Lessons from the Vanguard: cultivating innovation and the role of evaluation

This short paper sets out learning from Dudley on the above topic. It describes the need for innovation backed by evaluation - and the ways in which Dudley has addressed this need by experimenting with new services while nurturing a culture to support this.

The paper was produced by Dudley Clinical Commissioning Group (CCG) and its partners the Strategy Unit. It draws on Dudley's experience as a 'Vanguard' site under the New Care Models programme. Readers wanting further information on this experience may therefore be interested in the microsite produced as part of Dudley's local evaluation.

Background to the topic

The problems facing health and care services are so well known as to be frequently documented in the media. Primarily these problems arise from a mismatch between need (growing in scale; increasing in complexity) and provision (highly and multiply constrained; not well configured). With no reason to assume a change in this mismatch, 'more of the same' is not a viable response.

Innovation must therefore be the backlight of any effective strategy. To get the best results from the resources available, services need to do things differently. This requires a constant, detailed focus on spotting problems, implementing responses and realising improvements. Services also need to do different things. This requires a broader view and a constant questioning as to whether the right investments are being made and the right types of services are being provided.

So innovation – in both product and process – is needed. Yet innovation doesn't just happen; it must be encouraged and nurtured. Very often this requires a change of culture and mindset.

Summary of Dudley's Vanguard programme

Against this background, Dudley's Vanguard programme set out to transform the local health and care system: to shift the locus of care away from hospital and into community and primary care settings. Fundamentally, the aim was – and still is - to simultaneously improve patient experience, population outcomes and resource use. To achieve this, Dudley's local system set out a need for better integration of:

- *The workforce* – to bring previously separate teams and professionals together to better coordinate care: especially for the most vulnerable in the population;
- *Patient goals and professional actions* – to support people (especially those with long-term conditions) to define outcomes that matter to them and to plan support accordingly;

The Strategy Unit.

NHS Dudley Clinical Commissioning Group

- *Contractual and financial incentives* – to align measures and payment mechanisms across the system to promote a focus on outcomes rather than activity; and,
- *Organisations* – to remove zero-sum thinking and any incentive to 'shunt' demand (patients) around the system rather than addressing it.

To bring about this integration, Dudley's programme had two main strands:

1. Set up new services, new ways of working – and a better system culture - to engender and exemplify the new care model; and

2. Use of a large-scale procurement exercise to commission and contract for the new model. The end point of this would be a new type of provider organisation (the 'Multispecialty Community Provider' (MCP), which would hold a new type of 'Integrated Care Provider' contract.

This paper focuses exclusively on the first of these strands; a companion paper on procurement examines the second.

Innovation and evaluation within the Dudley Vanguard

Being awarded Vanguard status brought additional resources to support transformation. In Dudley, to achieve the aims described above, a portion of this funding was invested in new services and the augmentation / alteration of exisiting ones. These innovations were established knowing that not all of them would succeed – and also that (of those that did) not all could be afforded as part of mainstream and ongoing investment by the CCG. Decisions would therefore be needed as to whether innovations should be: stopped, scaled or refined.

Therefore, as a vital input to these decisions, the CCG worked with the Strategy Unit and its partners (ICF and Health Services Management Centre at the University of Birmingham) to evaluate the changes made. The aim was to ensure that decisions on innovations would be evidence based.

A programme of evaluation was undertaken to provide this evidence. Reports were made public on a dedicated microsite. Evaluations undertaken included:

- A very rapid-cycle assessment of new schemes funded as part of the Vanguard programme. This looked across nine innovations and provided a common, assessment of their design,

implementation and effectiveness. Results were presented to Dudley's Partnership Board, which used this evidence to decide which schemes should continue and which should be stopped;

- An evaluation of the Multi-Disciplinary Teams in primary care. While not showing a reduction in emergency admissions, the evaluation found some reduction in length of stay – alongside benefits for the staff and patients. Recommendations focused on improving consistency;
- An early process evaluation of the Dudley Quality Outcomes for Health Framework (which replaced the national Quality Outcomes Framework (QOF) for primary care). This found some early gains in efficiency alongside scope for reducing variation. This was backed by a more experimental economic evaluation, which suggested that – implemented fully – approaches promoted by the Framework (e.g. better care planning) could have system-wide benefits;
- Focused evaluation of the use of the Patient Activation Measure (PAM) and health coaching. This found that personalised advice and guidance was essential to lifestyle changes; it also recommended ways in which this could be rolled out across Dudley;
- A related rapid evaluation of the use of other patient reported outcome measures. This highlighted the need for significant further efforts before this type of data becomes 'mainstream' – as is intended under the MCP's contract.

These service-specific evaluations were backed by broader 'system level' evaluation. This included:

- Two rounds of in-depth interviews with local strategic stakeholders. The first of which – the Early Findings report – set out views on the rationale for system change and early progress with implementing the new model of care. And the second of which provided an update on progress alongside an assessment of the procurement process referred to above; and
- Monitoring of selected system-wide performance measures.

Creating the right environment for innovation

In isolation, each of the above examples says something about the design, testing and evaluation of the specific innovations and changes concerned. Yet it is perhaps more instructive to take a step back and to consider the environment they sprang from - and to ask whether this provides any recommendations for the NHS more broadly.

Innovation thrives in a particular culture. Evaluation – and a plain, objective assessment of innovation – also requires a supportive environment. Both are encouraged by a specific mode of leadership. The changes outlined in this paper could not happen in a system that: saw no need to do things differently; had a leadership that punished failed experiments; or was defensive and protectionist.

In many ways, Dudley offers an illustration of the environment needed to foster innovation. Dudley's approach was confident, open and non-defensive; innovations were encouraged and supported; they were evaluated and results were shared and used; crucially, where things didn't work findings were not glossed.

> *"Programmes as high profile and 'political' as the NCM programme are not often characterised by a desire to create and share learning, by taking an open and plain view of progress, and by doing so as events unfold. Yet Dudley has commissioned a transparent assessment of its work; it has done so in support of the NCM programme's intention to test, experiment and learn; it has further done so in an environment where the easier (and more usual) option would be the production of 'good news' case studies."*
>
> Early Findings Report

This approach was supported by high levels of engagement across the local system to build shared understanding and relationships. This took place through mechanisms such as: the system-wide Partnership Board; staff engagement events; public meetings and forums; and development sessions (such as Dudley's Scenario Planning exercise).

So – at this broad level – what does Dudley's experience recommend for the NHS?

- It suggests that organisations and local systems should dedicate efforts to creating an expectation of innovation, backed by evaluation. Systems may also want to develop specific sources of expertise, such as intelligence functions dedicated to innovation, R&D and evaluation;
- This would require a proactive and deliberate culture of experimentation, learning and sharing. Failure to share and learn would seen as far worse than failure to achieve; and
- It follows that traditional, top-down modes of leadership and management would need to be inverted. Leaders would not prescribe specific innovations. They would concentrate on unblocking barriers to innovation and creating the conditions for experimentation and learning. Leaders would equip frontline teams with the ability, tools and space to innovate, evaluate and become self-improving.

Much of this is counter-cultural for the NHS and it is disheartening to reflect that Dudley's example is unusual. Public services are designed and built around accountability and use of the public pound; leaders and organisations often perceive the downside risks of innovation (being held to account for failure) as outweighing its potential gains; 'command and control' remains a more typical operating template than 'licence, support and learn'. Nonetheless, changes of the type described here are needed if the system is to successfully address the many challenges it faces.