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and Improvement

Making a bigger difference

A guide for NHS front-line staff and leaders on assessing and stimulating service innovation

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Contents

Summary 2

Introduction 5
- About this guide
- Why be concerned with innovation?
- What does service innovation have to do with me?
- Are we up for the challenge?

Getting started 9
- Defining service innovation and related terms
- Overview of a 5-step approach to assessing and stimulating service innovation

Step 1: How big a difference does it make? Assessing the impact on performance indicators 13
- Synopsis
- Examples and frequently asked questions
- Practical applications for front-line staff and organisation leaders

Step 2: With what are you comparing the idea? Defining the context 23
- Synopsis
- Examples and frequently asked questions
- Practical applications for front-line staff and organisation leaders

Step 3: How big a change is it really? Constructing a 4Ws table 29
- Synopsis
- Examples and frequently asked questions
- Practical applications for front-line staff and organisation leaders

Step 4: What might make an even bigger difference? Stimulating further service innovation 37
- Synopsis
- Examples and frequently asked questions
- Practical applications for front-line staff and organisation leaders

Step 5: Overall, how would you characterise the idea? Summarising your thinking 43
- Synopsis
- Examples and frequently asked questions
- Practical applications for front-line staff and organisation leaders

Conclusion 49
- Are you making a bigger difference?

Appendices 51
- Further examples and commentary
- Description of tools
- Glossary of terms

Making a bigger difference

A guide for NHS front-line staff and leaders on assessing and stimulating service innovation

If we continue to do what we've always done, we will get the results we have always got. But when it comes to the ways that health services are delivered, members of the public, patients, professionals, and policy makers are increasingly asking for ***different*** results. In the efforts to meet those demands we want to raise attention to service delivery innovation to equal that given to innovations in treatment approaches, medications, surgical procedures, diagnostic equipment, and information technology.

We define service innovation as:

A step change in the Who, What, When, or Where (4Ws) of service delivery – relative to the usual approach in a comparison context – that produces a step change in performance when implemented.

In this publication, we seek to stimulate thinking and assess the extent to which a given change idea is a service innovation, using methods and tools that support a 5-step process for ***making a bigger difference.***

Summary

Step 1: How big a difference does it make? Assessing the impact on performance indicators. A natural place to start in assessing an idea is to look at its actual or potential impact. The ***Seven dimensions of performance*** tool presents a useful framework for thinking about measuring the impact of a service innovation idea. The output of this step is a set of before and after measurements, along with a judgment about whether these results represent a step change in performance.

Step 2: With what are you comparing the idea? Defining the context. Next, we need to determine if the details of the idea itself represent a step change in the way care is delivered compared with what is usual. This requires that we select a comparison context – the health care setting or system against which one wishes to consider the innovativeness of a new idea. The *Innovation claim framework* presents a range of choices for this selection. The output of this step is a clear description of the main context for comparison, as well as a secondary context that we can use to further challenge our thinking.

Step 3: How big a process change is it really? Constructing a 4Ws table. The *4Ws table* provides a format for a side-by-side comparison of a new idea to the typical approach regarding who is primarily involved in delivering the care, where and when it is delivered, and what the patients and carers experience while receiving the care. Properly constructed, the ***4Ws table*** is a simple, clear, powerful tool for assessing whether a given change idea is an incremental or step change in the way things are done.

Step 4: What might make an even bigger difference? Stimulating further service innovation. One of the main reasons for assessing an idea is to stretch our thinking toward even higher levels of innovation – making a bigger difference. Reviewing the 4Ws table, we ask such questions as: What did we really change in the system of care? What did we leave unchanged? What additional new possibilities and opportunities have we now created? What might be the next big idea that stretches beyond this? Imagine the power of a system where every change in health service delivery naturally leads to thinking about the next innovation! The output of this step is a list of more ideas that might make an even bigger difference for patients and carers that we can consider for future testing.

Step 5: Overall, how would you characterise the idea? Summarising your thinking. After the thorough analysis of the preceding steps we come to the ultimate question – Is this idea a service innovation in the sense of being a step change in both performance and process? The final output of this step is a short, descriptive summary of your assessment of the innovativeness of your idea relative to typical practice in the comparison context.

With each step we provide detailed instructions, examples, and practical advice on application geared to front-line staff and organisational leaders. An appendix provides five additional case examples, summaries of tools, and a glossary of terms.

While incremental change remains highly desirable, at perhaps no other time in its history has the NHS needed service delivery innovation – step changes in what we do and how we perform – more than now. This guide, along with companion publications from the ***NHS Institute for Innovation and Improvement***, is designed to stretch your thinking and get you started in your new role as NHS innovators.

Introduction

"Health care systems around the world are engaged in striving to make radical and sustainable changes through various programmatic approaches to improvement... The words… leave no doubt that what is being envisaged is big, bold, transformational change… Internationally, there is a parallel realization and understanding that the design of the existing health care system will not deliver what is required for the future."

Bate, P., Robert, G. & Bevan, H. (2004). The next phase of health care improvement: what can we learn from social movements? Quality and Safety in Health Care, 13 (1), 62-66.

About this guide

Innovation is a word that is often used.

Some say that the NHS needs to be more innovative in order to meet the challenges it faces. You and your colleagues may have some ideas that you think are quite innovative. Senior leaders may wonder whether all the changes in their organisations are just more of the same, or are really deeply challenging current ways of thinking.

This leads to several questions…

- **Does the NHS really need to be more innovative when it comes to the way services are delivered?**
- **What exactly do we mean by 'service innovation' ?**
- **How can I assess whether a given idea is innovative or not?**
- **How can we stimulate more innovation to get even better results in service delivery?**

These are the questions we will answer in this publication.

We assume that…

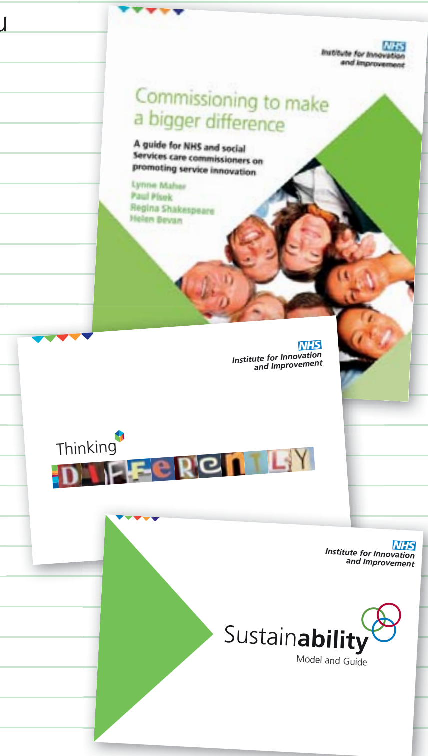
You are a front-line member of staff or a senior leader in an NHS service provider organisation.

*Another **Making a Bigger Difference** publication has been developed for commissioners. For more information go to: www.institute.nhs.uk/commissioners-bigger-difference*

You and your colleagues already have some ideas (which you may or may not have implemented) but you would like to know whether they really are innovative, or you would like to be challenged to stretch your thinking even further.

*If you are looking to generate innovative ideas, the **NHS Institute for Innovation and Improvement's** publication **Thinking Differently** can help you get started. www.institute.nhs.uk/thinkingdifferently*

As soon as you start to make changes you need to think about sustaining them. The NHS Sustainability Model and Guide will help: www.institute.nhs.uk/sustainability



Finally, while we will touch on the issue of organisational cultures that support innovation, that is not our focus here. You can learn more about this topic in a forthcoming publication from the NHS Institute for Innovation and Improvement ***Creating the Conditions for a Difference***.

For more information go to: www.institute.nhs.uk/creating-the-conditions

Why be concerned with innovation?

There is an old saying: If we continue to do what we've always done, we will get the results we have always got.

But when it comes to the ways that health services are delivered, members of the public, patients, professionals, and policy makers are increasingly asking for different results…improved access… less waiting… faster diagnosis and paths to treatment… more convenience… less anxiety… even better outcomes… more involvement in care… greater sensitivity to cultural differences…

"Without innovation, public services costs tend to rise faster than the rest of the economy. Without innovation, the inevitable pressure to contain costs can only be met by forcing already stretched staff to work harder."

Mulgan G. and Albury D. (2003), Innovation in the public sector, Strategy Unit, London

While continuous improvement has always been our ethos, many NHS organisations are coming to the realisation that incremental improvement alone – doing the same things, but a bit better – may not fully deliver against such rapidly rising expectations.

That is where innovation comes in. Innovation is about doing things differently, and doing different things, to create a step change in performance.

What does service innovation have to do with me?

Clinical researchers, pharmaceutical companies, device manufacturers, and IT firms (to list a few) have active processes for innovation that produce wonderful technologies for transforming care. But at times we do not achieve the maximum potential of these innovations because we embed them in existing service delivery processes that do not always provide **timely, patient-centred, safe, effective, efficient, co-ordinated, and equitable** health care services.

Front-line staff and leaders in NHS provider organisations are the only ones who can change all that.

The goal must be to raise the attention of service delivery innovation to equal that given to innovations in treatment approaches, medications, surgical procedures, diagnostic equipment, and information technology.

Are we up for the challenge?

Fortunately, we have a great asset in our pursuit of innovation in service delivery – the creative minds and passion of the people of the NHS.

Dispelling the myth that most innovations come from very senior leaders or policy makers – a study of public sector organisations in Commonwealth countries estimated that 82% of public sector innovations come from organisational staff*.

We have risen to the challenge of innovation in the past, and we absolutely **can** do it again.

Throughout the history of the NHS, clinicians, other staff and leaders have found new and better ways to make care available to the public. One-stop services, GPs with special interests, more care delivery in the community, and the use of telemedicine and the Internet are just a few of the more recent innovations.

In addition to these large-scale service delivery innovations, there are countless other local, small-scale examples of how NHS staff and leaders ***have done things differently and done different things*** in order to make a real and substantial difference in care and support for patients. We will look at several such examples in this publication.

We are concerned about innovation in health services delivery because the public increasingly expect it, we are more than capable of doing it, and it is the right thing to do.

** Freeman T, Dickinson H, & McIver S. (2006) Innovation in service delivery. Health Services Management Centre, School of Public Policy, University of Birmingham*

Getting started

Defining service innovation and related terms

The word 'innovation' is used frequently and naturally in conversation. But when you ask people exactly what they are talking about, you quickly learn that the precise meaning of the word is not always clear. Even in the published literature the term is often used without being defined, and to refer to things that can seem very different. The matter is further complicated by the fact that the terms 'improvement' and 'innovation' are also often used interchangeably.

Glossary of terms 76

We want to be clear in this publication about how we define innovation and, particularly, how we define it in the context of health service delivery.

"Innovation must not simply be another name for change, or for improvement, or even for doing something new lest almost anything qualify as innovation."

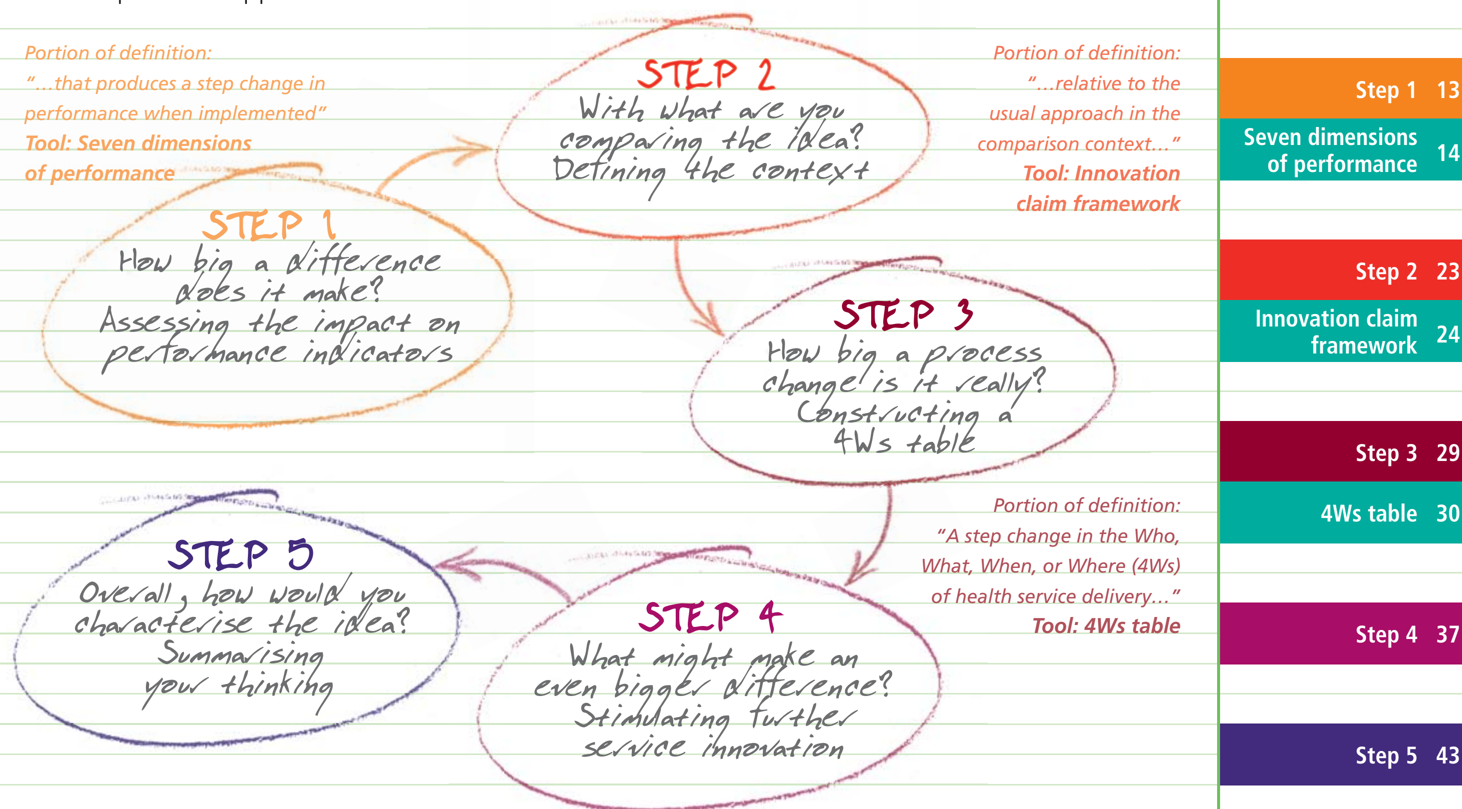
Lynn L. (1997) Innovation and the public interest: insights from the private sector. In A. Altchuler and R. Behn (Eds) *Innovation in American Government.* Brookings Institute, Washington D.C.

Term	Definition	Notes and discussion
Innovation	Doing things differently, and doing different things, to create a step change in performance.	The terms 'innovation' and 'improvement' are commonly used interchangeably and there is little value in arguing. What really matters is whether the change makes a small or large difference – that is, whether it is an incremental or step change in performance.
Incremental change	Making something a bit better and/or a change that maintains most of the underpinning thinking that we have come to take for granted as "the way it has always been".	Both incremental change and step change are useful and desirable. While an incremental change may have only a small impact in the setting in which it is first implemented, if it is subsequently spread it can have a rather large impact on a health economy or the NHS as a whole. Furthermore a step change can make a big difference in the site that implements it, but if it is not widely spread it might make very little difference in the system as a whole. In this publication, we are focused on assessing and stimulating health service innovation as it relates to a specific implementation of an idea, in a specific place. The subsequent spread and broader impact of a change idea is a separate issue which is beyond our scope here.
Step change	Achieving large gains in performance and/or fundamentally rethinking some of the things that we have come to take for granted as "the way it has always been".	
Service innovation	A step change in the Who, What, When, or Where (4Ws) of service delivery – relative to the usual approach in a comparison context – that produces a step change in performance when implemented.	Service innovation involves a step change in both how we do something and the resulting performance. In health care, service innovation is a necessary complement to innovation in medical, surgical, pharmaceutical, diagnostic, and information technology. We too often take innovations in these other areas and place them within a service delivery process that has had little fundamental change in decades.
4Ws of health service delivery	*Who* is involved in delivering the care, *where* and *when* it is delivered, and *what* the patients and their carers experience while receiving the care.	We will provide a practical tool to support this concept – the 4Ws table.
Comparison context	The setting or system against which one wishes to consider the innovativeness of a particular idea.	Innovation implies that an idea breaks with usual thinking, traditions, or assumptions. But something that is common in one setting might introduce a discontinuity in thinking – an innovation! – in another setting. It is, therefore, critically important to specify the context for comparison that is being used in the discussion of a given service innovation. Are we judging the innovativeness of an idea as it compares with the usual thinking of: ▪ an individual, team or department, ▪ a single organisation, ▪ a class of organisations (such as hospitals or GP surgeries), ▪ an industry or sector (such as all of health care), ▪ a region or country (England, UK, Europe), ▪ or society as a whole (as in the Nobel prize)? This is a messy issue that adds to the confusion over the terms innovation and improvement as they are used in health care today.

Overview of a 5-step approach to assessing and stimulating service innovation

Having defined our purpose and terms, we can now lay out a practical approach that results from systematically applying the definition of service innovation. We will start at the end of the definition and work our way back to the beginning – ***now that's thinking differently!*** – and then stimulate you to further innovative thinking.

The 5 steps of the approach are as follows…



Step 1 13
Seven dimensions of performance 14
Step 2 23
Innovation claim framework 24
Step 3 29
4Ws table 30
Step 4 37
Step 5 43

We will describe these steps further and explain how they might be practically used by:

Clinicians, middle managers, and other front-line staff desiring a self-assessment of their ideas and change efforts

Organisational leaders desiring a more formal and structured review of improvement and innovation efforts

We want to stress that while we are highlighting step change here, there is absolutely nothing wrong with incremental change. It is desirable, and may even be a more effective approach in a given situation due to considerations of risk, resources, stakeholder engagement and so on. We want step change… and we want incremental change as well.

The bottom line is about making a difference and having an impact. We are simply pointing out that while there is "making a difference", there is also "making a bigger difference". The latter is our focus here.

How big a

Step 1

difference does it make?

Assessing the impact on performance indicators

Synopsis

Whether making an incremental or step change, the intention clearly is to have a positive impact on health services. This is a minimum qualification for anything called an improvement or innovation. (We will say a word about learning from 'failure' in a moment.)

So, a natural place to start in assessing an idea is to look at its actual or potential impact.

- If you have already implemented or tested the idea you should have some data or observations on which to reflect.
- If the idea is still just an idea, you should at least be able to say what you *intend* to make better and by how much. Then plan to collect the required observations or data to review later.

A useful framework for thinking about impact is the 'domains of quality', first described by the US Institute of Medicine (IOM)*, and later expanded upon by leading thinkers in health systems in other countries†. The box on the next page entitled ***Tool: Seven dimensions of performance*** presents this framework, with examples of some indicators to consider under each dimension.

Seven dimensions of performance 14

If you cannot describe how your idea or change makes a real difference in at least one of these seven dimensions then it would be difficult to consider it an improvement or innovation.

It is amazing how often people say they have a great idea but are unable to clearly describe exactly what is better as a result of it.

The output of this step should be a set of before and after measurements, along with a judgment about whether these results represent a step change in performance.

* *IOM Committee on Quality of Health Care in America.* ***Crossing the Quality Chasm: A New Health System for the 21st Century.*** *Washington: National Academy Press, 2001*

† *See, for example, Norwegian National Directorate for Health and Social Affairs.* ***And It's Going to Get Better! National Strategy for Quality Improvement in Health and Social Services 2005-2015.*** *Oslo: National Directorate for Health and Social Affairs, 2005*

Tool: Seven dimensions of performance

Safety

For example…

- Absence of errors
- Prevention of harm
- Conformance to standards
- Reliability

Timeliness

For example…

- Waiting time
- Time to treatment (or between any other clearly defined points in the process of care)
- Time required to complete a task

Effectiveness

For example…

- Clinical outcomes
- Improved functional status or quality of life
- Free from complications

Efficiency

For example…

- Cost
- Consumption of provider time or resources
- Consumption of user or carer's time or resources

Equity

For example…

- Greater access and availability to all
- Cultural sensitivity
- Closing the gap in past inequalities

Co-ordination (across the whole system)

For example…

- Flow across whole journey/system
- Integration of care plans
- Shared information or assessments

Patient-centredness

For example…

- Ease of use
- Convenience
- Portability
- Influence
- Choice
- Ease of understanding
- Engagement/involvement in care
- Self-management
- Fit to lifestyle or needs
- Experience of care (patient and/or carer)

Examples and frequently asked questions

How do I produce evidence that something is better?

Ideally, you should be able to provide some measurement to support your claim of improvement or innovation. The data should, at a minimum, describe performance before and after the change.

Be practical here. We are not aiming to publish a paper in a scientific journal. Rather, we are trying to stretch our thinking and make things better for patients, carers, and staff at a practical level.

Think of it this way…
How would you make the case to a somewhat sceptical friend that what you had done really made something better?

Consider the following examples as illustrations.

A GP practice implements the idea of 'health coaches' for people with diabetes. Someone in the practice – not the doctor – meets with and counsels over the telephone patients whose condition is not well controlled to help them think through how they might better incorporate diet, exercise, and medication advice into their daily lifestyle. A year into the effort, the practice nurse examines the medical records of 20 patients with diabetes who have been part of the scheme and compares their most recent blood test results to those prior to the scheme. He finds that 16 out of 20 (80%) have gone from poor control of haemoglobin A1c (blood sugar) to satisfactory results based on the goals established for each patient by his or her clinician using the NICE guidelines. (Goals range from 6.5 to 7.5, based on risk factors. See… ***NHS National Diabetes Support Team. NICE and Diabetes: A summary of relevant guidelines****. July 2006. Available at: www.diabetes.nhs.uk accessed 21 November 2007.)*

This is a reasonably strong case for saying that the scheme provided a step change in clinical outcomes (the Effectiveness dimension in the Seven dimensions of performance tool). Comparison of this group of 20 patients to another group of poorly controlled people with diabetes who were not on the scheme (from within the practice or from a similar practice) would make a stronger case. A larger sample, or a registry, would be even better and a proper statistical analysis would be the ideal.

A hospital outpatients department makes a number of changes to improve access to care and cultural sensitivity for a targeted group. After implementing the changes, they ask several patients who frequently attend the service to provide comments via a videotaped interview. A review of the videotapes indicates that most comments were positive; including some stories of how these patients felt better able to cope with their conditions and avoid situations that would perhaps have led to hospitalisations in the past.

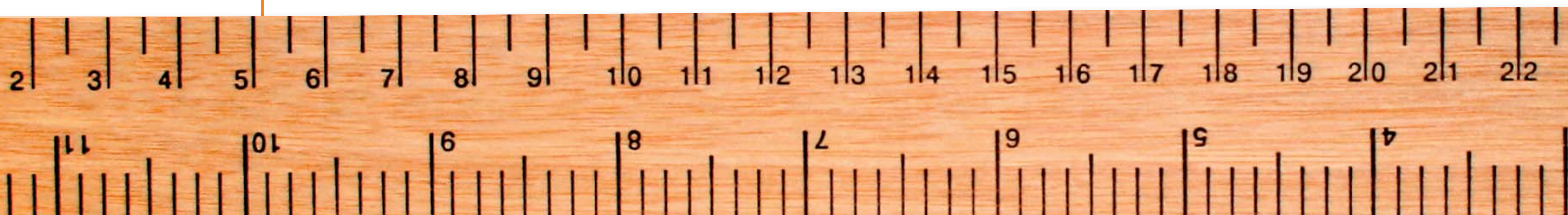
This is mild evidence of better results in the Effectiveness, Efficiency, Equity, and Patient-centredness dimensions. However without something more quantified, it is difficult to say whether the difference is incremental or a step change. A survey of more of the members of this patient group with regard to their experience of the care and degree of self-management, and a system to track things such as specific clinical outcomes, attendance rates, and hospitalisations, would provide much stronger evidence.

In the case of the Hospital Outpatients Department the evidence from the videotaped interviews might not be enough to justify a high level of expenditure to expand the programme, but it may be enough for the organisation and involved staff to know that they have made at least some difference, and to be encouraged to do even more. The stronger, quantitative evidence from the case reviews in the Health Coaches example should be even more encouraging to the staff and organisational leaders involved.

While we do not want to get carried away designing a research study, putting just a bit more effort into the evidence in each example could strengthen the case that the ideas have made a real difference.

The point is…

Just because an idea sounds good does not mean that it is actually better than the current approach. Further, an idea might make things better on one dimension while making things worse in another. You will not know unless you gather the data and observations. ***Measure something!***



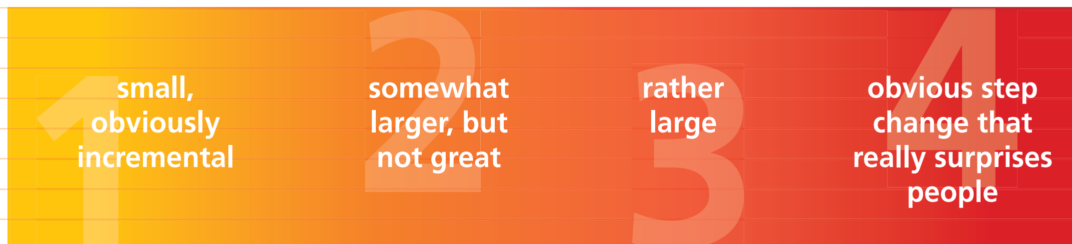
What constitutes an incremental versus step change in performance?

The answer to this question is really about a continuum that exists…

- from very small, obviously incremental, performance improvements…
- through to somewhat larger, but not great, improvements…
- to rather large improvements…
- all the way to obvious step changes in performance that really surprise people.

To meet our definition for a service innovation ("…produces a step change in performance when implemented") an idea must reach the fourth category.

Impact on performance is...



How might I practically assess whether my idea represents an incremental or step change in performance?

We recommend a simple 'jury of peers' approach. Share the results (or expected results if the idea has not yet been tested) with several people who have some expertise in the area and gauge their reaction. Use the four categories in the continuum above to ask colleagues which category they would put your idea in after hearing your results.

An alternative is to ask others to select a threshold beyond which they would call something a step change.

The team leader for the project on health coaches for people with diabetes asks several GP and nurse colleagues the following question… Suppose I told you I had an intervention that would help patients with poorly controlled blood sugar levels get to the target range. On what percentage would it have to be shown effective in order for you to say: "That is really very surprising, you must tell me more about that!"?

The colleagues respond that it would depend somewhat on the cost of the intervention.

So, the leader continues: "Say it requires a full-time nurse to work with these patients. If I told you it was effective on 5% of patients, would you be surprised and impressed? How about 10%... 20%...?" and so on.

The colleagues agree that an intervention that helps more than 30% of patients with poorly controlled diabetes would be very surprising and impressive, and therefore fits the fourth category in the continuum above.

The leader then shares the results from the chart review where 16 out of 20 patients (80%) achieved good results and the colleagues agree that that is indeed a surprising step change in performance.

While not an exact science, this approach works pretty well if we keep two things in mind:

- Every improvement in performance, no matter how small, is desirable, and the people who have done the work should be congratulated. We are not saying that every change must reach the level that really surprises people.
- In order to stretch our thinking towards making a bigger difference, we want to set a high bar for the use of the term 'service innovation'. If a change does not produce performance improvement that really makes others sit up and take notice, we should not be calling it a service innovation. To do so dampens the drive of the creative people of the NHS.

What if I measure something and find that I have failed to make a big difference in performance?

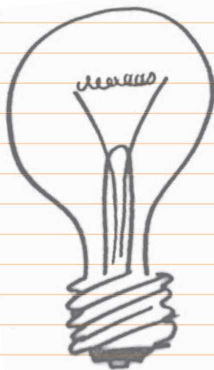
The innovation literature is quite clear that 'failure' is an integral part of the innovation process. For example, Thomas Edison famously remarked that he had to work through thousands of materials that did not make a satisfactory filament for his light bulb before he finally succeeded. You might think that our emphasis on evidence in this first step of assessing service innovation means that we are only interested in what is traditionally deemed a 'success'.

That is not the case.

Our emphasis is on learning. Data, measurement, and evidence are necessary for learning.

You see, Edison knew that thousands of materials that he tried were not satisfactory as filaments for his innovation – the electric light bulb – precisely because he was willing to subject his ideas to the harsh light of evidence (pardon the pun!).

You might say that Edison 'failed successfully' because he learned and moved beyond his initial choices and ideas. ***And…*** he failed successfully precisely because he was willing to gather the data and evidence associated with his ideas, and reflect critically on these. That is why we emphasise the collection of evidence as part of the service innovation process.



"I have not failed,
I have merely found
ten thousand ways
that won't work"

Thomas Edison, inventor of the light bulb

Practical applications for front-line staff and organisational leaders

If you are a front-line clinician, manager or other staff member…

62 Seven dimensions of performance

Review the material in this section and in the **Tools** appendix on the *Seven dimensions of performance* and ask yourself:

If my idea for change is really successful, what would I expect to observe?

- Identify relevant dimensions and think how you might practically gather some evidence before and after a change to make the case that you have indeed made something better.
- Think about existing data that, while maybe not perfect, would be highly suggestive.
- At the very least, gather detailed stories and examples of experiences before and after your change and analyse these.
- Measure something!

Then talk with colleagues and others who are familiar with the sort of problem that you are trying to address and get a sense from them how big a difference you would have to make in order to qualify as a step change in performance in their eyes. Compare the results you get with the points they suggest.

Remember that any improvement in performance is good and something you should be proud of. However, our intention here is to stretch your thinking and set a high bar by associating the term service innovation only with a step change in performance.

Order publications online at www.institute.nhs.uk

Please refer to other resources that focus on measurement available from the NHS Institute:

- Improvement Leaders' Guide – measuring for improvement
- Good Indicators Guide

Seven dimensions of performance 14

If you are an organisational leader…

Use the *Seven dimensions of performance* for both signposting and encouraging self-assessment of improvement and innovation efforts.

- **Signposting:**

  Invite staff to submit ideas that will enhance performance on a specific dimension. Being clear about your focus is key to your role as a leader and has been shown to be a factor in establishing an organisational culture for innovation.

> ***Many organisations have schemes that ask staff to send new ideas in for consideration. This results in different and varied suggestions, which is good, but many of the ideas submitted do not specifically relate to core challenges within the organisation. Providing a specific focus – for example: 'during the next 10 weeks send in any ideas that could improve the safety of patients', or 'during the next month we seek ideas that could reduce waste in your area' – often results in increased numbers and a better quality of ideas being submitted.***

- **Encouraging self-assessment:**

  It is your responsibility as a leader to ensure that those seeking recognition and support for improvements show reasonable evidence that they have made something better in at least one of the dimensions of performance. Encouraging self-assessment will also help foster better critical thinking in your organisation.

  In developing a culture for innovation and critical thinking, keep the following points in mind:

  - While step change in performance is clearly desirable, make it clear that any improvement is always welcomed.
  - Celebrating small differences will encourage staff to go for even bigger differences next time round.
  - Make it clear that you understand that learning from 'failure' is part of the process. Consider establishing some form of recognition for good examples of service delivery innovations that 'failed' in the traditional sense, but from which there was rich learning.

Make it a point to review and celebrate all attempts at making a difference – regardless of the results – and you will get more attempts.

With what are

you comparing the idea?

Defining the context

Synopsis

Having assessed the impact on performance, we need now to determine if the details of the idea itself represent a step change in the way care is delivered compared with what is usual. The need for comparison to the usual approach raises a critically important issue – context.

By comparison context we mean the health care setting or system against which one wishes to consider the innovativeness of a particular idea.

The box entitled ***Tool: Innovation claim framework*** overleaf presents the range of choices for a comparison context.

The output of this step should be a clear description of the main context against which you are comparing your idea, and a secondary context that you will use to further challenge your thinking.

Tool: Innovation claim framework

I am claiming that this idea is new and very different from the usual practice in…	
Level 1	My immediate team or department
Level 2	My local organisation (e.g., PCT, Trust)
Level 3	My setting (e.g., GP practice, cardiology service) in my health economy
Level 4	Any setting in my health economy
Level 5	My setting across the country
Level 6	Any setting across the country
Level 7	My setting internationally
Level 8	Any setting internationally
Level 9	The world at large, across sectors, industries, etc.

The main comparison context for an assessment should be obvious in a given situation; for example, comparing your new idea with the past practice in your immediate team or department. But, in addition, we encourage you to stretch your thinking and also compare your idea to broader contexts further down the framework.

Examples and frequently asked questions

Examples of use

A team within an organisation might want to assess a potential service innovation idea within their own context (level 1 or 2 on the framework), or perhaps within the context of other departments like them within their local health economy (level 3). A further stretch in thinking might come if they do a little enquiring to determine how innovative the idea is in comparison to similar services around the country (level 5).

An SHA sponsoring an award scheme seeking innovation in primary care would obviously want to assess in the context of primary care in that health economy (level 3). In addition, inviting contacts across the country, or in other countries, to offer friendly commentary on the entries from the perspective of what is usual practice in other places (levels 5-8) might serve to spur even more innovative thinking in next year's competition.

Is it really necessary to choose a comparison context?

As noted earlier, the word innovation implies that an idea breaks with usual thinking, traditions, or assumptions (we can use the general term **paradigm** to encompass all of these things). The degree of service innovation has to do with the degree of discontinuity with the current paradigm. But a concept or paradigm that is common in one setting might introduce a discontinuity in thinking – an innovation! – in another setting.

Glossary of terms 76

For example, while the concept of matching capacity to demand* was common in production planning in general industry, the first few hospitals who applied this thinking to patient flow were considered highly innovative. A manufacturing company that implements the idea of matching capacity to demand would not be considered innovative, but a hospital that implements the same idea is.

Or, suppose we are assessing the level of improvement or innovation in the context of primary care organisations. If someone adapts an idea that is rather commonplace in hospitals – but is rare and challenging to the usual way of thinking or doing something in primary care – then that idea would be judged as innovative in the context of primary care.

If, on the other hand, we say that the context we are evaluating is health care in general, then that same idea must be judged as only mildly innovative, since it is already rather commonplace in hospitals and is simply in a process of being spread more widely within the context of health care.

** NHS Institute for Innovation & Improvement (2006) 10 High Impact Changes for Service Improvement and Delivery*

It is, therefore, critically important to specify the context that is being used in the discussion of a given service innovation. Lack of clarity on this issue contributes to the confusion over the terms *innovation* and *improvement* as they are used in health care today.

Practical applications for front-line staff and organisational leaders

If you are a front-line clinician, staff member, or middle manager…

24 Innovation claim framework

Decide the context in which you wish to assess the innovativeness of your idea.

Use the Tool ***Innovation claim framework*** to guide your thinking.

Stretch your thinking by assessing your idea not only against the usual practice in your immediate setting, but also against the broadest context for which you think you know enough about current practice (or can find people who know).

If you are a ward sister, you might ask:

How new and innovative would my idea be in some of the best hospitals in the UK?

If you are a GP, you might ask:

What would the best GP practices across the country think of my idea?

If you are an organisational leader…

You have an important leadership role both in setting the challenge of wanting to be among the best in a broader context, and in bringing to your organisation information about what others are doing in service delivery.

- Continuously encourage your departmental and team leaders to purposefully reflect on ideas for change relative to their current practice.
- Decide if it is good enough to just be better than you were before (competing with yourself), or whether, in at least some aspect of service delivery, you would like to be among the most innovative organisations in your health economy or broader ("competing on a larger pitch").
- Realise that some of your departmental leaders and front-line staff may not know much about what others are doing beyond the walls of your organisation. Share the insights you gain through meetings and conferences, reports, journal articles, and your network of peers in other organisations.

If you are an organisational leader you should be asking:

How new and innovative are the ideas and changes that are taking place in my organisation when compared with what has already been going on elsewhere in organisations like mine?

If you really want your organisation to be highly innovative, you might even consider assessing yourself against all of health care in the UK, or to similar organisations in other countries.

How

Step
3

big a change is it really?

Constructing a 4Ws table

Synopsis

Having clarified the context, we can now compare our idea with the usual or past approach in that context to ask whether it really amounts to a step change in the way we do things.

The box entitled ***4Ws table*** on the next page shows a format that provides a side-by-side comparison regarding **who** is primarily involved in delivering the care, **where** and **when** it is delivered, and **what** the patients and carers experience while receiving the care.

4Ws table 30

Properly constructed, the 4Ws table is a simple, clear, powerful tool for assessing whether a given change idea is an incremental or step change in the way things are done. Again, as with the perfomance indicators, the differences will be shades of grey, but at least now we have framed the debate concretely.

The 4Ws table should always be reviewed for completeness and fairness of comparison by discussing it with those involved in the service innovation and with colleagues familiar with the typical good approach in the context against which you are assessing.

The output of this step should be the completed and reviewed 4Ws table.

30 4Ws table

Tool: 4Ws table

Idea:

Comparison context:

	Typical good approach	Our idea
Who		
What		
When		
Where		

Key results: *(tick one)* ☐ **Based on data** ☐ **Projected/expected**

68 4Ws table

A complete description of the steps in constructing the 4Ws table is given in the **Tools** appendix, along with an extended example. Below is a quick description of the various fields in the table.

- **Idea.** A brief description of your idea.
- **Comparison context.** The context identified in Step 2.
- **Typical good approach.** A headline description of the usual, routine, good quality practice in the comparison context.
- **Our idea.** A headline description of your idea.
- **Who.** List of individuals most actively and directly involved in delivering the care in the typical good approach and under your idea.
- **What.** The key, relevant elements of the care process experienced by patients and carers.
- **When.** The days and times when the activities described in the ***What*** row are available to patients and carers.
- **Where.** The places or settings in which the activities described in the ***What*** row are available to patients and carers.
- **Key results.** A summary of the impact on performance from Step 1, noting whether these are actual or projected results.

Examples and frequently asked questions

Example

Below is a completed 4Ws table for the diabetes health coaches example that we have been developing. The details of the construction are provided in the **Tools** appendix. There are several more examples of 4Ws tables in the **Further examples and commentary** section in the appendix.

4Ws table 68

Further examples and commentary 51

Read the table row by row and you will see that it is both a fair description of good usual practice and a nice summary of what is different about the health coaches approach. In a well-constructed 4Ws table, colleagues familiar with the usual practice in the comparison context should be able to read down that column and conclude, "Yes, that is a fair description of usual, good care."

Example of a 4Ws table for the idea of health coaches in a GP practice for people with diabetes

Idea: Health coaches in a GP practice for people with diabetes

Assessment context: GP practices in the Bloggton PCT

	Typical good approach across our PCT for people with uncontrolled diabetes	Diabetes health coaches
Who	• GP • Practice nurse	• GP • Practice nurse • Health coach • Patient/carer
What	• Patient's condition is monitored via periodic visits to the GP • GP and practice nurse provide advice and education regarding required lifestyle changes • Patient and carer invited to periodic educational classes	**Same as usual approach plus…** • GP identifies patients requiring extra help and introduces health coach to patient • Health coach establishes on-going and frequent telephone contact focused on lifestyle changes • Patient/carer sets agenda for changes they are willing to make • Both patient/carer and coach can initiate contact • Coach available to meet with patient/carer in home or community
When	Normal surgery hours	Normal surgery hours
Where	• Mostly in the surgery • Occasional home visits, or phone calls to patients who could be anywhere to take the call	**Same as usual care plus…** • The main focus shifts to telephone contact which the patient/carer can take anywhere • Coach also available to meet with patient/carer in the community as needed (e.g. go grocery shopping)

Key results: *(tick one)* ☑ **Based on data** ☐ **Projected/expected**

- Review of the records of 20 patients with poor control of HbA1c prior to introduction of the scheme show that 16 (80%) had a most recent reading within their target range
- Many positive comments from patients on the scheme

Examples and frequently asked questions

Since patients are always present during care, shouldn't they always be listed in the Who row for both the usual approach and the new idea?

We want to list the individuals who are *most actively and directly involved in delivering the care*, and avoid listing a host of people who may only have some peripheral involvement.

So, think carefully before you list the patient or carers. Are they really *actively* involved in *delivering* the care, or are they passive participants and recipients only?

68 4Ws table

The simple fact is that the latter is most often the case. The detailed description of the ***4Ws table*** in the **Tools** appendix provides several examples of ways in which patients might be active in delivery of care.

Patients are always making choices that impact on their health – shouldn't the When and Where rows always read '24 hours a day' and 'wherever the patient is' for both the usual approach and new idea?

The When and Where rows should track with the details of the service described by the idea itself and the What row. We want to focus on when and where these specific health care services are delivered.

What if I cannot really distinguish my new idea from what I have now identified as the usual good practice in the comparison context?

This does not negate the fact that you have done something in your setting to make care better for your patients and their carers. That is a good thing.

But you may have to admit that your idea might not be so 'innovative' if others are already doing it. You could say that you have succeeded in implementing a best practice. And that too is a good thing.

On the other hand, if you are comparing with one of the broader contexts further down on the **Innovation claim framework** – say, internationally or to a health care context that is very different from your own – you might still say that it is innovative in the sense that it is a surprising adaptation of an idea from a very distant context.

Obviously, you will have to assess this on a case-by-case basis.

Innovation claim framework 24

Practical applications for front-line staff and organisational leaders

If you are a front-line clinician, staff member, or middle manager…

Take the time to thoughtfully construct a 4Ws table for your ideas so that you can make a clear comparison and challenge your thinking.

68 4Ws table

- See the detailed instruction on the ***4Ws table*** in the **Tools** appendix.
- Remember, even if it turns out that your idea is more of an incremental change than a step change, you should celebrate any change that makes things better for patients and carers.
- Review your 4Ws tables with colleagues for completeness and fairness. They might even help to build upon your idea.
  - Take this as an opportunity to learn and to be encouraged to think even more broadly.
  - Don't be defensive or downcast if they suggest that you have unfairly characterised either the typical approach or your idea.
  - Take energy from what you have accomplished and learned in order to move on to make an even bigger difference.

If you are an organisational leader…

Consider making the 4Ws table a requirement for projects in your organisation. It forces a clarity of thinking that you will find helpful in the journey to create what has been called a 'learning organisation'. It is really not hard to construct the table and you should encourage its use especially by individuals and teams who are seeking your attention, support, and organisational resources.

As noted previously, one of your important leadership roles is to bring knowledge of what others are doing into your organisation as a way to challenge thinking.

- When reviewing a 4Ws table, look critically and constructively at how the team has described the typical good approach.
- Use this as an opportunity to share what you know about what others are doing, but be sure to do this in a helpful, constructive way.
- If you do not know what the current approach is in a particular area, ask the team to confirm that they have reviewed the table with others to assure that they have sought out this information.

An additional, powerful leadership responsibility is that of recognising and rewarding good effort.

- Acknowledge the contribution of the team and individuals, regardless of whether you see the work as incremental or step change.
- Be open and supportive of stories of 'failures' where there has been good learning.
- Use the 4Ws table as a memory jogger when visiting the area that has been testing the new idea. Staff are encouraged when a leader visits and demonstrates a detailed understanding of what they have been doing.

What might make an

Step 4

There is always an even better idea out there. No matter how big a difference you make, you can always make a bigger difference.

even bigger difference?

Stimulating further service innovation

Synopsis

The main point of this publication is to stretch your thinking towards even higher levels of innovation – ***making a bigger difference***. Before summarising the overall assessment of your idea, it is useful to pause and think about what more could be done.

- What did we really change in the system of care?
- What will be left unchanged?
- What additional new possibilities and opportunities have we now created?
- What might be the next big idea that stretches beyond this?

Imagine the power of a system where every change in health service delivery naturally leads to thinking about the next innovation! That is what we are after.

There is a guide for this reflection in Step 6 of the construction details for the ***4Ws table*** provided in the **Tools** section of the appendix.

If you have not already done so, now is also the time to assess your idea against a broader context further down the list in the ***Innovation claim framework***.

The output of this step should be a list of more ideas that might make an even bigger difference for patients and carers that you can consider for future testing.

4Ws table 68

Innovation claim framework 24

74 4Ws table

Examples and frequently asked questions

Example

The team reviewing the idea of health coaches for people with diabetes used the questions in Step 6 of the details for constructing a **4Ws table** in the **Tools** appendix and compiled the list of new ideas below.

Additional ideas and extensions of 'health coaches'…

- Extend the use of health coaches to other chronic diseases.
- Provide health coaches to people who are not yet in poor control of their chronic illness, but are at risk. Maybe health coaches can intervene earlier in helping to build good lifestyle habits in order to prevent further progression of a condition.
- Health coaches for people following an episode of illness; think of them as another form of rehabilitation or therapy following an illness.
- Explore the use of interactive technology on the web to enhance the telephone calls (e.g., use of video links, having both the coach and individual being able to work on a document on the screen together).
- Train more coaches in the community to handle cases where high levels of clinical knowledge are not needed; use volunteers or peers who have dealt with similar issues.
- Think about others in the community who could meet with patients face to face to help them; for example, partnerships with voluntary sector agencies, a registered dietician, social services, etc.
- Make coaches available outside normal Surgery hours. Work with NHS Choices to establish a service that, while not having the same personal relationship with the individual, would still be helpful outside normal clinic hours.
- Look at other settings in the community where coaching could take place… Would local shop managers, pub owners, or community pharmacists be willing to provide focused help in partnership with us?

The team also reviewed their health coaches' idea relative to a broader context.

- By inquiring about international best practice for helping people with diabetes who need to make lifestyle changes, the team discovered several resources in the form of websites for patients and carers, a training programme for health coaches, and relevant material in a variety of languages. The team also learned about cognitive behaviour therapy (CBT), which has been documented in several studies to be effective in helping patients make lifestyle changes.

- When they further evaluated their idea against best practice in helping people make lifestyle changes outside health care they thought about personal trainers, sports coaches, spiritual awareness raising groups, the military, and social activists. What might we learn from these other groups and setting that might further enhance our efforts within health? This is an example of a tool for idea generation called Fresh Eyes. To learn more about this and other tools for innovation see the guide **Thinking Differently,** available from the NHS Institute for Innovation and Improvement. ***www.institute.nhs.uk/thinkingdifferently***

Order publications online at
www.institute.nhs.uk

This team is really stretching its thinking now! This does not diminish the existing idea, but it certainly points to even bigger differences that could be made.

What if I stretch my thinking so far that I come to realise that my change is really just an incremental improvement compared with what could be done?

That would be a wonderful outcome!

This is not a failure of the process. Rather, it is the point of the process. Since there is nothing wrong with incremental change, there is no harm in identifying something as such. The good thing is that the 4Ws process resulted in giving you some additional innovative ideas, which you can now go on to pursue in the next round of change.

Practical applications for front-line staff and organisational leaders

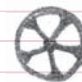
74 4Ws table

24 Innovation claim framework

If you are a front-line clinician, staff member, or middle manager…

Review your **4Ws table** using the guide in Step 6 of the construction details in the **Tools** appendix. Also take the opportunity to assess your idea against a broader context, as discussed in the Innovation claim framework.

- Make a list of additional thoughts and ideas for making an even bigger difference.
- If you do not know what typical best practice is in other contexts, find out. You can do this via a literature search or by simply asking colleagues and organisational leaders who you think might have a broader perspective.



If you are an organisational leader…

Challenge your teams to reflect on how they could make a bigger difference, using the process described left.

- Be open to requests for additional support to take things further.
- Make yourself available to teams with your knowledge of best practices in other contexts beyond the one that they initially assessed.

Resist the temptation to generate additional ideas yourself; this might be misinterpreted by the team that you are thinking their ideas are not good. People are always more excited about ideas they come up with themselves.

The effective leader encourages broader thinking, shares information, asks provocative questions, and leads others to the brink of new ideas, but allows them the thrill of discovery. Instead of saying, "Yes, of course, I thought of that", the effective leader says, "That's brilliant!"

Overall, how would

Step 5

you characterise the idea?

Summarising your thinking

Synopsis

At this point, you have given your idea a fairly thorough analysis. It remains only to come to some conclusion about it. Is it a service innovation by our definition? And, if so, what qualifiers or modifiers would you attach to it?

Recall that we have set a fairly high bar for something to meet our definition of a service innovation…

Service Innovation: A step change in the Who, What, When, or Where of service delivery – compared with the usual approach in the context of interest – that produces a step change in performance when implemented.

Therefore, in order to qualify as a service innovation, a change must be a step change in both process and outcome. Again, improvements that fall short of this high standard are still highly desirable, we are simply reserving the term service innovation for a special class of changes.

In this section we provide guidance to help you create a simple, plain language summary assessment of your idea. Additional examples are provided in the **Further examples and commentary** section of the appendix.

Further examples and commentary 51

The output of this step should be a short, descriptive summary of your assessment of the innovativeness of your idea relative to typical practice in the comparison context.

Examples and frequently asked questions

How do I go about creating a short, descriptive summary of my assessment of an idea?

Your summary statement should reflect the two aspects of service innovation – the degree of change in performance and process.

1. Impact on performance.

Look at the *results* you have achieved, or hope to achieve, relative to what others said would surprise them and make them take notice. Consider the words and phrases below and select the ones that seem to fit best:

- **Incremental improvement…** a small, positive change, but would not result in someone being really impressed or surprised.
- **Large improvement…** a large, positive change, but short of the level of surprise.
- **Step change in performance…** meets or exceeds the level of surprise.
- **Large step change in performance…** greatly exceeds the level of surprise, say, by more than 50%.

Note whether the enhanced performance is mainly on one indicator, or across multiple indicators.

Use a word like 'potential' in front of the phrase selected above if you have not yet measured the actual impact on performance, or your measurements are weak or anecdotal.

Finally, consider adding an explanation to further clarify what more is needed or to further emphasise your point.

For example, a change might be described as…

- ***A potential step change in performance that has not yet been tested.***
- ***A large improvement across several indicators of performance.***
- ***An incremental improvement in performance.***
- ***A potentially large step change in performance on X (name the indicators), but further study should be done.***
- ***A step change in performance across multiple indicators.***

2. Impact on the process.

Review your 4Ws table, in the light of your list of additional ideas, and make similar statements about the degree to which the process and experience of care has been changed. Consider the words and phrases below and select the ones that seem to fit best.

- **Incremental change…** a change, but one that is a natural extension of our current practice, or does not deeply challenge the prevailing thinking in the context we have selected.
- **Adaptation…** a change that results from the natural spread of an existing idea that has been applied elsewhere within our context (e.g., a version of a one-stop service for a certain group of patients, when you know that it has already been done before within the context you are assessing).
- **Step change…** a change that challenges deeply-held paradigms about the way things are done in the context of interest.

Note whether the change mainly challenges thinking in one dimension, or across several of the Who, What, When and Where dimensions.

Consider adding an explanation to further clarify what you are saying.

For example, a change might be described as…

- ***An incremental change regarding when the services are available.***
- ***A step change in the Who, What and When of care.***
- ***While there are some unique aspects of how things were done in this case, the changes really are an adaptation of the concept of X (describe), which we have seen elsewhere in this context.***
- ***An incremental change in what the patients and carers experience and where the service is offered.***
- ***A step change in who is actively and directly involved in the care.***

3. Combine the two phrases selected and state your overall conclusion.

In the final summary statement, consider restating the context that you are assessing within and say clearly whether you think your idea is a service innovation or not. Feel free to add further explanation as needed.

For example, a change might be described as…

- ***An incremental change in what the patients and carers experience and where the service is offered that resulted in a large improvement across several indicators of performance, but one that does not really rise to the level of a service innovation. We now have some new step change ideas to take things much further.***
- ***A clear service innovation in the context of our local health economy – a step change in the Who, What and When of care that led to a step change in performance across multiple indicators. While we discovered that similar changes have been previously implemented in other parts of the country, we are nevertheless proud that we independently came up with these innovative approaches in our local context.***
- ***A potentially important service innovation in the context of primary care that requires further evaluation. It is clearly a step change in the process of care, but the assessment of performance was based on a very small number of patients and anecdotal reports. We are not aware of anything quite like what we have done anywhere else in primary care in the UK.***

Example

Returning now to our example of the health coaches, the team might summarise its work as follows…

The health coaches appear to be an important service innovation for people with diabetes in the Bloggton PCT. It represents a step change in the Who, What and Where of care, and our sample of 20 patients on the scheme yielded a large step change in performance on an important clinical indicator – 80% of these patients who had uncontrolled haemoglobin A1c levels are now within their target range. We want to gather more data on a larger sample, and we look to further expand and enhance the scheme.

51 Further examples and commentary

Additional examples are provided in the **Further examples and commentary** section of the appendix.

Practical applications for front-line staff and organisational leaders

If you are a front-line clinician, staff member, or middle manager…

Follow the directions in this section and summarise your assessment.

- Be honest and positive.
- Give yourself credit where credit is due, but also point out where you think you could do more.

If you are an organisational leader…

Consider requiring summary statements such as these on all improvement efforts in your organisation; whether they are intended to be incremental or step changes.

- You might establish categories to classify efforts such as: small incremental improvements, incremental improvements with large impact, step changes in process that fell short of making large performance differences, true service innovations, and 'failures' from which we learned a lot.
- Over a period of time, a well functioning organisation should have a portfolio of projects that span all such categories. You could monitor this as a measure of organisational performance.

Are you ma

Conclusion

king a bigger difference?

We have now answered the four questions with which we began. Let's summarise:

- **Does the NHS really need to be more innovative when it comes to the way services are delivered?**

  We think so. We are concerned about innovation in health services delivery because the public increasingly expect it, we are more than capable of doing it, and it is the right thing to do.

- **What exactly do we mean by 'service innovation'?**

  Service Innovation: A step change in the Who, What, When, or Where of service delivery – compared with the usual approach in the context of interest – that produces a step change in performance when implemented.

- **How can I assess whether a given idea is innovative or not?**

  We have demonstrated the use of the tools of the Seven dimensions of performance, Innovation claim framework, and the 4Ws table; and provided directions and several examples of the overall process.

- **How can we stimulate more innovation to get even better results in service delivery?**

  Reflect on the items in the 4Ws table and look beyond your immediate context to stretch your thinking about what more you could do.

While we have stressed throughout that incremental change is still desirable, at perhaps no other time in its history has the NHS needed service delivery innovation – step changes in what we do and how we perform – more than now. This guide, along with the companion publication from the NHS Institute for Innovation and Improvement, the ***Thinking Differently*** toolkit, are designed to stretch your thinking and get you started in your new role as NHS innovators.

What are you waiting for?

*Order publications online at **www.institute.nhs.uk***

Further examples and commentary 51

Description of tools 62

Glossary of terms 76

Appendices

Further examples and commentary

The following pages provide a range of examples to illustrate the tools and overall assessment process that we have described. The examples are based on cases taken from projects submitted to the NHS Live Awards, efforts highlighted in an NHS Confederation publication* describing the efforts of leading PCTs, and from ideas generated by the NHS Institute for Innovation and Improvement.

** NHS Confederation. Primary Care Trusts: Serving Communities. 2006. Available at: www.nhsconfed.org/publications*

We have taken these real examples, which predate this publication, and created a hypothetical assessment using the tools described here. The teams involved in the actual cases might have chosen different contexts for assessment and may have had additional information. These examples are for illustration purposes only, and are not intended to reflect on the efforts of the actual teams involved.

Further case studies can be found on the NHS Institute for Innovation and Improvement website.

Further case studies are available at www.institute.nhs.uk/bigger-difference

* A hospital-based example that also illustrates how the 4Ws table can be tied to process mapping

An emergency care radiology team reports…

Nearly 50% of all A&E patients with injury require an X-ray to assist diagnosis. After radiology they wait to see a clinician again for the decision on whether they require further treatment or can be discharged. Traditionally the A&E department would interpret results immediately, but this was followed up by an official radiology report, creating delays for patients.

The concept of the new radiographer discharge service, utilising hot reporting (where radiology results are available immediately) which allows radiographers to assess and refer or discharge patients as needed. The idea was to improve patient pathways in A&E and provide the same level of access to the new radiographer service, regardless of referrer.

The team reports that patient journey time and speed of diagnosis and referrals are vastly improved. Some patients were so surprised at being discharged so quickly that they questioned whether something might have been missed. However, the number of patients needing to be recalled to A&E due to disagreements over X-ray reports actually decreased by 52% compared with the older, slower process.

Idea: Radiographer-led referral and discharge

Assessment context: Our radiology department in the Trust

	Typical good approach	Radiographer-led referral and discharge
Who	• A&E, GP, and walk-in centre clinicians • Radiology department clinicians	**Same as typical good approach plus…** • Expanded role for radiographers (allied health professionals)
What	• Patient in A&E, surgery, or walk-in centre –> go to Radiology –> return to A&E –> wait –> A&E clinicians treat, refer, or discharge as appropriate • Various levels and pathways of access to Radiology from A&E, surgery, or walk-in centre	New pathway with much less waiting: Patient in A&E, surgery, or walk-in centre –> go to Radiology –> results available immediately via hot reporting –> radiographer (AHP) refers or discharge as appropriate via protocols Standard access to new service regardless of referrer
When	As initiated by patient turning up at A&E, surgery, or walk-in centre	Same as typical good approach
Where	• Initial access at A&E, surgery, or walk-in centre • Patient goes to Radiology and then to A&E to wait • Discharge/referral occurs at A&E	• Initial access at A&E, surgery, or walk-in centre • Patient goes to Radiology • Discharge/referral occurs in Radiology

Key results: *(tick one)* ☑ **Based on data** ☐ **Projected/expected**

- Vastly improved patient journey time
- Vastly improved speed of diagnosis of acute problems and referral to specialists
- Number of patients recalled to A&E with disagreements over X-ray reports decreased 52%
- Some concerns expressed that speed might result in missing something (needs follow-up study)

Assessment for innovativeness and commentary…

A step change in the process that seems to result in a step change in performance. Although actual data on patient journey times would be helpful and a further study should be done to assure that there are no adverse clinical outcomes, it appears that this is a significant service innovation in the context of how radiology services have been typically delivered in this Trust.

A hospital-based example where the idea ends up being assessed as an incremental improvement

An audiology team reports…

It was clear that to reduce waiting times from over 12 months to 18 weeks would require major changes and the input of both stakeholders and patients. Many processes, procedures and systems differed from site to site, so additional aims were therefore established to improve the GP referral process, optimise clinic booking procedures, the use of clinic, staff and equipment time, reduce the rate of 'Did Not Attends', ensure efficient recording of activity and improve the overall patient experience.

During the project, patient pathways have been streamlined, GP referrals have been standardised, and group fittings of digital hearing aids have been established. New booking and data capture systems, processes and procedures have been implemented and all existing systems evaluated and better utilised.

All core aims have been achieved and the waiting time to first fitting reduced to 16 weeks from a baseline of 50 weeks. (NB: Other details and performance data are provided in a write-up developed by the team.)

Idea: Streamline access to audiology services

Assessment context: Our audiology service

	Our old approach	New audiology service
Who	• Audiology clinicians and staff • GPs	Same
What	• Access to services following GP referral were inefficient • Patients always seen one at a time • Patient pathways and many processes, procedures and systems differed from site to site • Booking and data capture systems inefficient • Little team spirit	• Created standard processes across sites • Rationalised and improved the GP referral process • Optimised clinic booking procedures • Eliminated inefficiencies in the use of clinic, staff and equipment time • Created new systems for more efficient recording of activity • Patient pathways streamlined • Group fittings of digital hearing aids • New booking and data capture systems, processes and procedures • Created greater sense of team spirit
When	During normal clinic days and hours	Same
Where	In hospital-based audiology clinic	Same

Key results: *(tick one)* ☑ **Based on data** ☐ **Projected/expected**

- Reduce waiting time to first fitting to 16 weeks from 50 weeks at baseline, improvements continuing
- Reduced the rate of 'Did Not Attends'
- Improvements in staff satisfaction and sense of team spirit

Assessment for innovativeness and commentary…

While there has clearly been a step change in performance on waiting time to first service, this result has come about as the result of numerous incremental improvements.

This is an excellent example of why incremental improvement is still desirable, and shows how it can contribute to major improvements in the patients' experience. This team has obviously done a massive amount of work and deserves praise, but we cannot apply the term 'service innovation' here.

A hospital-based example that illustrates an innovative device that does not, by itself, result in an innovation in service delivery

An idea for redesigning the bedside urine catheter bag system

In nearly all hospitals in the UK, nurses are required to monitor, maintain, and document urine output from bedside catheter bags for a substantial number of patients. Our idea is to develop a new technology to eliminate this aspect of nurses' work in order to free up more time for other duties.

The new urine bag – which we hope to get a technology company to develop – would be connected to the patient's catheter, an information system, and a drain. Sensors in the bag would automatically measure urine output and transmit this data to the patient's medical record. After recording the output, the sensors would open the bag to the drain to empty it. No nursing effort is required, other than to provide supervision of the system and to provide care to the patient as required.

Idea: An automated, bedside urine catheter bag

Assessment context: Hospitals in the UK

	Usual good approach	New system
Who	Nurse	No one required for the old task of measuring, recording and emptying bedside catheter bags; all done by computer
What	Patient discharges urine –> nurse measures urine output –> nurse records information in chart –> nurse empties bag	Same basic process as before, but the nurse is replaced by a computer
When	Approximately hourly	At every urine discharge episode
Where	At the bedside	Same

Key results: *(tick one)* ☐ **Based on data** ☑ **Projected/expected**

- Elimination of this task from nurses' daily work; frees up time for other care activities

Assessment for innovativeness and commentary…

This is a step change in the process that makes an important difference in the utilisation of nurses' time. It is important to note, however, that as currently described, the idea does not necessarily create a step change in the patient's experience of care. Indeed, as it stands now, implementation of such a system could actually have the effect that nurses are at the bedside less frequently.

Actual construction, testing and proof of the impact of such a system could be considered a service innovation if it is linked to efforts to refocus the saved nursing time onto the delivery of more care for patients. For example, a team on an elderly care ward might couple this innovative device with a process to take the nursing time released and use it to help patients at meal times, thereby improving levels of nutrition. Otherwise, the change as currently described might be considered a process or technology innovation that, while maybe having important and desirable benefits in terms of cost savings or nursing satisfaction, does not really change the patient's experience of care.

A primary care example that illustrates that even when there is a very good reason for our traditional approach, it still bears looking at it for a challenge

A PCT team works on managing long term conditions

GPs practising in a suburb outside London, have been working with people with chronic obstructive pulmonary disease (COPD), which includes conditions like chronic bronchitis and emphysema. In one quarter, the GPs saw over 1,300 COPD patients to review their care and develop a self-treatment plan that included educating patients about what they themselves could do if their health got worse. Patients were also given a prescription for emergency antibiotics and steroids to keep at home with an instruction sheet detailing when they should take the drugs and how they could re-order them. This initiative reduced the number of emergency admissions by 20 per cent, saved the NHS over £370,000 and received positive feedback from patients and staff.

Idea: Give COPD patients prescriptions and instructions for activating them in emergency situations

Assessment context: Long term care in our PCT

	Typical good approach	Our new service
Who	• GP and practice staff	• GP and practice staff • Educated and activated patient and carer
What	• Care for persons with COPD is provided when the patient experiences something that causes them to turn up at the GP surgery or A&E	**Same as typical good approach plus…** • Each patient given a personalised self-treatment plan and appropriate education • Patient given prescription for emergency steroids and antibiotics and instructions on when and how to use them
When	• During normal surgery hours • Out of hours, go to A&E	**Same as typical good approach plus…** • Can access community pharmacy with prescriptions during pharmacy business hours, which typically are extended compared with GP surgery • Patient/carer can provide good quality self-care 24/7 because of education provided
Where	• GP surgery • A&E	**Same as typical good approach plus…** • At home • Community pharmacy

Key results: *(tick one)* ☑ **Based on data** ☐ **Projected/expected**

- 20% reduction in emergency admissions
- £370,000 savings
- Positive feedback from patients and staff

Assessment for innovativeness and commentary…

Giving patients prescriptions in advance of their need and allowing them to make an informed judgment as to when to activate the plan is a step change in the process. In this case, it clearly also resulted in a rather large, measured improvement in performance. This clearly meets our definition for a service innovation, in the context in which it was assessed.

For many good reasons, the concept of having to seek out a clinician to get a prescription when you need it is a rather deeply embedded paradigm in the health service. What this team has realised is the people with chronic diseases like COPD are often quite expert in their own disease and are unlikely to engage in the risky behaviours that makes the usual rule necessary in most other cases.

In addition, this idea easily stimulates further thinking about how this concept might be adapted to other chronic conditions, or even episodic conditions that have clear signs and symptoms that a patient or carer could be taught to assess.

A PCT-based example that illustrates that we can have step change in one aspect of care while leaving other, major portions of the process unchallenged

Redesigning unscheduled care

Our PCT is redesigning unscheduled care services both in and out of hours. The changes involve substantial redesign of the workforce and the introduction of 21 PCT-employed Emergency Care Practitioners (ECPs) who lead local services. Central to the project has been the development of two local walk-in urgent care centres – one open 24 hours a day and the other open from 9-5. This redesign has enabled around 50,000 people to benefit from local treatment. Previously patients had to travel some nine miles to the nearest A&E department.

Key outcomes have been a reduction in A&E attendances of around 40 per cent, high levels of patient and staff satisfaction and the delivery of value-for-money services. One ECP said: "It is a positive experience, being at the forefront of pioneering changes in urgent care." A patient said: "I was treated with respect and found the consultation with the ECP to be very in-depth as well as sympathetic."

Idea: Develop walk-in urgent care centres and a new professional called Emergency Care Practitioners (ECPs)

Assessment context: Urgent care in the UK

	Typical good approach	Our service
Who	• Usual NHS clinicians and staff	**Same as typical approach plus:** • ECPs
What	• Patients seek care at GP surgeries or A&E • A few walk-in urgent care centres exist in some parts of the country, but estimates are that only a small percentage of the population have access to these and they are typically staffed by doctors (therefore, there can be an issue of staffing costs)	• Establish a training programme for a new class of professional – the ECP • Set up conveniently located walk-in urgent care centres staffed and led by ECPs • Patients also have the choice to continue to seek care at GP surgeries or A&Es
When	• A&E access is 24/7 • GP surgery available in normal hours	**Same as typical approach plus:** • One walk-in centre is open 24/7 • Due to financial constraints, second centre open only 9-5
Where	A&E and GP surgery	Walk-in centres

Key results: *(tick one)* ☑ **Based on data** ☐ **Projected/expected**

- 50,000 patients treated in walk-in centres who would normally go to A&E – 40% reduction in A&E attendance
- Reduced burden on the A&Es where costs and waiting times are typically higher; study shows good value-for-money
- Patients receive care closer to home; less travel required
- High levels of patient satisfaction
- High levels of staff satisfaction
- No significant increase in adverse outcomes

Assessment for innovativeness and commentary…

This is a step change in workforce and in the patient's experience of care. The service is closer to home, waiting is reduced, and the care is less costly to provide. Performance results are clearly a step change. This meets our definition of a service innovation, provided that the assessment is accurate that such centres are rare across the UK (the context of interest) and that these ECPs are indeed a new class of professional. It would be good to show this to other, more nationally knowledgable colleagues to see what they say.

Although the location of care is new and the professional taking the lead is new, we wonder if the actual processes of care are not all that different from the A&E that it replaces? Do patients still have to register at the front desk, wait to be triaged by a nurse, then wait to see the ECP? If so, then focusing attention on the opportunity to innovative in the flows within the walk-in centre would be a challenge that might stimulate further innovative thinking.

Another important point is that while the second centre is only open 9-5 and this seems a step backwards compared with around the clock A&E access, it is not untypical for innovations to first be tested in limited settings until they are proven. This approach to managing the risk inherent in a new idea is a natural part of the innovation process and should not detract from the assessment of the idea itself.

Tool: Seven dimensions of performance

What is it?

The seven dimensions of performance are based on a health care measurement framework originally developed in the US and enhanced by leading thinkers in European countries. The seven dimensions and examples of potential things to measure are provided in the table below.

Safety

For example…

- Absence of errors
- Prevention of harm
- Conformance to standards
- Reliability

Timeliness

For example…

- Waiting time
- Time to treatment (or between any other clearly defined points in the process of care)
- Time required to complete a task

Effectiveness

For example…

- Clinical outcomes
- Improved functional status or quality of life
- Free from complications

Efficiency

For example…

- Cost
- Consumption of provider time or resources
- Consumption of user or carer's time or resources

Equity

For example…

- Greater access and availability to all
- Cultural sensitivity
- Closing the gap in past inequalities

Co-ordination (across the whole system)

For example…

- Flow across whole journey/system
- Integration of care plans
- Shared information or assessments

Patient-centredness

For example…

- Ease of use
- Convenience
- Portability
- Influence
- Choice
- Ease of understanding
- Engagement/involvement in care
- Self-management
- Fit to lifestyle or needs
- Experience of care (patient and/or carer)

How do I use it?

Use the seven dimensions and examples to stimulate your thinking about what you might measure in order to determine the impact of your change idea.

The basic question to ask is:

If my idea or change is really successful, what would I expect to observe?

When do I use it?

Consult the seven dimensions of performance tool ***before*** you implement or test your idea. This will help you plan for observation and data collection both before and after you implement your change.

Examples and tips

Example: Health coaches for people with diabetes.

The idea: Someone in the practice other than the doctor meets in person with and counsels over the telephone patients whose disease is not well controlled (according to goals based upon NICE guidelines) to help them think through how they might better incorporate diet, exercise, and medication advice into their daily lifestyle.

Use of the seven dimensions of performance tool:
If this effort is a success, what would we expect to observe?

- Dimension: Effectiveness (clinical outcomes)
  - Specific indicator: Percentage of patients who were not meeting haemoglobin A1c blood sugar goals (based on NICE guidelines) who are now meeting their goals after one year with a health coach. (Goals range from 6.5 to 7.5, based on risk factors. See… NHS National Diabetes Support Team. *NICE and Diabetes: A summary of relevant guidelines*. July 2006. Available at: www.diabetes.nhs.uk accessed 21 November 2007.)

Measurement and results: After a year, the practice nurse examines the medical records of 20 patients with diabetes who have been part of the scheme and compares their most recent blood test results with those prior to the scheme. He finds that 16 of 20 (80%) have gone from not meeting their haemoglobin A1c goals, to satisfactory results.

Tip: *While you do not necessarily need to design a formal research study, consider how you might provide a bit more rigour in your assessment in order to make an even stronger case for your change idea*

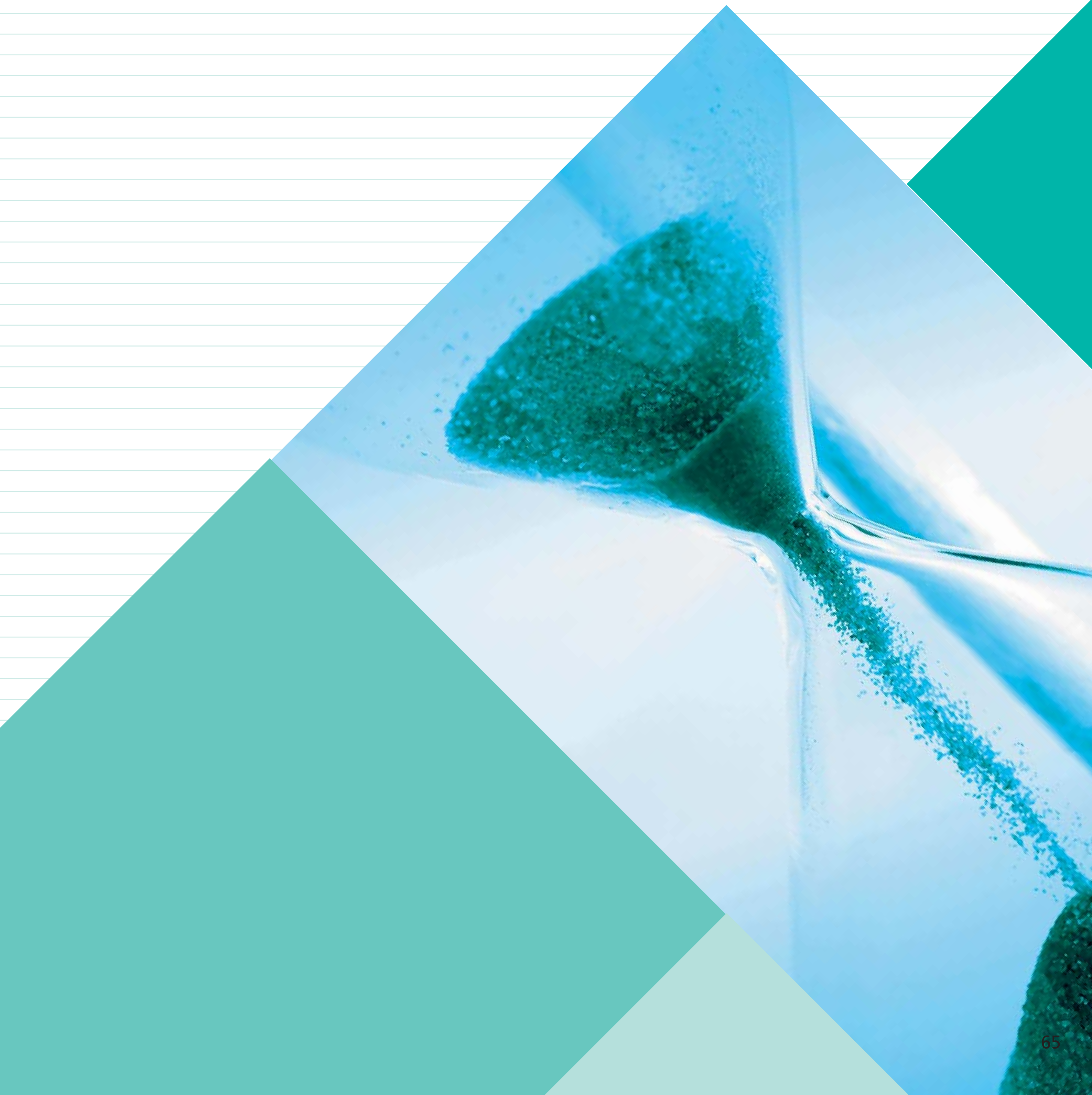
For example, the team in the health coaches example might have also done a comparison of this group of 20 patients to another group of poorly controlled people with diabetes who were not on the scheme (from within the practice or from a similar practice). Taking a larger sample, developing a formal registry, and/or a proper statistical analysis would be even better.

Tip: *Consider measurements in multiple dimensions*

Reflecting on other dimensions in the case of the health coaches example, it would be helpful to also gather data on the time and expense (resources) consumed by the health coaches under the Efficiency dimension. In addition, the team could gather at least some experience-based reports or stories from patients in the scheme regarding their sense of self-management, engagement in their own care, fit to lifestyle, and views about the service under the Patient-centredness dimension.

Tip: *If it is difficult to measure what you'd like to measure directly, look for something else to which you could make a plausible association. Be clever!*

For example, suppose you are working to lower infection rates in a hospital ward and you have come up with an innovative idea to improve compliance with hand washing standards (Effectiveness and Safety dimensions). Maybe you cannot watch over all staff at all times to record whether they have indeed washed their hands, but you could keep track of the usage of hand soap and gels. If more soap and gel is being used, it is reasonable to assume that more hand washing is going on.



Tool: Innovation claim framework

What is it?

The Innovation claim framework provides a structure for identifying a context to which you are comparing your idea as you assess its innovativeness. The contexts progress from narrow to broad as you go down the framework.

I am claiming that this idea is new and very different from the usual practice in…

- My immediate team or department
- My local organisation (e.g., PCT, Trust)
- My setting (e.g., GP practice, cardiology service) in my health economy
- Any setting in my health economy
- My setting across the country
- Any setting across the country
- My setting internationally
- Any setting internationally
- The world at large, across sectors, industries, etc.

How do I use it?

Use the Innovation claim framework both to achieve clarity on the comparison context and to stretch your thinking beyond your local context.

The basic questions to ask are:

1. To what setting am I claiming that my idea is innovative compared with usual practice?
2. To what other, broader settings would it be interesting and challenging to compare my idea?

Examples and tips

Example: Health coaches for people with diabetes

Use of the innovation claim framework: The team decides to assess the innovativeness of the health coaches ideas compared with the typical approach to care for patients with diabetes across their PCT. As a further stretch, the GP on the team suggests that she will do a literature search so that they can compare their work with best practices around the world in hopes that they might get further ideas for local innovation.

Tip: Strive to go at least 2-4 levels further in the framework beyond the obvious or initial comparison context.

Tip: Do not let comparisons beyond your local context discourage you. Rather, let them spur you on to even better ideas.

If an idea represents a change for you locally and is better than what you were doing before, then it is a good idea and you should be proud of your efforts. You have made a difference for your patients and their carers and you should celebrate that fact.

At the same time, use what you learn by comparing your idea with a broader context to challenge your thinking and encourage you to do even more to deliver the very best service possible to your patients and their carers. That is ***making a bigger difference!***

Tool: 4Ws table

What is it?

The 4Ws table guides assessment of the innovativeness of an idea by providing a side-by-side comparison regarding **Who** is primarily involved in delivering the care, **Where** and **When** it is delivered, and **What** the patients and carers experience while receiving the care.

Idea:

Comparison context:

	Typical good approach	Our idea
Who		
What		
When		
Where		

Key results: *(tick one)* ☐ **Based on data** ☐ **Projected/expected**

How do I use it?

Use the 4Ws table to clarify your thinking about what is really different about your new idea compared with usual practice. Also use the table to further challenge and stretch your thinking.

The basic questions to ask are:

1. How would I describe my idea?
2. How is it different from usual practice?
3. How could I further extend my idea and make it even more innovative?

When do I use it?

Construct a 4Ws table when you have a fully developed idea that you are ready to assess.

Examples and tips

The steps below illustrate the construction of a 4Ws table, along with several tips, for the idea of health coaches for people with diabetes in a GP practice. Additional examples are provided in the **Further examples and commentary** section of this appendix.

Further examples and commentary 51

Innovation claim framework 24

1. **Define the context for the assessment.** This is described in Step 2 of our process using the ***innovation claim framework*** tool.

   Our team wishes to compare their new service with the usual practice for handling patients with uncontrolled diabetes across the PCT. They write: 'GP practices in the Bloggton PCT'.

2. **Create column headings to describe the typical good approach and your idea.** Note the phrase 'typical good approach'. We want to compare our new idea with some of the best that the current system routinely offers. It is no real credit to your team if all you show is that your idea is much better than some of the worst things that go on in the current system. Set a high standard. We would even challenge you to consider labelling this first column 'best known current practice' and really set a high bar.

   However, in either case, this column is about best *routine* current practice, not what might happen to only a rare few patients under very special circumstances. Indeed, your innovative idea might be to take something that happens very rarely and make it the routine practice. Reflecting on what you do in special cases can be a very good source for service innovation ideas.

   The team writes: 'Typical good approach across our PCT for people with uncontrolled diabetes' as the heading for the first column, and 'Diabetes health coaches' as the heading for the second.

3. **Fill in the cells under each column with a brief description – a bullet list will do – using the information below as a guide.**

   a. **Who.** List the individuals who are *most actively and directly involved in delivering the care*. Avoid listing everyone who may have some peripheral involvement; focus on the main characters only.

   Especially think carefully before you list the patient or carers. Are they really *actively* involved in *delivering* the care, or are they passive participants and recipients of care? The simple fact is that the latter is most often the case. Examples of patients being active in delivery of care include:

   - Self-adjustment of medications using a protocol from a clinician,
   - Regular self-monitoring where the measurements are actually used in the care process (trusted and not repeated by clinicians),
   - Making important and real choices about critical aspect of the care based on information and genuine options described by clinicians.

   Remember, we are trying to set a high bar for the use of the term 'service innovation'. Most of the mild forms of patient involvement we see today are no longer considered innovative (they are now expected really).

   The team writes: 'GP, practice nurse' under the typical good approach column and 'GP, practice nurse, health coach, patient/carer' in the second column.

   There is some debate as to whether 'patient' should be included under the usual approach, but there is general agreement that actually the patient is often little more than a passive recipient of information – and that is sometimes why their diabetes is uncontrolled!

   b. **What.** Describe the key, relevant elements of the care process experienced by the patients and carers. By relevant we mean: relevant to the comparison that you wish to make. Focus on the things that you think are really different about your idea and contrast them with what happens in the typical approach – keeping in mind that you want to compare with the best that the current system routinely offers to patients and carers. Avoid exaggerated, judgmental, or pejorative statements. Be fair and positive about both the current and new approaches. Mentally stepping through the flow of the process, or telling a story of a typical patient's journey and experience, might help you determine what to put in this row.

   Under the usual approach column the team writes: 'Patient's condition is monitored via periodic visits to the GP, GP and practice nurse provide advice and education regarding required lifestyle changes, patient and carer invited to periodic educational classes.'

   Under the health coaches column the team writes: 'Same as usual approach plus…, GP identifies patients requiring extra help and introduces health coach to patient, health coach establishes ongoing and frequent telephone contact focused on lifestyle changes, patient/carer sets agenda for changes they are willing to make, both patient/ carer and coach can initiate contact, coach available to meet with patient/carer in home or community.'

Example of a 4Ws table for the idea of health coaches in a GP practice for people with diabetes.

Idea: Health coaches in a GP practice for people with diabetes

Assessment context: GP practices in the Bloggton PCT

	Typical good approach across our PCT for people with uncontrolled diabetes	Diabetes health coaches
Who	• GP • Practice nurse	• GP • Practice nurse • Health coach • Patient/carer
What	• Patient's condition is monitored via periodic visits to the GP • GP and practice nurse provide advice and education regarding required lifestyle changes • Patient and carer invited to periodic educational classes	**Same as usual approach plus…** • GP identifies patients requiring extra help and introduces health coach to patient • Health coach establishes ongoing and frequent telephone contact focused on lifestyle changes • Patient/carer sets agenda for changes they are willing to make • Both patient/carer and coach can initiate contact • Coach available to meet with patient/carer in home or community
When	Normal surgery hours	Normal surgery hours
Where	• Mostly in the surgery • Occasional home visits, or phone calls to patients who could be anywhere to take the call	**Same as usual care plus…** • The main focus shifts to telephone contact which the patient/carer can take anywhere • Coach also available to meet with patient/carer in the community as needed (e.g., go grocery shopping).

Key results: *(tick one)* ☑ **Based on data** ☐ **Projected/expected**

- Review of the records of 20 patients with poor control of HbA1c prior to introduction of the scheme show that 16 (80%) had a most recent reading within their target range
- Many positive comments from patients on the scheme

The next two rows – When and Where – should follow on from the points in the What row. Obviously, activities and choices that impact a patient's health are going on at all hours of the day, and wherever the patient is. However, we want to focus on when and where the specific service delivery items described in the What row are taking place.

c. **When.** Note the times when the activities described in the What row are available to the patient/carer. Think carefully and critically here and avoid unfairly exaggerating your idea relative to the usual approach.

Our team begins by writing: 'Normal surgery hours' under the typical approach and '24/7/365' under the health coaches idea.

A team member notes: "Because we now have these patients more engaged in self-care, they are really working on their lifestyle all the time."

But another team member comments: "Come on, be fair. The patient was just as fully empowered to work on their lifestyle around the clock under the usual approach, weren't they? The new service that we are offering and have just described in the What box revolves around the health coach. And we all know that the health coach is only available during normal surgery hours. The patient can initiate a call to the coach any time, but the coach only answers the phone during normal hours. My point is that the new service we are offering is really only available during normal hours as well."

They agree – reluctantly – and change the entry to 'normal surgery hours' in both columns.

d. **Where.** Likewise, note here the place where the patient and carer experience the care described in the What row. Again, be critical and fair in your comparison.

After having to give in a little on the When description, the first team member quickly points out that while the usual care requires that the patient turn up at the surgery, with the new telephone-based service the patient can be anywhere. Everyone agrees that this is a fair point. But in further fairness, someone else points out that even in usual care the GP or nurse might make a home visit or have a telephone chat. While this does not happen all that often, it is a part of what is considered routine and should be noted as such.

In the typical approach column the team writes: 'Mostly in the surgery, occasional home visits or phone calls to patients who could be anywhere to take the call'. In the health coaches column they write: 'Same as usual care plus… the main focus shifts to telephone contact which the patient/carer can take anywhere, coach also available to meet with patient/carer in the community as needed (e.g., to go grocery shopping).'

14 Seven dimensions of performance

4. **Note the impact on performance in the key results section.** See Step 1 and the ***seven dimensions of performance*** for more about this. Note whether you have data to back up your claims.

   The completed table, with the performance results previously noted is shown on page 71.

5. **Review the 4Ws table for accuracy.** It is important to test the 4Ws table for completeness and fairness by discussing it with those involved in the service innovation, and with colleagues familiar with the typical good approach in the context you are assessing.

   - Read down the column describing the potential service innovation to make sure that you have described it completely, accurately, and fairly. If you make modifications, review the corresponding cell under the usual approach to see if you need to modify there as well. Don't exaggerate.

   - Now read down the column for the typical good approach to assure completeness, accuracy, and fairness. This should be done with colleagues not on the team, but who are familiar with the usual approach in the context of interest. The test is that after hearing the description of the usual approach they should say: "Yes, that is a fair description of what typically happens in good sites."

Be open to the possibility that you might learn that your idea, or a part of it, is actually already being done elsewhere within your context, or in a broader context. This does not negate the fact that you and your team are to be given full marks for coming up with the idea independently. But, in fairness, you cannot really call your idea 'innovative' if it is already being done routinely by others. You might say that it is innovative in a smaller context – for example, innovative for you and your organisation, but not for the health economy as a whole.

When one has put so much effort into a new approach it is only natural to play up the good points of the idea and perhaps be a bit less generous in describing the usual approach that it replaces. This might even slip over into somewhat critical or negative statements about the usual approach such as: "Rushed GP will only spend a few minutes with patient" or "Patients/carers can only get care by coming into the surgery". Such statements are not helpful – and, of course, are not true. Putting your 4Ws table to the test by reviewing it with knowledgeable colleagues within and outside your team will help to avoid this.

6. **Reflect on the 4Ws table for the purpose of stimulating more ideas.** An added benefit of a 4Ws table is that you will often find that new ideas emerge naturally from the dialogue and thinking that go into constructing it. Immediately following the construction is a good time to capture some of that new thinking. Consider some of the following questions…

   Reflecting on the headline for the idea…

   - Can we see a way to extend the application of the idea beyond current boundaries (e.g., to other types of patients or to other settings)?

   Reflecting on the Who line…

   - Are there opportunities to include more or other people in active involvement in this care process?
   - Who can we partner with or link to in order to expand the benefits of the idea?
   - Can we possibly modify someone's role and redeploy him or her elsewhere?

   Reflecting on the What line…

   - What are the essential differences in what we are doing compared with the usual approach?
   - What have we left essentially unchanged in the process and what new ideas does that stimulate?
   - As we look at the details of what we did, can we expand on some of these?
   - How might technology help us do this even better?

   Reflecting on the When line…

   - How can we get even closer to the ideal of making health service available around the clock?
   - Should we consider reviewing the time frame in which this service is available in order to reduce cost or waste, better focus the effort, or better serve the patients and carers?

   Reflecting on the Where line…

   - Where else could we offer this?
   - Where do the patients and carers naturally go in their daily lives and how can we better link this new idea up with those places?
   - Have we considered the needs of patients who cannot leave their homes, or for whom transportation is difficult?

This is by no means an exhaustive list of questions. Simply let the thinking and reflection flow naturally in your team and among your colleagues and you may be surprised what comes out of it.

Referring to the 4Ws table for our example of the health coaches for people with diabetes…

The team held a quick brainstorming session using the questions on the previous page to stimulate thinking and came up with the following additional ideas…

- Extend the use of health coaches to other chronic diseases.
- Provide health coaches to people who are not yet in poor control of their chronic illness, but are at risk. Maybe health coaches can intervene earlier in helping to build good lifestyle habits in order to prevent further progression of a condition.
- Health coaches for people following an episode of illness; think of them as another form of rehabilitation or therapy following an illness.
- Explore the use of interactive technology on the web to enhance the telephone calls (e.g., use of video links, having both the coach and individual being able to work on a document on the screen together).
- Train more coaches in the community to handle cases where high levels of clinical knowledge are not needed; use volunteers or peers who have dealt with similar issues.
- Think about others in the community who could meet with patients face to face to help them; for example, partnerships with voluntary sector agencies, a registered dietician, social services, etc.
- Make coaches available outside normal surgery hours. Work with NHS Choices to establish a service that, while not having the same personal relationship with the individual, would still be helpful outside normal clinic hours.
- Other settings in the community where coaching could take place… would local shop managers, pub owners, or community pharmacists be willing to provide focused help in partnership with us?

This team is really stretching its thinking now! This does not diminish the existing idea, but it certainly points to some even bigger differences that could be made.

Glossary of terms

4Ws of health service delivery: ***Who*** is involved in delivering the care, ***where*** and ***when*** it is delivered, and ***what*** the patients and their carers experience while receiving the care.

Adaptation: A change that results from the natural spread of an existing idea that has been applied elsewhere within our context. ***For example…*** a version of a one-stop service for a certain group of patients, when you know that it has already been done before within the context you are assessing).

Comparison context: The setting or system against which one wishes to consider the innovativeness of a particular idea.

First order change: *See incremental change.*

Incremental change: Making something a bit better and/or a change that maintains most of the underpinning thinking that we have come to take for granted as "the way it has always been" (sometimes called 'first order change').

Innovation: Doing things differently, and doing different things, to create a step change in performance.

Paradigm: Our usual thinking, traditions, or assumptions about how we do something. *For example…* the receptionist at the GP surgery with whom you must check in when you arrive is a paradigm associated with how we acknowledge the arrival of a service user. It is not the only way to do things (a kiosk would be another way) but it is the way we have traditionally done it.

Second order change: *See step change.*

Service innovation: A step change in the Who, What, When, or Where of service delivery – compared with the usual approach in the context of interest – that produces a step change in performance when implemented.

Step change: Achieving large gains in performance and/or fundamentally rethinking some of the things that we have come to take for granted as 'the way it has always been' (sometimes called 'second order change').

Thank you

The development of this book has been an exciting and truly collaborative process. We would like to thank everyone within the NHS and International health care systems who contributed their enthusiasm, experiences and knowledge throughout the different sections and case studies.

The core design and content team for **Making a bigger difference** are:
Lynne Maher, Paul Plsek, Helen Bevan.

Make a bigger difference

A guide for NHS front-line staff and leaders on assessing and stimulating service innovation

The health care environment is rapidly changing amid the rising expectations of the public, politicians and professionals. Fortunately, continuous improvement has always been a health care ethos. But now, in addition to incremental change, it is even more essential that we stimulate innovation – doing things differently, and doing different things, to create a step-change in performance – if we are to deliver against today's challenges. You and your colleagues at the front-lines of care might have some ideas for making health service delivery better, but are they as innovative as they could be? Or, perhaps you are a health care leader who wonders: Is my organisation meeting the challenge of service delivery innovation, and how might I stimulate even more? This useful guide describes a 5-step process, with supportive tools, for assessing and stimulating service delivery innovations. It provides a wealth of practical tips for application by both front-line staff and organisational leaders. Examples and case studies drawn from a cross-section of health care settings illustrate the methods at a hands-on level that will really stretch your thinking. Health care in the 21st century needs your energy and your innovative ideas. What are you waiting for?

"Health care systems around the world are engaged in striving to make radical and sustainable changes...The words…leave no doubt that what is being envisaged is big, bold, transformational change…Internationally, there is a parallel realisation and understanding that the design of the existing health care system will not deliver what is required for the future."

Bate, P., Robert, G. & Bevan, H. (2004). The next phase of health care improvement: what can we learn from social movements? Quality and Safety in Health Care, 13 (1), 62-66.

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