INNOVATION

HOW THE NHS CAN LEARN MORE FROM AFRICA AND ASIA

BACKGROUND

Throughout 2019, THET worked in partnership with Imperial College London and with the support of the Bill & Melinda Gates Foundation and Health Education England (HEE), to examine the role Health Partnerships can play in increasing the flow of learning from low- and middle-income countries (LMICs) to the NHS, looking in particular at what is termed 'frugal' or 'reverse' innovation.[1] THET's energies are focused on examining Health Partnerships, the myriad twinning arrangements between UK health institutions and their counterparts in LMICs which the charity has done so much to support in partnership with the Department for International Development (DFID), the Department for Health and Social Care (DHSC), HEE and others.

THET acknowledges that Health Partnerships are just one, albeit significant, mechanism for transmitting such learning. Innovation formed the focus of three meetings in the course of 2019, the development of a Toolkit and the award of Fellowships, and it was a thematic priority for the 2019 THET Annual Conference. Further information can be found on our Health Innovation Platform.

THET's interest in reverse or frugal innovation flowed from the results of the 2017 independent evaluation of the DFID-funded Health Partnership Scheme (HPS), which found that 24 percent of health professionals involved had identified innovations.[2] Tantalizingly, the evaluation did not go on to systematically document how these innovations were being developed or what their value was to either to the individual or the UK healthcare system.

THET is strongly influenced by our long-standing partnerships with those who have led thinking in this space for many years, including our Patron, Lord Nigel Crisp, in his publication *Turning the World Upside Down*, Dr Shams Syed of the World Health Organization (WHO) with whom we work closely as an NGO in Official Relations, and Dr Matthew Harris of Imperial College who, in 2017, co-authored the article '*Do International Health Partnerships contribute to reverse innovation? A mixed methods study of THET-supported partnerships in the UK*'.

Coinciding with this November Roundtable, Dr Harris and Hamdi Issa published an article entitled '*Delivering cost effective healthcare through reverse innovation*'. This provides a number of well-evidenced examples of reverse innovations and a clear rationale for adopting them in the NHS, making reference to the work undertaken with THET.

THE DISCUSSION

On 19th November, THET convened the third and final meeting of its 2019 innovation work, a three hour discussion chaired by Lord Crisp, bringing together members of the Steering Group formed to oversee this work and experts from across HEE, the NHS, Whitehall, the media and academia.[3] Participants reviewed the outcomes of THET's 2019 innovation programme before turning to the specific topic of the session: *Innovation: How the NHS can learn more from Africa and Asia.*

Reflections on THET's Health Innovation Platform

Reflecting on the findings of the THET programme, it was agreed that the programme has furthered the growing body of evidence on the potential to learn from innovations emerging in LMICs. THET itself now has a database of 42 such examples. However, the volume and quality of these examples is less than had initially been hoped for, considering the number of innovations reported in the 2017 HPS Evaluation. We suspect this mismatch is related to differences in definitions of innovation and the challenges individuals have in writing-up their findings on top of busy day jobs and active volunteering commitments.

The award of Health Innovation Fellowships to encourage NHS staff involved in Health Partnerships to study and write-up findings of innovation has also seen limited results when taken in isolation due to the small amounts of funding and limited timeframes available. However, in the context of a more long term process of reverse innovation, these may see results down the line.

The Innovation Toolkit for Health Partnerships, written by Hamdi Issa with support from Graeme Chisholm, Policy and Learning Manager at THET, has been a great piece of thinking which has strengthened our understanding around unconscious bias. While dissemination has been extensive, we now face the challenge of integrating this toolkit into the work of volunteer-sending agencies across the NHS.

MOVING FORWARD

On uptake and dissemination across the NHS, the meeting focused on three streams of work which could help increase the flow of ideas: individuals, institutions and the wider environment.

The importance of individuals and Health Partnerships as transmitters of ideas

Our discussions acknowledged the importance of individuals as transmitters of innovative ideas. As Layla McCay (NHS Confederation) commented on a draft of this report: "*Learning from LMICs does not come into the UK via passive diffusion: active and purposeful engagement by multiple stakeholders is needed*."

Two groups were identified as being of particular interest:

1. Those travelling overseas as part of Health Partnerships or wider global health activities.
2. Members of the diaspora who are working in the NHS.

Those travelling overseas as part of Health Partnerships or wider global health activities

There are a range of points throughout the volunteering journey where individuals need to be supported to identify innovations. Because innovation is contextual, open to personal interpretation, and can take different forms (radical, incremental) it is important, as Fleur Kitsell (HEE) suggested, that we are clear on what is meant by innovation without reducing the space for individual enquiry.

The need to better understand how different cadres can be supported in the identification and communication of innovative ideas was raised by Lord Crisp who, noting the crucial role nurses play in health systems and acknowledging that their status could be a barrier to their innovations being validated by senior leaders in the workforce.

Similarly, it is important that we are clear on the purpose of Health Partnerships.

As Dr Harris commented, when these are defined around a specific objective, it is hard to accommodate for opportunities to learn. Thus, we must create a partnership model which sets about identifying innovation from the start. The Innovation Toolkit co-developed by THET and Imperial College begins to do this, but there is further work to be done. We need to see doing good development work and innovating as not mutually exclusive but as complementary.

Extensive consideration was given at the meeting to the importance of addressing unconscious bias. This was recognised as a major inhibitor to the flow of learning by UK personnel visiting LMICs and has been identified as an important component of the Toolkit.

Often innovations are not fully patented or licensed in the high-income country (HIC), thus creating a barrier in terms of convincing potential users of their value. It is crucial that champions of reverse innovations in HICs make a conscious effort to license their innovations correctly, exploring options such as social enterprise models to do so. There is a second ethical dimension to licensing and patenting, where innovators should make an effort to recognise and include LMIC partners and teams.

Members of the diaspora who are working in the NHS

Participants reflected on the very significant number of overseas nationals working in the NHS. To-date, efforts have primarily been focused on inducting such staff into the NHS 'ways of doing things'. However, our discussion led to the proposal that such staff could be a resource of ideas around how the NHS might innovate, drawing on their knowledge of other health systems. To-date there has been no systematic effort to document such workers' perceptions of the NHS. This thinking could extend to those on Medical Training Initiative or Earn, Learn and Return schemes which could be designed to more effectively harness such bidirectional learning.

The importance of system-wide thinking and action

Participants agreed on the need to capitalise on the systems that are in place to support individuals. Teaching on innovation is not enough, individuals must have the chance to operationalise learning and gain first-hand experience. Two examples provided were focused on:

1. HEE's Improving Global Health (IGH) Programme has been a source of learning around behaviour change for many years. As highlighted by Fleur Kitsell, we need volunteers who recognise change and innovation, but more importantly we need schemes which train people to implement change. It is also important that we understand the timescales associated with uptake and the length of this process.

2. Future Health Partnership schemes funded by DFID and/or DHSC which will allow for unprecedented levels of activity by NHS staff in LMICs.

The importance of shaping the wider environment and health system

Participants agreed that learning and the identification of innovations from LMICs cannot be left to individuals, vital as this is. Our concluding discussion was therefore on how we might set about shaping the environment in ways that encourage the uptake and dissemination of ideas. Participants agreed there were numerous opportunities in this regard:

- Dr Navina Evans (NHS East London Trust) highlighted the connections with the new Long-Term NHS Plan which is looking to boost recruitment but also change mindsets across cadres.

- The group broadly agreed on the importance of targeting senior management within organisations, who have the potential to become agents for change at an institutional level. It was felt that NHS Employers could take a more formal role here.

- Looking at reverse innovation in the wider context and not in isolation. Professor Ged Byrne (HEE) raised the question: is part of the solution to increasing adoption of frugal innovations addressing barriers to the adoption of innovation in general within the NHS? As suggested by Jonathan Brown and Rachel Parr, who pioneered the development of the PULSE Programme when working at GSK, perhaps ideas can be drawn from private sector practice on to how to better achieve this .

- Using networks. Do networks dedicated to promoting adoption provide a useful vehicle, or do they create an additional barrier in the process?

- Messaging around reverse innovation was also acknowledged as crucial. The NHS and clinicians themselves, it was argued by Dr Yaser Bhatti (QMUL), often respond better to innovations when framed around the added value they can bring to the NHS in terms of improved performance and practice.

- Engaging with the NHS Volunteering Network, chaired by HEE.

PROPOSED ACTIONS

The participants made a range of suggestions on how we might further the adoption of reverse innovations:

Volunteer Engagement

- **The use of the Innovation Toolkit for Health Partnerships** will support greater volunteer engagement with reverse innovations and support their identification. There is a need for clear dissemination routes in order to promote uptake within the NHS. Layla McCay of NHS Confederation is to work with THET on this route.

- **Clarity on how innovation features in the context of Health Partnerships.** In 2020, Imperial College London and THET aim to address this by mainstreaming identification and dissemination of innovations into the Health Partnership model.

- **Surveying members of the diaspora** working in the NHS to gain a better understanding of their possible inputs regarding innovation. This will form part of THET's partnership with HEE and the Bill & Melinda Gates Foundation in 2020.

Communications

- **Recognition**. Participating in a**wards or ranking systems** which help with publicity for the innovations. These could include media-publicised rankings or professional body sponsored rankings, such as that run by the Royal College of General Practitioners (RCGP). Following the model of the Darzi Fellowships within the NHS, THET, HEE and Imperial College could co-brand a set of awards to drive partnership-led research over time.

- **Collating information**. A depository or portal for reverse innovations was discussed as an option for gathering this data, although it was not deemed the most appropriate format.

- **Packaging the benefits of reverse innovations.** In order to make people more receptive to the benefits of reverse innovations, these should be framed in the context of benefits to NHS Trusts in terms of staff engagement and performance.

- **Dissemination and the power of personal testimony**. As suggested by Victoria MacDonald, it is important to use human stories, case studies and testimonies which show how individuals have identified innovations, not just for dissemination purposes, but also to gain a deeper understanding of what catalyses change in behaviour.

Strategic

- **Acknowledging differences in mindset**, **cultural dynamics and resource constraints in different geographical areas within the UK** and targeting those which are most likely to be receptive when looking for NHS engagement.

- **Use of Quality Improvement methodologies** can promote learning along the way, thus reducing the time lag between identification, development and adoption.

- The group concluded that there is a need for **further cross-sectoral collaboration** and connections between partners if we are to succeed in advancing the reverse innovation agenda further afield.

Enabling environment

- **Creating a constructive environment and supportive structures within institutions** will help overcome individual level barriers. This environment can encourage innovators who would initially be deterred from pursuing innovations due to the prospect of lengthy and complex processes.

APPENDIX: AGENDA

Timing	Session	Lead	Speakers
10:00 -10:05	Arrival and Coffee		
10:05- 10:10	Welcome & Introductions	Lord Crisp, APPG Global Health	- Lord Crisp - Dr Matthew Harris, Imperial College London - Ben Simms, THET
10:10 – 10:30	THET's Innovation Programme: summary of progress	Graeme Chisholm, THET	- Graeme Chisholm, THET (overview) - Richard Skone-James, THET (fellowships) - Charlotte Ashton, THET (case studies & video) - Hamdi Issa, Imperial College London (Innovation Toolkit)
10:30 – 11:00	How far has this programme demonstrated the case for such learning? Perspectives from across the UK.	Victoria Macdonald, Channel 4	Responses & Initial thoughts: - Fleur Kitsell, HEE - Dr Yaser Bhatti, QMUL Followed by discussion.
11:00- 11:15	Coffee Break		
11:15– 12:50	Conclusion: Building a roadmap for action for improving flow and uptake of ideas in 2020.	Professor Ged Byrne, HEE	Discussion
12:50– 13:00	Concluding remarks / next steps	Lord Crisp, APPG Global Health	

REFERENCES

1 The meeting acknowledged that the use of both terms - 'reverse' and 'frugal' - are contested terms. THET consciously chooses to use these terms precisely because they draw our attention to the power imbalances and assumptions that are made about innovations from LMICs being somehow of secondary status. This was the position proposed by Dr Matthew Harris at the meeting.

2 DFID. (2017). *Independent report: Evaluation of Health Partnership Scheme*. Available at: https://www.gov.uk/government/publications/evaluation-of-health-partnership-scheme.

3 Participants: Lord Nigel Crisp (Co-Chair, APPG Global Health), Professor Ged Byrne (Director Global Engagement Directorate, HEE), Victoria MacDonald (Health Correspondent, Channel 4), Dr Matthew Harris (Hon Consultant in Public Health Medicine Imperial College NHS Trust), Hamdi Issa (PhD, Imperial College London), Bruna Galobardes (Senior Portfolio Developer, Wellcome Trust), Fleur Kitsell (IGH Programme Lead and Chief Integration and Transformation Officer, HEE), Jonathan Brown (COO Global Engagement Directorate, HEE), Daphne Amevenu (Programme Manager, Health Foundation), Dr. Yaser Bhatti (Lecturer Innovation and Strategy, Queen Mary University of London), Dr Layla McCay (Director of International Relations, NHS Confederation), Professor Mike Holmes (Vice-Chair RCGP), Dr Pritesh Mistry (RCGP Head of Innovation), Rachel Parr (COO Health Faculties, Kings College London), Dr Navina Evans (CEO, NHS East London Trust).