them with their next steps. One has set up a steering group dedicated to this and we are members of this. We've helped a trust to re-design and re-launch its innovation pump priming fund and another to develop a new innovation policy and pathway.**

Prior to the Covid-19 pandemic, our ambition was to continue to develop this workstream. Despite pausing this work through the first Covid-19 wave in England, this ambition remains. We have begun developing our methodology to both adapt it to accommodate Covid-19 but to also consider longitudinal data and quantitative data. To date, we have only completed reviews with acute hospitals but we have the ambition to work with local health systems, community trusts, mental health trusts, care homes, commissioners, and also national charities to complete similar work from different perspectives.

For the past six months the AHSN has been developing a new Rapid Insight offer, working alongside members to capture learning about the changes that they had put in place to support their response to Covid-19 and to help them understand which of these changes they would want to keep and develop in the longer term. Significant learning from our Rapid Insight approach will be relevant to this work in the future. The nature of this work supports the embedding of beneficial change derived from the Covid-19 response in a systematic and sustainable way.

As part of the dissemination of this report, we will arrange a number of workshops with the purpose of bringing together colleagues from different parts of the health system to begin and continue conversations about how all organisations can further develop their innovation and improvement cultures from the innovation adoption perspective.

