Summary Rapid Insight Analysis — Innovation Ecosystem Programme

Virtual Kick-off meeting 11 December 2023

Innovation, Research, Life Sciences and Strategy (IRLSS), NHS England, along with Health Innovation Wessex, Health Innovation South West, and Health Innovation West of England.

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"Our vision is to improve how the public and private sector work in partnership with the UK Life Sciences sector in order to drive innovation adoption and spread. This will be delivered through developing a better understanding of how best to align and mobilise the NHS infrastructure at local, regional and national level to work with the Research and Life Sciences sectors and support the adoption of priority innovations. This will crystalise the role of the NHS within the ecosystem as an outstanding partner in research and innovation."

Innovation, Research, Life Sciences and Strategy (IRLSS)

Executive Summary

The aim of the Learning by Doing workstream is to generate insights from the health innovation ecosystem to improve research mobilisation and the adoption and spread of innovation. In December 2023, the Innovation, Research, Life Sciences, and Strategy (IRLSS) team from NHS England, along with Health Innovation Wessex, Health Innovation South West, and Health Innovation West of England, held a virtual kick-off meeting. This report summarises the findings from that meeting and outlines the next steps.

While the NHS has a long history of innovation that has transformed patients' lives and benefited the UK economy and society, there are challenges within the health innovation ecosystem. The kick-off meeting is part of a wider programme exploring how we can improve this for the future as part of the Innovation Ecosystem Programme.

Based on case studies shared with the national team, a set of nine hypotheses were proposed for exploration during the session. These initial nine hypotheses have now been refined and reordered based on immediate feedback from attendees at the session.

The methodology is based on the Health Innovation Wessex Rapid Insight approach (Chandler et al, 2023) and this report summarises the findings from the four stages of high-level descriptive statistics, resonance analysis, thematic mind-mapping, and assimilation and review to identify emergent further themes.

A total of 76 attendees from 32 organisations (12 health innovation networks and 22 non-HIN organisations, including 4 innovators) participated, and 356 responses were received for analysis. Most of the hypotheses resonated with participants, with a very low percentage (4%) strongly disagreeing[1] However, feedback commonly highlighted the need for simplifying the language used. After the event, the IRLSS team undertook further revision of the hypotheses taking on board this feedback, creating a second iteration.

Thematic analysis of the responses found there were consistently caveats or 'builds' to be made on the original statements presented including: working together on healthcare pathways **[Hypothesis 1]** is crucial to empower stakeholders, encourage collaboration,

[1] Based on the sub-thematic analysis – predominance of yes, with caveats

provide context and understanding in complex situations, and identify unintended consequences. This collaborative approach leads to increased awareness of the value and

impact of the innovation **[Hypothesis 2],** enabling it to be scaled up and sustained. The value and impact of the innovation are linked to how useful it is in addressing healthcare challenges, with a focus on working with patients and adapting it to local needs for better spread.

Attendees emphasised the importance of having the right level of evidence **[Hypothesis 7]** matched to the stage of adoption. Balancing the speed of innovation and managing risks effectively requires real-world evidence to provide insights on implementation, use, and assessment of innovation value. Making this evidence meaningful for stakeholders is important to ensure its effective utilisation in decision-making and driving positive outcomes.

There was agreement that clinical leadership **[Hypothesis 4],** within wider partnership and system working arrangements, holds significant importance in the local context. A broader group of change-makers who champion innovations **[Hypothesis 8],** supported by targeted training and increased capacity and capability, contributes to creating an enabling environment that fosters innovation and sustainability.

Although financial incentives play a critical role in aligning with longer-term sustainability goals, attendees mentioned that it was necessary to consider a broader range of benefits and involve the right stakeholders in decision-making processes **[Hypothesis 6]**. Coordinated incentives that support flexibility and longer-term funding alignment could enable transformative change at system level.

Accessible, timely, and high-quality data **[Hypothesis 5]** resonated as an essential component of the innovation ecosystem. Such data provides valuable insights and supports evidence-based decision-making, enabling efficient implementation and evaluation of innovations.

The innovation ecosystem pathway is complex, **[Hypothesis 9]** and adaptability to local circumstances, building strong relationships, and sharing learnings and best practice contribute to embedding innovations effectively **[Hypothesis 3]**.

In addition to the original nine hypotheses, several prerequisites for an innovation ecosystem were identified by attendees. These include listening to the voice of patients and the community, ensuring financial stability, having support from teams focused on transformation, incorporating high-priority themes such as health inequalities, sharing best practice with decision-makers, and aligning multiple strategies for scalability. This shift from a policy/management approach to making innovation part of business as usual is crucial for long-term success.

The kick-off event and analysis have generated depth of insight around the opportunities and challenges. These will be further explored in more detail in three Learning Collaborative sessions planned for January-February 2024.

Context

The Innovation, Research, Life Sciences and Strategy (IRLSS) team, NHS England, along with Health Innovation Wessex, Health Innovation South West and Health Innovation West of England held a virtual kick-off meeting on **Monday 11 December 2023** as part of Workstream 1 of the Innovation Ecosystem Programme, 'Learning by Doing'**.** This work will also contribute to Workstream 3, which is responsible for developing a blueprint for a conceptual operating model for the health innovation landscape, by supporting understanding of how the current ecosystem works (or not).

The aim of the Learning by Doing workstream is to generate insights from the health innovation ecosystem, including insights from the NHS, academia, industry, and patients/public. The kick-off meeting was the first step in this journey. This and subsequent sessions will foster collaboration and learning from pathway transformation initiatives across the innovation ecosystem pathway. This, in turn, will enable the refinement of Innovation Ecosystem blueprint and provide insight into how to improve research mobilisation and the adoption and spread of innovation.

Background

The NHS has a long history of innovation which has transformed both patients' lives and brought huge benefits to the UK economy and society. Innovation is now more important than ever but is not without its challenges within the wider health innovation ecosystem. There is a need for all partners in the life sciences ecosystem to align efforts more closely and to support this in ensuring innovations can go further, faster in the future. NHSE will work with the Innovation, Research and Life Sciences (IRLSS) team to engage national innovation partners, local systems, industry and research charities to develop a clear blueprint for how the NHS can best support, and benefit from, a strong life sciences ecosystem.

Roland Sinker, Chief Executive, Cambridge University Hospitals NHS Foundation Trust, Professor Gary Ford, Chief Executive Officer, Heath Innovation Oxford & Thames Valley, Dr Sam Roberts, Chief Executive, NICE are overseeing the Innovation Ecosystem development for Workstream 1.

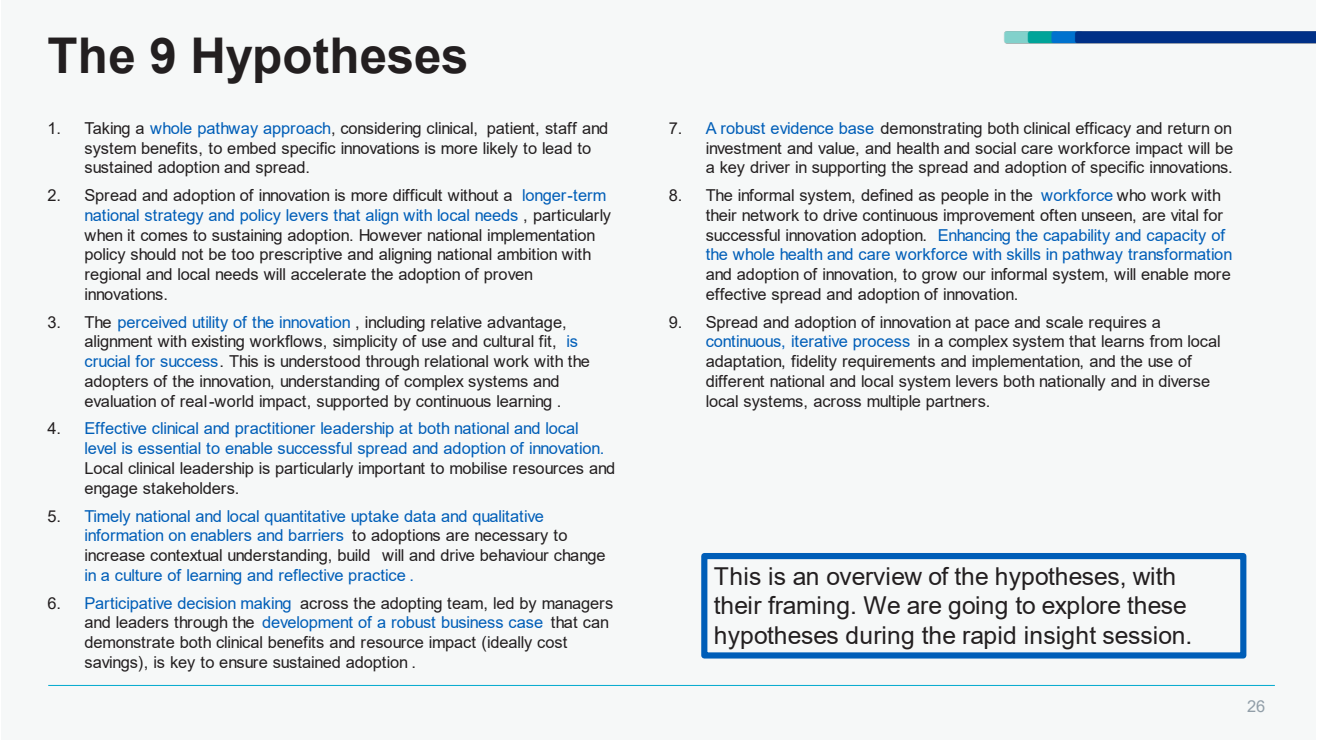
The goal of Workstream 1 is to generate insights from the health innovation ecosystem including NHS, academia, industry, and patients/public, to collaborate and learn from pathway transformation initiatives across the innovation pathway. The specific focus will be on addressing challenges related to Life Sciences Vision (LSV) mission areas, which include early detection of cancer, mental health, dementia, obesity, and cardiovascular disease (CVD).

The Programme of work has taken learning from previous work and valuable insights from past national innovation spread and adoption programmes to develop a suite of hypotheses that describe the conditions for success. Recognising the importance of system-led pathway transformation, IRLSS proposed partnering with selected localities on their ongoing

transformation initiatives to capture learning and identify areas for system improvement to test and refine these hypotheses.

Building on the 27 locality project submissions that systems submitted during September/October 2023[2], delegates had the opportunity to take part in a fast-paced intelligence gathering, rapid insight session to test and explore nine draft innovation and adoption hypotheses, iteration 1 (**Table 1**).

Table 1: 9 Innovation Ecosystem hypotheses [Iteration 1]



The 9 Hypotheses

1. Taking a whole pathway approach, considering clinical, patient, staff and system benefits, to embed specific innovations is more likely to lead to sustained adoption and spread.
2. Spread and adoption of innovation is more difficult without a longer-term national strategy and policy levers that align with local needs , particularly when it comes to sustaining adoption. However national implementation policy should not be too prescriptive and aligning national ambition with regional and local needs will accelerate the adoption of proven innovations.
3. The perceived utility of the innovation , including relative advantage, alignment with existing workflows, simplicity of use and cultural fit, is crucial for success. This is understood through relational work with the adopters of the innovation, understanding of complex systems and evaluation of real-world impact, supported by continuous learning .
4. Effective clinical and practitioner leadership at both national and local level is essential to enable successful spread and adoption of innovation. Local clinical leadership is particularly important to mobilise resources and engage stakeholders.
5. Timely national and local quantitative uptake data and qualitative information on enablers and barriers to adoptions are necessary to increase contextual understanding, build will and drive behaviour change in a culture of learning and reflective practice .
6. Participative decision making across the adopting team, led by managers and leaders through the development of a robust business case that can demonstrate both clinical benefits and resource impact (ideally cost savings), is key to ensure sustained adoption .
7. A robust evidence base demonstrating both clinical efficacy and return on investment and value, and health and social care workforce impact will be a key driver in supporting the spread and adoption of specific innovations.
8. The informal system, defined as people in the workforce who work with their network to drive continuous improvement often unseen, are vital for successful innovation adoption. Enhancing the capability and capacity of the whole health and care workforce with skills in pathway transformation and adoption of innovation, to grow our informal system, will enable more effective spread and adoption of innovation.
9. Spread and adoption of innovation at pace and scale requires a continuous, iterative process in a complex system that learns from local adaptation, fidelity requirements and implementation, and the use of different national and local system levers both nationally and in diverse local systems, across multiple partners.

This is an overview of the hypotheses, with their framing. We are going to explore these hypotheses during the rapid insight session.

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Methodology

A kick-off event, utilising the Health Innovation Wessex Rapid Insight methodology (Chandler et al, 2023), was delivered to gather feedback on the nine hypotheses **[Table 1].** A Microsoft Form was also developed to mirror the rapid insight event questions to enable colleagues to contribute to the discussion if they were unable to attend the session.

We took a four-stage approach to the analysis:

Stage 1: Data validation and alignment, including the production of high-level statistics.

[2] Further details of the spread and breadth of the locality submissions can be found as part of Innovation and Research Ecosystem Review – Kick off meeting 11 December 2023

Stage 2: Resonance analysis, including the identification of where there could be improvements made to the hypotheses.

Stage 3: Mind maps identifying practical insights related to each hypothesis – i.e. moving to considering what specific actions would need to be taken to bring each hypothesis to life.

Stage 4: Assimilation and review of findings and identification of emergent further themes.

A team of four analysts from across Health Innovation Wessex and Health Innovation West of England undertook thematic analysis to identify, by locality and health innovation network, which hypotheses resonated, and which did not.

Where hypotheses did not resonate, or there were recommendations for amending the wording of the hypotheses, this has been identified with direct verbatim feedback from respondents to aid wider reflection.

Before progressing to the mind mapping stage, an internal review of the hypotheses against the IRLSS Innovation Adoption Champion Programme themes of Theory, Data/Evaluation, Culture, Network and Leadership was undertaken. We identified a prominence of the themes towards theory, and less prominence on culture. This mapping will allow synergy with other IRLSS programmes of work.

Findings

Please note for the rapid insight event, the first iteration of the 9 hypotheses was used.

Post event, following reflection by the IRLSS team, the hypotheses were adapted and amended to created iteration 2 [Appendix A]. For the resonance and mind map analysis, we used iteration 1 of the hypotheses to retain fidelity.

For consistency and to demonstrate the journey the hypotheses have already undergone, we have retained the real-world feedback from the event against the first iteration of the analysis.

Common feedback themes to be considered across all hypotheses:

- Plain, simple language is needed.
- Remove ambiguity of terms, clarify terminology where appropriate.
- Consider the use of population/citizen/people terminology rather than patient to embrace the whole population.

Stage 1: High level summary statistics

		
76 attendees to event [1 MS form follow up] with excellent retention rate to the end of the session	46% locality attendees 12 health innovation networks represented 22 non-HIN organisations represented including 4 innovators	356 responses received for analysis* *17 responses excluded as they were not relevant to the innovation ecosystem hypotheses

Stage 2: Resonance analysis:

It is important to recognise that feedback regarding resonance and areas for consideration were weighted towards health innovation network colleagues.

Most of the innovation ecosystem hypotheses resonated with participants, with a low percentage fully disagreeing with the hypotheses; (4%) across all 9 hypotheses. Table 2 summarises resonance.[3]

It must be noted the analysis is based on the analyst's subjective perspective.

[3] The underlying data was re-reviewed and recategorized using the yes and yes with recommendations criteria, so have increased in resonance value following initial discussion and validation.

Table 2: Resonance values

Hypothesis	% stating yes/yes with recommendations	Number of responses
Hypothesis 1: Taking a whole **pathway** approach, considering clinical, patient, staff and system benefits, to embed specific innovations is more likely to lead to sustained adoption and spread.	93.33%	42/45
Hypothesis 2: Spread and adoption of innovation is more difficult without a clear, relevant national strategy and policy **levers that align** with local needs, particularly when it comes to implementation. However, national implementation policy should not be too prescriptive and aligning national ambition with regional and local needs will accelerate the adoption of proven innovations.	93.87%	46/49
Hypothesis 3: The perceived **utility** of the innovation, including relative advantage, alignment with existing workflows, simplicity of use and cultural fit, are crucial for success. This is understood through relational work with the adopters of the innovation, understanding of complex systems and evaluation of real-world impact, supported by continuous learning.	81.81%	27/33
Hypothesis 4: Effective clinical and practitioner **leadership** at both national and local level is essential to enable successful spread and adoption of innovation. Local clinical leadership is particularly important to mobilise resources and engage stakeholders.	97.22%	35/36
Hypothesis 5: Timely national and local quantitative uptake **data** and qualitative information on enablers and barriers to adoptions are necessary to increase contextual understanding, will build and drive behaviour change in a culture of learning and reflective practice.	97.22%	35/36
Hypothesis 6: Participative **decision making** across the adopting team, led by managers and leaders through the development of a robust business case that can demonstrate both clinical benefits and resource impact (ideally cost savings), is key to ensure sustained adoption.	69.9%	23/33
Hypothesis 7: A robust **evidence base** demonstrating both clinical efficacy and return on investment and value, and health and social care workforce impact will be a key driver in supporting the spread and adoption of specific innovations.	86.66%	26/30

Hypothesis	% stating yes/yes with recommendations	Number of responses
Hypothesis 8: The informal system, defined as people in the **workforce** who work with their network to drive continuous improvement often unseen, is vital for successful innovation adoption. Enhancing the capability and capacity of the whole health and care workforce with skills in pathway transformation and adoption of innovation, to grow our informal system, will enable more effective spread and adoption of innovation.	100%	29/29
Hypothesis 9: Spread and adoption of innovation at pace and scale requires a continuous, iterative **process** that learns from local adaptation, fidelity requirements, and implementation, and the use of different national and local system levers in diverse systems.	89.65%	26/29

The resonance analysis should be read in tandem to the feedback from participants section which offers additional insight into aspects to be further considered.

Stage 3: Mind maps

Positive resonance with examples

A series of mind maps have been produced to identify potential solutioning as part of the Innovation Ecosystem Blueprint journey. The mind map analysis can found in the accompanying analysis documentation.

Hypotheses	Mind map analysis
Hypothesis 1: Taking a whole **pathway** approach, considering clinical, patient, staff and system benefits, to embed specific innovations is more likely to lead to sustained adoption and spread.	Pathway mind map
Hypothesis 2: Spread and adoption of innovation is more difficult without a clear, relevant national strategy and policy **levers that align** with local needs, particularly when it comes to implementation. However, national implementation policy should not be too prescriptive and aligning national ambition with regional and local needs will accelerate the adoption of proven innovations.	Aligned levers mind map
Hypothesis 3: The perceived **utility** of the innovation, including relative advantage, alignment with existing workflows, simplicity of use and cultural fit, are crucial for success. This is understood through relational work with the adopters of the innovation, understanding of complex systems and evaluation of real-world impact, supported by continuous learning.	Utility mind map
Hypothesis 4: Effective clinical and practitioner **leadership** at both national and local level is essential to enable successful spread and adoption of innovation. Local clinical leadership is particularly important to mobilise resources and engage stakeholders.	Leadership mind map

Hypotheses	Mind map analysis
Hypothesis 5: Timely national and local quantitative uptake **data** and qualitative information on enablers and barriers to adoptions are necessary to increase contextual understanding, will build and drive behaviour change in a culture of learning and reflective practice.	Data mind map
Hypothesis 6: Participative **decision making** across the adopting team, led by managers and leaders through the development of a robust business case that can demonstrate both clinical benefits and resource impact (ideally cost savings), is key to ensure sustained adoption.	Decision making mind map
Hypothesis 7: A robust **evidence base** demonstrating both clinical efficacy and return on investment and value, and health and social care workforce impact will be a key driver in supporting the spread and adoption of specific innovations.	Evidence base mind map
Hypothesis 8: The informal system, defined as people in the **workforce** who work with their network to drive continuous improvement often unseen, is vital for successful innovation adoption. Enhancing the capability and capacity of the whole health and care workforce with skills in pathway transformation and adoption of innovation, to grow our informal system, will enable more effective spread and adoption of innovation.	Workforce mind map
Hypothesis 9: Spread and adoption of innovation at pace and scale requires a continuous, iterative **process** that learns from local adaptation, fidelity requirements, and implementation, and the use of different national and local system levers in diverse systems.	Process mind map

Listed below are some examples of responses from the hypothesis testing where respondents felt that they did not resonate fully or could be worded differently.

Hypothesis 1:

Taking a whole **pathway** approach, considering clinical, patient, staff and system benefits, to embed specific innovations is more likely to lead to sustained adoption and spread.

> *"I think this does resonate however a population rather than patient approach may lead to a better outcome for citizens."* [Innovator]

> *"It fits well for complexity of change across organisations, but favours taking a disease specific approach so might leave out truly transformational approaches which cut across (groups of) conditions / patients."* [Locality]

> "*It resonates fully but needs to be underpinned by a deep and data rich understanding of the existing pathway if one is to then look at optimizing and measuring the value of a given innovation. this can take a while to generate but will help you to look at how to support system readiness and acceptance of proposed innovations that can be embedded and adopted in complex systems of care." [Health innovation network]*

> "*Yes in terms of a system wide and all stakeholders approach, but no in terms of disease-specific pathway approach (e.g. people with multiple conditions or wider determinants of health issues) or silos of care as we then default into what we have always done, what is already there and often forget social care, voluntary sector and self-management."* [Locality]

Iteration 2 of hypothesis post event by IRLSS:

Hypothesis 1 - Pathway: Taking a whole pathway approach, considering clinical, patient, staff and system benefits, to embed specific innovations is more likely to lead to sustained adoption and spread.

Hypothesis 2:

Spread and adoption of innovation is more difficult without a clear, relevant national strategy and policy levers that align with local needs, particularly when it comes to implementation. However, national implementation policy should not be too prescriptive and aligning national ambition with regional and local needs will accelerate the adoption of proven innovations.

> *"Broadly agree (although I think we need to make this hypothesis a bit more concise/ clear!)."* [Locality]
>
> *"The phrase "policy levers" is too vague — better to talk about incentives, especially in primary care, local governance, and resource availability in providers."* [Locality]
>
> *"It resonates to a degree, but national policy needs to be balanced against the nuances of local populations and providers."* [Locality]
>
> *"I am not sure as feel statement is a little ambiguous. There are some national drivers that are very specific and this is really helpful / easy to adapt locally to enhance clinical practice. If all national policy had the same clarity this would make aligning and standardising policy across System's easier."* [Locality]
>
> *"It depends whether you mean a national strategy for a specific "innovation" or national strategy and policy levers that are conducive to innovation adoption more broadly. National policy levers can help give local places the flexibility, confidence and resource to adopt innovative practice. This is likely more effective than specific policy/ strategy for specific innovation over the longer term — supports developments of culture of innovation rather than mandated adoption. Sometimes misaligned policy that isn't keeping up to date with latest evidence and research can actively undermine the spread and adoption of innovation, so policy needs to keep pace."* [Health innovation network]
>
> *"More difficult but not impossible if you have the right people involved i.e., good clinical leadership, good relationships with industry and the system etc. Lack of funding has the potential to limit spread more so."* [Health innovation network]
>
> *"Funding and greater focus on national delivery and oversight when addressed to local needs. But for some innovations the level of demand is too low to register as a local need but when consider nationally the innovation will have significant impact — these will need national oversight and direction to drive adoption at local level."* [Health innovation network]
>
> *"National strategy and policy levers assist by providing enabling funding and greater focus on national delivery and oversight when addressed to local needs. But for some innovations the level of demand is too low to register as a local need but when consider*

nationally the innovation will have significant impact — these will need national oversight and direction to drive adoption at local level."
[Health innovation network]

"It partly resonates as policy drivers are one tool that supports spread and adoption, but they are one of many tools. The timing of the national strategy is also key here, as we have seen national strategies landed after local longer term strategies have been agreed and they don't always align and sometimes actively compete. Strategy that is centrally driven can miss the nuances within local contexts and does not always meet the needs (of usually rural and coastal) of all areas." [Health innovation network]

"The opportunity is to recognise that the ability to accelerate the impact and value of innovation when 'levers' at a national, regional and local level are aligned. But it's not just about policy at a national. level, it's also about aligning the role of different agencies in the research and innovation ecosystem (at national, regional and local level)." [Health innovation network]

"Strategy that is centrally driven can miss the nuances within local contexts and does not always meet the needs (of usually rural and coastal) of all areas." [Health innovation network]

Iteration 2 of hypothesis post event by IRLSS:

Hypothesis 7 - Incentives: Spread and adoption of innovation is more difficult without a longer-term national strategy, policy levers and funding mechanisms that align with local needs, particularly when it comes to sustaining adoption.

Hypothesis 3:

The perceived **utility** of the innovation, including relative advantage, alignment with existing workflows, simplicity of use and cultural fit, are crucial for success. This is understood through relational work with the adopters of the innovation, understanding of complex systems and evaluation of real-world impact, supported by continuous learning.

"Yes, but perception of utility will be hampered by cultural and urgent operational factors within the health and care sector. People often tire of the "new thing" before it is even in place because it requires change, time and effort and people are burnt out in this sector, particularly in the frontline workforce." [Locality]

"Agree — this hypothesis recognises the reality of complex systems rather than wishing it was different! However, it isn't either/or and needs to be technical and relational — to work with the governance, decision making processes within the system." [Locality]

"Agree to an extent in as much as it is critical that an innovation can be viewed easily through a range of lenses and that there will be a very strong focus on co-design in terms of how innovations are developed and then landed into system — if the innovation is too disruptive and requires non-existent resources then they become almost impossible to adopt. The need

to have a quality improvement mindset and highly collaborative design phases are critical." [Health innovation network]

"Partially resonates. This focuses on benefit to clinicians/ system but what about patient/ public this to me is missing in this hypothesis. Relational work is key but with all who will be impacted. Who is going to support the continuous learning given the strains in the system?" [Health innovation network]

"Broadly agree with this statement, although the importance of patient and public involvement and voice on utility of innovations could be brought out more strongly. Otherwise, we are at risk of not listening to those it will actually impact." [Health innovation network]

"Broadly, yes. Perception is reality. However, it needs to be acknowledged that minds can be changed (though first impressions can potentially hamper the chances of an innovation that has been around for a while and we tend to be in thrall to the new or "shiny"). Exploring utility within the system is a vital part of innovation but should be achieved as rapidly as possible so that we don't flog too many dead (digital) horses." [Health innovation network]

Iteration 2 of hypothesis post event by IRLSS:

Hypothesis 2 - Utility: The perceived utility of the innovation, including patient benefit, alignment with local needs and existing workflows, simplicity of use and cultural fit, are crucial for success. This is understood through work with the adopters of the innovation, understanding of complex systems and evaluation of real-world impact, supported by continuous learning.

Hypothesis 4:

Effective clinical and practitioner **leadership** at both national and local level is essential to enable successful spread and adoption of innovation. Local clinical leadership is particularly important to mobilise resources and engage stakeholders.

"Yes, but this is perhaps being diluted with current restructuring within the overall health system, and at ICS level due to the mandated reduction in running costs. No change in health will work without early buy-in from clinicians and practitioners, if they don't like something they simply wait it out until the next change in leadership, usually in the wake of a general election." [Locality]

"Clinical and Practitioner Leadership is key but this needs to be about System Leadership, as Leaders exist in all parts of the system and with influencers and stakeholders. If you do not bring the team with you then you will have issues." [Locality]

"Yes and No, clinical and practitioner leadership is crucial for successful spread and adoption but we also need to consider what other types of leadership we need to enable sustained adoption? What about innovation that cuts across different clinical areas where clinicians on one may not agree with colleagues on a different clinical area? What about taking into account colleagues from procurement?" [Health innovation network]

"Yes. First you need to establish the clinical need then identify a strong clinical champion to drive / promote the need for change with the rest of the system. Clinicians talking peer-to-peer

is incredibly powerful. But...need to understand the local system that the innovation is being adopted into — one size does not fit all." [Health innovation network]

"Yes. First you need to establish the clinical need then identify a strong clinical champion to drive / promote the need for change with the rest of the system. Clinicians talking peer-to-peer is incredibly powerful. But...need to understand the local system that the innovation is being adopted into — one size does not fit all." [Health innovation network]

"...The thing that is sometimes missed is connecting/ integrating local clinical leadership with wider system change that needs to occur to realise benefits from innovation at scale. For example, if this integration doesn't happen, you risk having passionate clinical leadership without the mechanism for embedding and sustaining and change in the long term." [Health innovation network]

Iteration 2 of hypothesis post event by IRLSS:

Hypothesis 4 - Leadership: Effective clinical and practitioner leadership at both national and local level is essential to enable successful spread and adoption of innovation. Local clinical leadership is particularly important to mobilise resources and engage stakeholders, with responsibility for innovation adoption within individual organisations.

Hypothesis 5:

Timely national and local quantitative uptake **data** and qualitative information on enablers and barriers to adoptions are necessary to increase contextual understanding, will build and drive behaviour change in a culture of learning and reflective practice.

"Reliable, relevant and timely data is always welcome - but is often hard to find and gather. This can "build will and drive behaviour change" but there are many other factors at play; particularly when engaging with clinicians. Clinicians have strong views as to what works (or won't work) for "their patients" and behaviour change really involves hearts and minds. Facts alone will not win anyone over (other than academics). We ignore "the emotional" or "the gut" at our peril. Clinical champions who can tell a persuasive story with facts and figures and quotes will be pivotal in some sections of the health service. Reflective practice is vital in all aspects - but how do we achieve this meaningfully "on the ground." [Health innovation network]

Iteration 2 of hypothesis post event by IRLSS:

Hypothesis 9 - Using Data: Timely national and local quantitative uptake data and qualitative information on enablers and barriers to adoptions are necessary to increase contextual understanding, build will, and drive behaviour change in a culture of learning and reflective practice.

Hypothesis 6:

Participative decision making across the adopting team, led by managers and leaders through the development of a robust business case that can demonstrate both clinical benefits and resource impact (ideally cost savings), is key to ensure sustained adoption.

> *"A business case is important for initial adoption, but it's not the key for sustained adoption (it's the starting point, but culture, workforce, real world evidence of impact, buy in — is what will sustain it). In reality, it's not the case that every stage of the adoption journey is participative in examples of successful spread — this is a gold standard we think is best, but I don't think the evidence suggests it's necessarily required."* [Health innovation network]

> *"I think this is conflating two separate things. Clearly the adopting team needs to make a decision as a team on whether/how to do it. But the business case may equally have been prepared by the innovators or early adopters, and the local team will be adapting it to local circumstances."* [Health innovation network]

> *"In an ideal world, maybe but this overly simplifies adoption which is messy and iterative and may require many decisions by different people in a very wide 'adoption' team. Sustained adoption isn't necessarily delivered by a business case but by local buy in and observed benefits."* [Health innovation network]

Iteration 2 of hypothesis post event by IRLSS:

> **Hypothesis 6 - Making the Case:** Participative decision making across the adopting team, led by managers and leaders through the development of a robust business case that can demonstrate both clinical benefits and the positive impact on NHS productivity, is key to ensure sustained adoption.

Hypothesis 7:

A robust **evidence base** demonstrating both clinical efficacy and return on investment and value, and health and social care workforce impact will be a key driver in supporting the spread and adoption of specific innovations.

> *"Local systems will sometimes accept less than robust if the innovation is above the line (i.e. Medtech classified but light on evidence) if the innovation is unique and has some early signs of benefits. They would expect to and be willing to work on creating evidence base."* [Locality]

> *"[There is] a difference here between evidence required to test locally, and evidence required to have the confidence to scale nationally. But even at local level there is a minimum evidence threshold that has to be met."* [Health innovation network]

> *"There's a tension between really innovative innovation and evidenced innovation. The former may offer huge potential but the latter offers certainty?"* [Health innovation network]

"Return on Investment (ROI) is difficult with the ROI sometimes being very long term whereas NHS planning cycles are very short term, we need to consider pragmatism." [Innovator]

Iteration 2 of hypothesis post event by IRLSS:

> **Hypothesis 3 - Evidence:** A robust evidence base demonstrating both clinical efficacy and return on investment and value, and health and social care workforce impact will be a key driver in supporting the spread and adoption of specific innovations.

Hypothesis 8:

The informal system, defined as people in the **workforce** who work with their network to drive continuous improvement often unseen, is vital for successful innovation adoption. Enhancing the capability and capacity of the whole health and care workforce with skills in pathway transformation and adoption of innovation, to grow our informal system, will enable more effective spread and adoption of innovation.

"The vast majority of frontline staff don't have the time, space or headspace to be thinking about 'innovation' — it needs to be built in as part of their personal development and job plans. Lots of examples of innovation being tagged on to their day job at personal cost to them." [Health innovation network]

"It is important for people that are able to influence innovation have an understanding of how to build an idea into a transformation and be supported to do so. Anyone can have the idea but a team of other people with specific skills can support that develop. It's important that the people with the idea know that they have potential to grow and that is about culture as well." [Locality]

"It is broader than health and care workforce — and transformation of pathways, voluntary, community and social enterprises (VCSE) as an example and people's journey and engagement does not often follow linear pathways." [Locality]

"I don't think enhancing the capability of the WHOLE workforce is necessary. That feels cumbersome and unrealistic to achieve (especially given levels of staff turnover). However, I believe that is absolutely vital that we identify and/or install champions within teams who are naturally "early adopters" and who have the aptitude and attributes to ably motivate, problem-solve, and support colleagues as they get to drip with new ways of working." [Health innovation network]

Iteration 2 of hypothesis post event by IRLSS:

> **Hypothesis 5 - Change Makers:** The informal system, defined as people in the workforce who work with their network to drive continuous improvement often unseen, are vital for successful innovation adoption. Enhancing the capability and capacity of the whole health and care workforce with skills in pathway transformation and adoption of innovation, to grow our informal system, will enable more effective spread and adoption of innovation.

Hypothesis 9:

Spread and adoption of innovation at pace and scale requires a continuous, iterative process that learns from local adaptation, fidelity requirements, and implementation, and the use of different national and local system levers in diverse systems.

> *"There needs to be clear decision gateways along the way to hold pace and accountability for delivery — and deployment should not happen until the system have secured agreement. It's the solutioning and preparatory work that takes the most time, then implementation should be relatively straightforward."* [Health innovation network]

> *"Probably. I worry that this does not always happen as heads are invariably turned by "the next big thing". The constant round of short pilot projects speaks to this concern. We tend to run things once or twice and then look at something else. This mindset and approach will be hard to break given the short rounds of funding. A mature system that acknowledges (and accepts) that innovation is an iterative process would be a step in the right direction (tightly managed, to avoid "drift" or mission creep). But this feels like a dream and something we are unlikely to witness any time soon given the current climate (politically and economically)."* [Health innovation network]

> *"Spread and adoption needs a national to local approach, not a local to national. National problems, adapted to local needs with a collaborative mindset across partners."* [Health innovation network]

Iteration 2 of hypothesis post event by IRLSS:

> **Hypothesis 8: Complexity:** Spread and adoption of innovation at pace and scale requires a continuous, iterative process in a complex system that learns from local context, adaptation, fidelity requirements and implementation, and the use of different national and local levers, across strong partner coalitions.

Stage 4: Assimilation

As part of our final stage of analysis, the analyst team reviewed common themes across all hypotheses and linked them into the supplementary question to explore any missing hypotheses.

Because of this further analysis, it is recommended that the following thematic areas are considered as part of the Blueprint development and mirror some of the pre-requisites identified the missing hypotheses:

1. **The Patient Voice — Engaging Patients in innovation programmes**

   "Stakeholders across the system including lived experience members, with encouragement at a national level are key to spread /adoption. The systems are certainly difficult to navigate if the innovation is effective across many pathways and organisations." [Locality]

2. **Financial stability — Finance, commissioning and evidencing cost savings**

   "Challenge is around cost savings. We know we are working with decreases resources so a best utilisation of these is needed. I would like us to shift the paradigm of cost reduction to better utilisation of cost and improve pathway efficiencies, where cost is not necessarily decreased but we achieve better outcomes for the same cost." [Health innovation network]

3. **Cross sector partnership working**

   "We need real partnership and joint agency approach including industry … we make it hard for innovators to navigate." [Locality]

4. **Exploring real world issues and solutions**

   "...I want to hear the dirty nitty gritty of what didn't work and how things got resolved (e.g. who in the exec team had to champion, who were the detractors and how did you bring them onside, how did you get through finance, how did you sustainably fund, how did you get the required data to prove your business case, how did you procure, how did you market the innovation, how did you create a culture of change, etc.) NHS isn't a learning organisation, and we are often at fault when things take longer." [Locality]

   "How do you know what the enablers and barriers are until you engage with the system? They can change from month to month (even day to day!), so not sure what is meant by timely. What is more important is having the relationship with the system in which you are working so you are better placed to support behavioural change and new learning." [Health innovation network]

   "Teams need support to be empowered and not feel overwhelmed to make the changes." [Locality]

5. **System level approach is key alongside supporting systems to be adoption ready**

   "ICBs have the mandate ...." [Health innovation network]

"Innovations are often incremental and additive — a whole system approach enable all challenges and enablers to be identified and worked on at a system level that allow rapid, agile adoption." [Health innovation network]

"We can't afford to underestimate how important it is to have organisations/systems that have 'adoption ready' staff who have the skills, capability and indeed capacity to implement innovations effectively. Leadership is fundamentally important but need to expand beyond leadership — it is vital to have improvement and implementation capability throughout an organisation/system, to ensure there is a receptive and skilled workforce to safely test and implement innovation in their real-world settings." [Health innovation network]

"Experience has shown that the best innovations will not achieve full potential or spread where whole system thinking around implementation isn't applied." [Health innovation network]

Conclusion

The kick-off meeting and analysis yielded impressive depth and detail of the opportunities and challenges to be considered as part of the Innovation Ecosystem Programme. This will form a firm foundation for the Learning Collaborative sessions planned during January — February 2024 and has provided emergent signals for further blueprint development.

The summary analysis provides validation that the hypotheses resonate with colleagues working within an innovation ecosystem so will provide a robust framework to develop the blueprint.

This correlation, in turn, provides a firm foundation for the planned learning collaboratives, which will delve deeper into the challenges of realising these hypotheses and how localities have overcome them, which will provide solutioning approaches to the development of the blueprint.

However, it is important to recognise that, despite locality colleagues engaging in the session, the qualitative feedback received regarding areas for consideration is weighted towards health innovation network colleagues.

Learning Collaborative sessions are taking place during January and February 2024 to take a deeper dive into each hypothesis. Each session will explore 3 hypotheses, hearing from localities to showcase how some of the innovation ecosystem challenges can be overcome.

In preparation for the series of learning collaboratives and building on our learning from the kick of meeting, we will seek support from our health innovation network partners to facilitate deeper engagement with localities to optimise and magnify their insights. We are proactively ensuring the sessions are accessible for all. The development of an inclusive learning community that begins to solve problems and challenges for the Innovation Ecosystem Programme to actively contribute and influence national policy is one of our key aims.

Directly after the event, the IRLSS team reconvened to review the showcased hypotheses following the live and active feedback from the delegate. The hypotheses were reordered

and iterated and simplified, which highlights the immediate value of this inclusive, rapid insight approach in amplifying diverse voices from the innovation ecosystem.

Appendix A: 9 Hypotheses — Iteration 2 [12 December 2023]

1. **Pathway:** Taking a whole pathway approach, considering clinical, patient, staff and system benefits, to embed specific innovations is more likely to lead to sustained adoption and spread.
2. **Utility:** The perceived utility of the innovation, including patient benefit, alignment with local needs and existing workflows, simplicity of use and cultural fit, are crucial for success. This is understood through relational work with the adopters of the innovation, understanding of complex systems and evaluation of real-world impact, supported by continuous learning.
3. **Evidence:** A robust evidence base demonstrating both clinical efficacy and return on investment and value, and health and social care workforce impact will be a key driver in supporting the spread and adoption of specific innovations.
4. **Leadership:** Effective clinical and practitioner leadership at both national and local level is essential to enable successful spread and adoption of innovation. Local clinical leadership is particularly important to mobilise resources and engage stakeholders, with responsibility for innovation adoption within individual organisations.
5. **Change Makers:** The informal system, defined as people in the workforce who work with their network to drive continuous improvement often unseen, are vital for successful innovation adoption. Enhancing the capability and capacity of the whole health and care workforce with skills in pathway transformation and adoption of innovation, to grow our informal system, will enable more effective spread and adoption of innovation.
6. **Making the Case:** Participative decision making across the adopting team, led by managers and leaders with involvement of patient groups through the development of a robust business case that can demonstrate both clinical benefits and the positive impact on NHS productivity, is key to ensure sustained adoption.
7. **Incentives:** Spread and adoption of innovation is more difficult without a longer-term national strategy, policy levers and funding mechanisms that align with local needs, particularly when it comes to sustaining adoption. However national implementation policy should not be too prescriptive and aligning national ambition with regional and local needs will accelerate the adoption of proven innovations.
8. **Complexity:** Spread and adoption of innovation at pace and scale requires a continuous, iterative process in a complex system that learns from local context, adaptation and implementation, and the use of different national and local levers, across strong partner coalitions.
9. **Using Data:** Timely national and local quantitative uptake data and qualitative information on enablers and barriers to adoptions are necessary to increase contextual understanding, build will, and drive behaviour change in a culture of learning and reflective practice.