

Futureproofing our NHS: A generational shift

Views from a Student-led Health Commission

March 2018



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Ushering in a future perspective

It is often said that the generation who ushered in the NHS 70 years ago have different expectations from their counterparts today. If that's true, then what would the NHS look like if it were being redesigned by that generation today? We wanted to seek out and explore [the perspectives of the future users of the NHS on how to 'radically' upgrade the health and social care system](#).

We established a Student-led Health Commission to employ a group of students and recent alumni from across the different Faculties at King's College London to gain insights from young people on how the NHS can better deliver for the future. To address the task, we set out four guiding principles. The Commission would:

1. **Engage the future users of the service.** By involving young people now, we can expect 'buy in' from those who will use the service in 15 years' time.
2. **Include people who think differently.** We want radical and creative individuals with a vested interest in health and social care, who understand the current context but are unconstrained by baggage of the present or past.
3. **Create a space for participants to come together and deliberate upon different aspects of health and care, and to debate potential policy options.** By giving them the tools and the time, the Commission members can better inform themselves to work collaboratively, source solutions from a broad range of options and develop recommendations.
4. **Train and develop the next generation of health and social care leaders.** By guiding the commissioners on how to do policy analysis and explaining the life cycle of a policy, we hope to build engaged leaders for tomorrow.

To find 'out of the box' thinkers, we asked applicants to pitch a creative solution to improve health and social care in the UK. The Policy Institute at King's selected and employed students and recent alumni to work on the Commission, and over a period of nine months our team prepared them for the ambitious initiative that lay ahead.

The King's College London staff team, including Dr Saba Hinrichs-Krapels, Alexandra Pollitt and Erin Montague, provided training and mentoring, as well as connecting the commissioners to prominent stakeholders through the Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care and other policy networks. The commissioners honed these new skills and facilitated policy labs (small, interactive workshops) with key stakeholders, experts and people of interest. They also collected and analysed data from interviews, surveys and desk research, to arrive at the 10 recommendations outlined in this report.

The 17 commissioners have generated recommendations which are practical and actionable now. As you read this report, we ask that you consider to whom we can present these recommendations and how you can support us to build a social movement for change. We hope you will help us generate support for the insights of the next generation of service users and workforce, so that together we can deliver solutions which will futureproof today's NHS.

Sincerely,

Anne Marie Rafferty CBE, Professor of Nursing Policy, King's College London
Jonathan Grant, Vice-President/Vice-Principal (Service), King's College London,
and Professor of Public Policy

Report summary

Our task

As it approaches its 70th anniversary, the NHS is faced with increasing demand and insufficient resources to meet it. This report, *Futureproofing our NHS: A generational shift*, is the product of an initiative that originated at King's College London. In a quest to generate fresh and original thinking about the current and future challenges faced by the NHS, the Policy Institute at King's College London recruited a diverse group of forward-thinking students and recent graduates. We, a Student-led Health Commission, were tasked with identifying young people's views of what they want a healthcare system to deliver in the future. Our outputs were not expected to match existing strategy or current thinking – instead, we were encouraged to take a fresh look at the future role of the NHS. While NHS England supported the Commission, we had editorial independence to ensure this report accurately reflected our findings and our voice.

Our approach

The outlook of the Commission has been overwhelmingly positive. Every member is proud to be associated with one of the most celebrated organisations in the modern world. Indeed, our priorities have centred on creating a fairer and more dynamic system for both patients and employees; we have been less focused on economic modelling or financial viability. Yet it is clear to us, as representatives of a younger generation, that staff happiness, motivation and passion can make a huge difference to the overall success of the NHS. These factors have a direct influence on patient care and quality of healthcare services.

Our 15-year vision: 2018–2033

Over the next 15 years, our generation will be dealing with changes brought about by Brexit, continuing trends of non-communicable diseases among an aging population and the growing influence of technology. We believe in an NHS which is free to be flexible, inclusive and innovative. Our recommendations aim to make this a reality.

Given current political events and activity, we expect a future characterised by uncertainty. We must, therefore, be prepared for any eventuality which may affect our workforce, healthcare budget and the delivery of healthcare – whether positive or negative. We believe that flexibility and innovative thinking lie at the heart of overcoming the challenges we will face in the future.

We see a future in which current healthcare trends, should they continue, will encumber service delivery. We anticipate a progressively aging population managing increasingly complex and numerous health conditions. In particular, we foresee a continuing rise in life-long diseases such as obesity, with associated diabetes and age-related illnesses. We feel that inclusivity and innovation will play a vital role in tackling these trends. Through greater inclusivity, we foresee patients and staff working together to balance the interests of patients, while also recognising the voices of healthcare workers. We believe in an NHS in which service users and healthcare workers feel supported to innovate and generate creative solutions.

Technology is already an integral part of our day-to-day lives, and we believe in an NHS that embraces new advances, not one that fails to keep pace with our fast-moving society. We visualise a widespread move towards paperless electronic records. We believe in the use of technology to build networks and encourage social inclusion. We imagine a digital era which encourages connection, innovation and healthy living.

Our recommendations are intended to introduce this vision against our predicted backdrop.

Themes

We identified three main themes to guide our agenda: ‘**shared health**’, ‘**workforce**’, and ‘**normovation**’, with the latter referring to the integration of innovation into everyday practice. In order for our NHS to be sustainable for the future, we also identified a need for a long-term vision shared between patients, politicians and the workforce, i.e. a ‘**depoliticising**’ of the NHS.

Through group discussion, research, and small, informal, interactive workshops called ‘policy labs,’ we formulated novel solutions with medium- to long-term impact. This led us to the 10 recommendations outlined in the box to the right.

Freedom is the ‘golden thread’ which runs through the core of our insights. We recognise that staff and patients have a direct impact on each other, but neither has sufficient autonomy to optimise outcomes for mutual gain. Both groups must be equipped with the tools needed to enable and leverage greater freedom within the NHS. This is reflected in our three main themes:

- By **shared health**, we mean the freedom to access targeted resources and tailored support that enables people to lead healthy lifestyles. We have identified tools that can be used to facilitate this through health networks, generating health capital.
- The **workforce** can be given the freedom to achieve work-life balance by introducing flexible, adaptable rotas and the ability to change careers, empowering staff to have more autonomy over their work. By redesigning the workforce, the NHS can better meet increasing demand, while maintaining patient safety.
- **Normovation** is the idea that innovation is implemented in everyday practice, and in so doing, staff and patients have the freedom to apply ideas in order to bring about change.

This requires a ‘depoliticised’ NHS, as freedom will not be possible if there is too much political intervention.

We want the NHS to give staff and patients these tools now, so that in 15 years our vision will be a reality.

Summary of practical recommendations

Depoliticise the NHS to secure sustainability

1. Establish an **Independent Health Policy Committee**, modelled on the Monetary Policy Committee.

Shared health

2. Ensure all communities have a multi-layered support system consisting of a **Health Champion** and **Health Coach**.

3. Bring **healthcare to everyday locations** to encourage consistent health promotion beyond clinical settings.

4. Create an integrated ‘**shared health**’ **digital platform** to connect social network communities and enable the next generation to live healthy lifestyles.

Workforce

5. Support **re-specialisation** and offer **greater flexibility in access to career opportunities** for staff.

6. Step up **flexible staffing** to give rota managers the power to customise and incentivise rotas according to local demand.

7. **Support patients** in using services efficiently and communicating their needs and preferences.

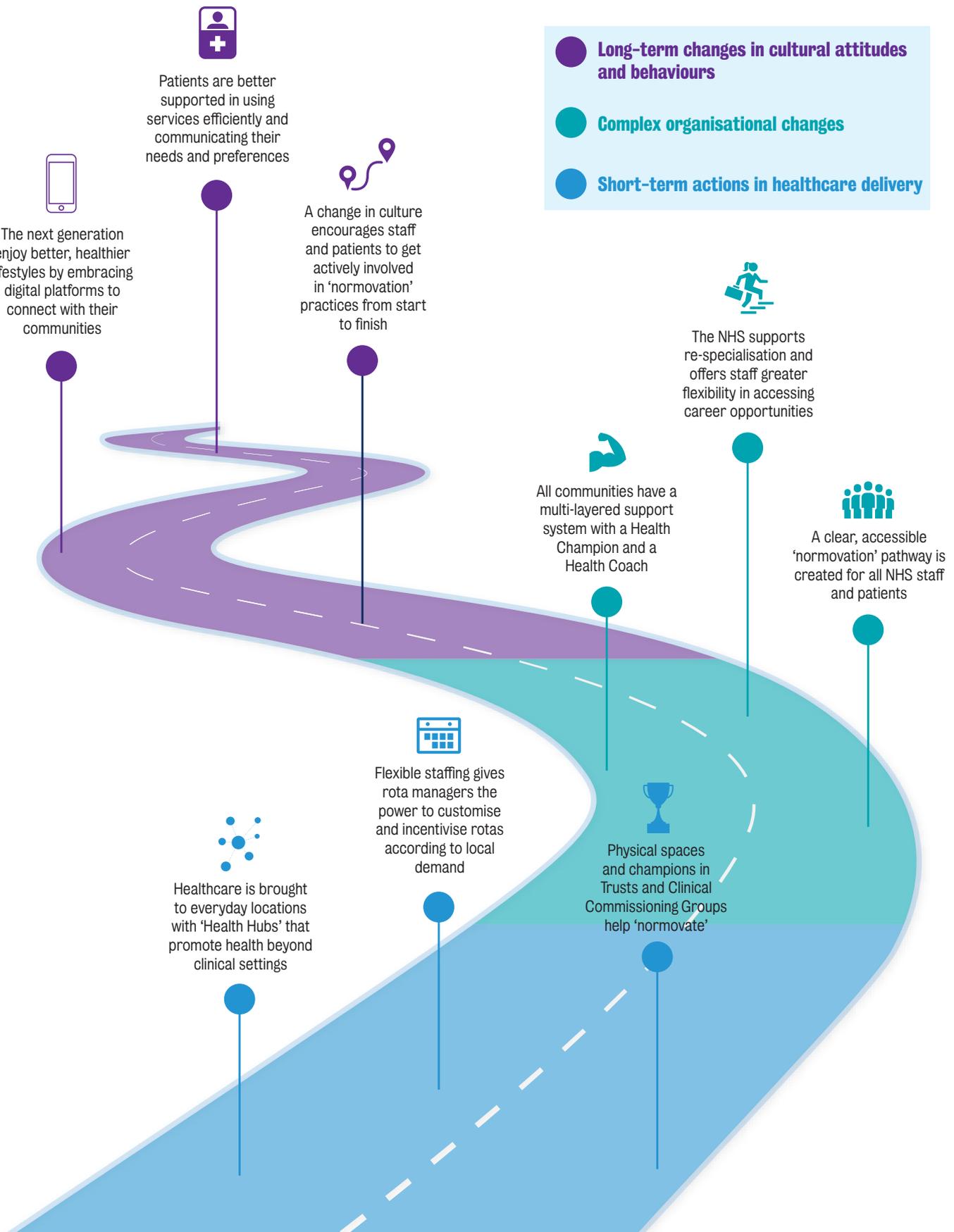
Normovation

8. Create a **clear, accessible normovation pathway** for all NHS staff and patients.

9. Embed a **cultural shift by involving staff and patients** in the practice of **normovation** from start to finish, in a movement towards **open innovation**.

10. Trusts and Clinical Commissioning Groups (CCGs) should issue **physical spaces and champions for normovation**.

The future of the NHS over the next 15 years in a depoliticised landscape



Prologue

As the rain beats down against the window, Becky prepares to leave for the hospital. A sense of dread fills the pit of her stomach, knowing she will have to return to the place to which she has dedicated so many years. It is with sadness that she thinks about seeing Margaret there today. Margaret, a neighbour for many years, has been more like an aunt to Becky.

Becky thinks back to 15 years ago. The transformation in both herself and Margaret feels stark. She feels that they have both been failed by a health system struggling under strain. Becky had battled with deciding whether nursing was the right option for her, while she saw Margaret battling with her weight at the same time and felt unsure as to how she could help.

As Becky embarked upon her nurse training, her unease grew. She heard people speak of the overwhelming working conditions that would await her. During this time, Margaret continued to gain weight and was prescribed antidepressants after visiting her general practitioner and complaining of feeling low.

Upon beginning her nursing career, Becky quickly felt the reality of the working conditions she had feared. The long hours and inflexibility of her rota made her feel her work-life balance was slipping away. She felt that community nursing would offer her some of the changes she needed.

However, the difficulty in transitioning to the role and the pay cut she was required to take made the option feel impossible. It was months since Becky had managed to see Margaret and she had now heard that Margaret had type 2 diabetes.

Becky had ideas for how to improve some of the systems on her ward but these were inconsistently taken up by the ward manager. When her ideas were carried forward, Becky felt frustrated that they did not permeate further than her ward – not even down the corridor.

Becky considered handing her notice in many times; the stress continued to mount and she no longer felt she was being the best possible nurse she could be. Increasingly unrealistic targets were set by those above her. The sight of queues of people stretching outside the door in need of care no longer shocked Becky. Where she had once felt compassion and thought of Margaret when she saw patients with preventable illnesses, she now felt frustration and resentment.

On the day Becky decided to hand her notice in, she received a phone call from Margaret, who explained between tears that she was going to have her foot amputated. This resulted from complications following her diabetes, which she had struggled to manage.

As Becky grabs her umbrella to go and visit Margaret on the ward following her surgery, she reflects sadly on both their journeys through the health system, wishing they could have been different.

Introduction

This July, the NHS celebrates its 70th birthday. This is an opportunity for us to reflect proudly on the achievements of our health service and consider what the future might bring.

We – a Student-led Health Commission – were asked to visualise what the NHS should look like on its 85th birthday, in 2033. We were challenged to identify young people's views of what our healthcare system should deliver in the future, producing a novel vision looking forward 15 years.

The Commission was drawn from students and recent graduates with a wide range of academic and geographic backgrounds – from Medicine to English Literature, and from Romania to Malaysia. We were recruited and mentored by staff from King's College London to carry out policy analysis relating to the sustainability and improvement of the health service. The Commission was supported by NHS England.

As a Commission of young people, some of whom are embarking on careers in the health service and all of whom have experience of the NHS either directly or through friends and family, we wanted to rewrite the narrative of two individuals, Becky and Margaret, found in the prologue and epilogue of this report.

Through discussion, research, analysis and reflection, we identified three big issues that we felt needed rethinking in the NHS: (1) the way we tackle prevention, (2) the way we support the workforce, and (3) the way we respond to innovation. These form the three themes highlighted in this report: 'shared health', 'workforce', and 'normovation', with the latter referring to the integration of innovation into everyday practice.

In developing our agenda, we asked how the political context of the NHS hinders or facilitates its success. An additional theme used for our report is therefore 'depoliticising the NHS to secure sustainability'.

Over the autumn of 2017, we conducted research and held 'policy labs' to develop our ideas, which culminated in this final report of our findings and recommendations. On Friday 16 March 2018, we hosted an 'unconference', to share and build on our ideas with a range of participants, including senior NHS leadership.

The 'golden thread' that runs through our analysis is the recognition that **freedom** is vital to how services are delivered in the future. We recognise that staff and patients have a direct impact on each other. Currently, neither group has the power to maximise this relationship. Both groups must be equipped with the tools needed to enable and leverage greater freedom within the NHS. It starts with a depoliticised health service, a shift of power, because it is our opinion that freedom cannot happen with political intervention.

This report is interlaced with case studies to highlight projects and initiatives we feel have worked well. These signpost readers to ways in which, together, we can work to transform the NHS into a system that can meet its challenges. In this report, the reader is invited to follow the illustrative story of Becky and Margaret, whose lives are affected by the way the NHS functions. We request you keep them in the back of your mind while reading our findings and recommendations, as their stories demonstrate the better future we aspire to achieve.





Depoliticise the NHS to secure sustainability

All aboard for lasting change

The NHS will touch the lives of almost everybody in the population. Through its success, the NHS has built a world-renowned reputation as being the most trusted of public institutions.¹ This gives it almost sacrosanct status as one of Britain’s most cherished institutions.^{2,3}

Ensuring that patient care comes first remains a central priority, and the NHS has taken strides to detach decision-making from political agendas. Since its establishment in 1948, the government has enacted policies to ensure operational independence of the NHS at ‘arm’s length’ from the Department of Health. But it is also the case that the NHS has been, is and will continue to be a political football driven by short-term priorities.

We sense that the public is aware of the influence of political priorities on the NHS,⁴ and that there is a desire for the NHS to be owned by and contributed to by everyone, shifting power away from politicians. An Ipsos MORI survey for the British Medical Association in 2014 found that 73% of the approximately 2,000 surveyed adults in the UK believed that policies designed by political parties about the NHS are there to win votes, not do what is best for the health service.⁵ The same survey found that two-thirds of the public were in favour of doctors having a greater say in how the NHS is run. We seek to further strengthen the independence of the NHS and protect it from short-term political priorities by establishing a body operating in much the same way as the Monetary Policy Committee (MPC).

In 1998, the government handed over responsibility for monetary policy, and specifically interest rates, to an independent committee at the Bank of England. The rationale was that political factors were influencing decision-making and therefore had the potential to destabilise the economic environment. Thus, members of the MPC were expected to have expertise in the field of economics and monetary policy, but not represent groups or geographical areas – they would instead be independent.

The MPC reduced the political grip on monetary policy. What if a similar principle were applied to the NHS?⁶ An independent Health Policy Committee, with the power to set priorities, could protect the long-term (15 years plus) interests of the NHS, without it having to battle the short five-year life cycle of the UK’s party-political system.

The aim of this report is to identify possible areas of improvement in the way the NHS functions, and to suggest how they may be implemented. The reason for commenting on the political landscape in which the NHS currently resides is that, throughout the Commission, we have perceived it as a major barrier to operational independence. On the themes outlined in this report – ‘shared health’, ‘workforce’ and ‘normovation’ – a power shift is required.

We do not believe that Becky and Margaret will have a better future if the NHS continues as it is: a key pawn in a political chess game. It must be depoliticised. This underpins our first recommendation:

1 **Recommendation**
Establish an **Independent Health Policy Committee**, modelled on the Monetary Policy Committee.



Shared health

Creating and nurturing health capital

Current NHS resources are failing to keep up with demand. In the future, greater numbers of people will require healthcare, and the predicted deficit of the NHS could result in a growing gap between what is expected by patients and what can actually be delivered.⁷ We need a new and radical way of rethinking our relationship with health and care if we wish for demand to not outstrip supply.

We propose that decision-makers at the NHS (and at the Department of Health and Social Care) support a social movement that prioritises shared health at its core. Through this, individuals, communities, groups and organisations can come together around common ideas relating to healthy lifestyle choices. This will turn the NHS on its head – *from a top-down monolith, to a bottom-up movement.*

Definition: health capital
The access people have to educational health information and networks which support and encourage healthy behaviours. Providing opportunities to increase motivation and ability to improve health and wellbeing.

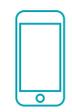
Every day, members of our generation interact with friends through social media. We represent the ‘social media generation’, globally connected through relationships sustained by small, steady interactions over various platforms. These platforms create communities, both virtual and physical; they provide people who have common interests, viewpoints and opinions with a tool to come together. This defining characteristic of our generation is something we wish to build into the future NHS. We envisage improvements in the health of the UK by creating a community-led, community-owned and community-delivered social movement for shared health.

Under shared health, we have three sub-themes, which we will look at in turn.

Shared health sub-themes

 **Shared health:** providing targeted and tailored support to communities

 **‘A nudge a day keeps poor health at bay’:** taking healthcare away from the clinical setting and integrating it into the community

 **‘Swipe right’ on health:** using digital technologies to create a network that mobilises the existing assets of the community

a) Shared health: providing targeted and tailored support to communities

Health Coaches and Health Champions currently exist in some communities as part of an initiative of social prescribing endorsed by NHS England in the *General Practice Forward View*.^{8,9} Social prescribing is a means of enabling primary care professionals to refer people to local non-clinical services. There is a body of evidence to support the benefits of these roles, including improved patient outcomes, reduced demand for GP appointments, and financial savings for health services.^{10,11,12,13} However, the current system is inconsistent, and in many areas Health Coaches are not supported by the presence of Health Champions.¹⁴

2 Recommendation
Ensure all communities have a multi-layered support system consisting of a **Health Champion** and **Health Coach**.

The support offered by Health Champions and Coaches should holistically consider physical and mental health to help those with long-term conditions manage their care. Aspects of people's lifestyles, including diet, exercise, mental health, social isolation and knowledge of disease prevention should be incorporated, providing people with the tools to improve their own wellbeing. We see these two roles working side by side, as shown in Table 1.

When interviewed about the Health Champion role, one expert stated, 'we need to be thinking upstream – it's a lot more than behavioural change; it's about goal setting and action planning'. She further commented that 'we live in an obesogenic society' and that modern lifestyles were a leading cause of this. This statement puts the magnitude of our task into

perspective and is supported by evidence from Public Health England,¹⁵ identifying that adult obesity is expected to reach 70% by 2034.

The Health Champion initiative has been mainly used to target communities viewed as 'hard to reach'. For example, in our interviews, we discovered a voluntary women's group targeted towards women of ethnic minority backgrounds; for over 70% of those attending, it was the first time they had participated in a community event providing information about public health. Such initiatives are capable of greatly empowering marginalised groups. The role of a Health Champion could be the first level of support within the community, with the Health Coach providing extra support for those who need this onward referral.

Table 1: The complementary roles of a Health Coach and Health Champion

Health Coach	Health Champion
<p>This is a paid role for which people apply. They are also often referred to as 'link workers', 'care navigators' or 'health advisors' across current social prescribing schemes.</p> <p>Referrals of individuals to Health Coaches can come from health professionals, Health Champions or self-referral.</p>	<p>The Community Health Champions Evidence Review has defined a 'Health Champion' as an 'individual(s) who volunteers to informally or formally promote health within their communities.'</p> <p>Currently anyone can register to become a Health Champion by downloading resources from the Public Health England website. We suggest an application system and formal training delivered by Health Coaches.</p>
<p>Role:</p> <ul style="list-style-type: none"> • Build up knowledge of groups and organisations in the local community and develop links with them. • Provide more intensive support, helping people to identify their needs and goals and – where required – develop a support plan. • Hold weekly follow-up meetings with individuals receiving support, to review their progress. • Make referrals to support groups and accompany people for the first visit, where needed. • Provide basic-level training to, and maintain links with, Health Champions, sharing and receiving information about local community groups and organisations. 	<p>Role:</p> <ul style="list-style-type: none"> • Peer education: advise individuals through shared characteristics (e.g. ethnicity or age group) or shared experience (e.g. motherhood or diabetes). • Utilise their training to provide advice on how to improve wellbeing. • Signpost people to activities and groups in their area and develop their own group(s) if they identify a need and potential benefit. • In cases where more intensive support is needed, refer people to a Health Coach.

Case study: Health Coaches in action

A scheme in Bradford sees people connected with services including literacy classes, an allotment group, dance classes, the Citizens Advice Bureau and Samaritans. This had positive results for patients who participated in the scheme, including weight loss, increased physical activity and a reduction in symptoms of anxiety. However, the current system is not widely adopted or consistently integrated. This partly stems from the funding for the initiative being too dependent upon individual councils and their intrinsic disparities in funding allocation.¹⁶

b) 'A nudge a day, keeps poor health at bay': taking healthcare away from the clinical setting and integrating it into the community

Real change will only occur when we rethink the concept of health spaces. Clinics and hospitals are viewed by many in our generation as centres only for the 'sick', prompting negative perceptions.¹⁷ A new perspective on the health needs of a community can resolve this, whereby everyone becomes service users, rather than just the 'unwell'. A more proactive role needs to be considered if we are to move towards a service focused on prevention. Thus, we need to bring health promotion initiatives to places where healthy people gather and can be found, to promote wellbeing.

3

Recommendation

Bring **healthcare to everyday locations** to encourage consistent health promotion beyond clinical settings.

Our notion of integrated care means that care is integrated into *the fabric of everyday life and living*.

This recommendation was deliberated in our policy lab, which was attended by professionals from the NHS, other industry representatives with an interest in healthy living, as well as by patient representatives. Participants were asked to consider how people could be better supported to live healthy lives. They spoke about the need for greater outreach in the community and the need to develop a more preventative approach to healthcare.

Our expert interviewee said: 'there already are arrangements in place where supermarkets in new housing estates fund GP practice – those are potentially good models of practice'.

We suggest this integration could be achieved by placing Health Coaches at 'Health Hubs' – non-clinical spaces which are flexible and based around their populations, rather than the health and social care workforce. These could include public locations such as supermarkets, railway stations, businesses and faith centres. Health Coaches could design their own activities such as regular 'healthy shopping and eating tours' around the supermarket, to show people what a healthy trolley might look like. Alongside this activity, volunteer Health Champions could promote healthy lifestyles within their own environments, such as workplaces and schools.

We envisage the creation of Health Hubs throughout communities, an approach that could be applied to the majority of NHS services, such as GP surgeries, screening services and community nurses.

Another benefit of using such non-clinical spaces is possible funding and endorsements from the organisations in question. Potentially, Health Coaches could bring more customers to a business and encourage the management to promote healthier habits which link to their firms.

In the face of the looming public health crisis, our initiative to create Health Hubs could raise awareness of how to prevent disease and provide people with the skills, support, resources and motivation to help do so. Initiatives embracing similar principles have proven effective in other parts of the world.

Case study: HIV clubs

In South Africa, where there is a drive to tackle the HIV epidemic which has seen a 37% prevalence rate among townships, Médecins Sans Frontières (MSF) has created 'HIV clubs', which relieve pressure on medical services by helping patients with HIV manage their symptoms and providing antiretroviral drug refills. The project has been credited with reaching people in hard-to-reach communities, by de-medicalising treatment and better humanising patients. A service user described the benefits as follows: 'By coming here, I can see friends, get my medicine, discuss my symptoms, and I can still get to work on time.'¹⁸

c) Media technologies to create a network that mobilises the existing assets of the community

We see a future where connectivity and networking are paramount to mobilising the assets already present but under-utilised in our communities. We believe that creating a cohesive and robust network using technology would act as a catalyst for communities to achieve shared, positive health outcomes.

4

Recommendation

Create an integrated **'shared health' digital platform** to connect social network communities and enable the next generation to live healthy lifestyles.

The rise of health apps supports delivery of a new form of health information and support: digital lifestyle coaching. It reflects the population's increased appetite for, and use of, the internet and related technology. In 2012, the King's Fund looked 20 years forward and projected that, in 2032, everyone would have access to the internet.¹⁹ Technology-based solutions to health issues, in the form of well-researched and well-developed apps and other digital platforms, will become an increasingly vital resource for the NHS to tap into.

A shared health platform could be a vital step in bridging the gap between community services and users. The initiative could benefit those who may be socially isolated, by reducing feelings of loneliness and creating a sense of community. Such a platform could also benefit people who may be

part of a family or friendship group who lead and reinforce unhealthy lifestyles, allowing them to be part of an online community that promotes healthier behaviours.

Supported by the findings from our interviews with specialists and our policy lab, community mobilisation strategies form an essential part of our agenda for the future of healthcare. But they will require time, dedication and funding.

Although health capital takes time to grow and commitment to foster, shared determination of communities can continue to flourish in challenging times with limited national direction. In recognition of this, practitioners who currently socially prescribe have formed a Social Prescribing Network alongside academics, researchers and healthcare professionals to share knowledge, as there is no existing national body to do so. This reflects practitioners' goals to combat loneliness and isolation and the negative outcomes these can have on the mental and physical health of patients.

Social prescribing is already being used by the NHS as a solution, but in the next 15 years we propose that the NHS adapts to take this further through a shared health digital platform. The features of such a platform are shown in Figure 1 and Table 2 over the page. This platform would be integrated with, and give communities access to, the multi-layered system of support offered by Health Coaches and Health Champions. The platform could provide information about healthy activities in the local area, promoting wellbeing. Social mapping could allow users to explore events in their chosen area and discover a range of workshops, classes and community groups related to healthy lifestyles, such as community cooking classes to promote healthy eating. Currently, such information is scattered across different sources.

Figure 1: Visualisation of the core benefits that a shared health digital platform could offer

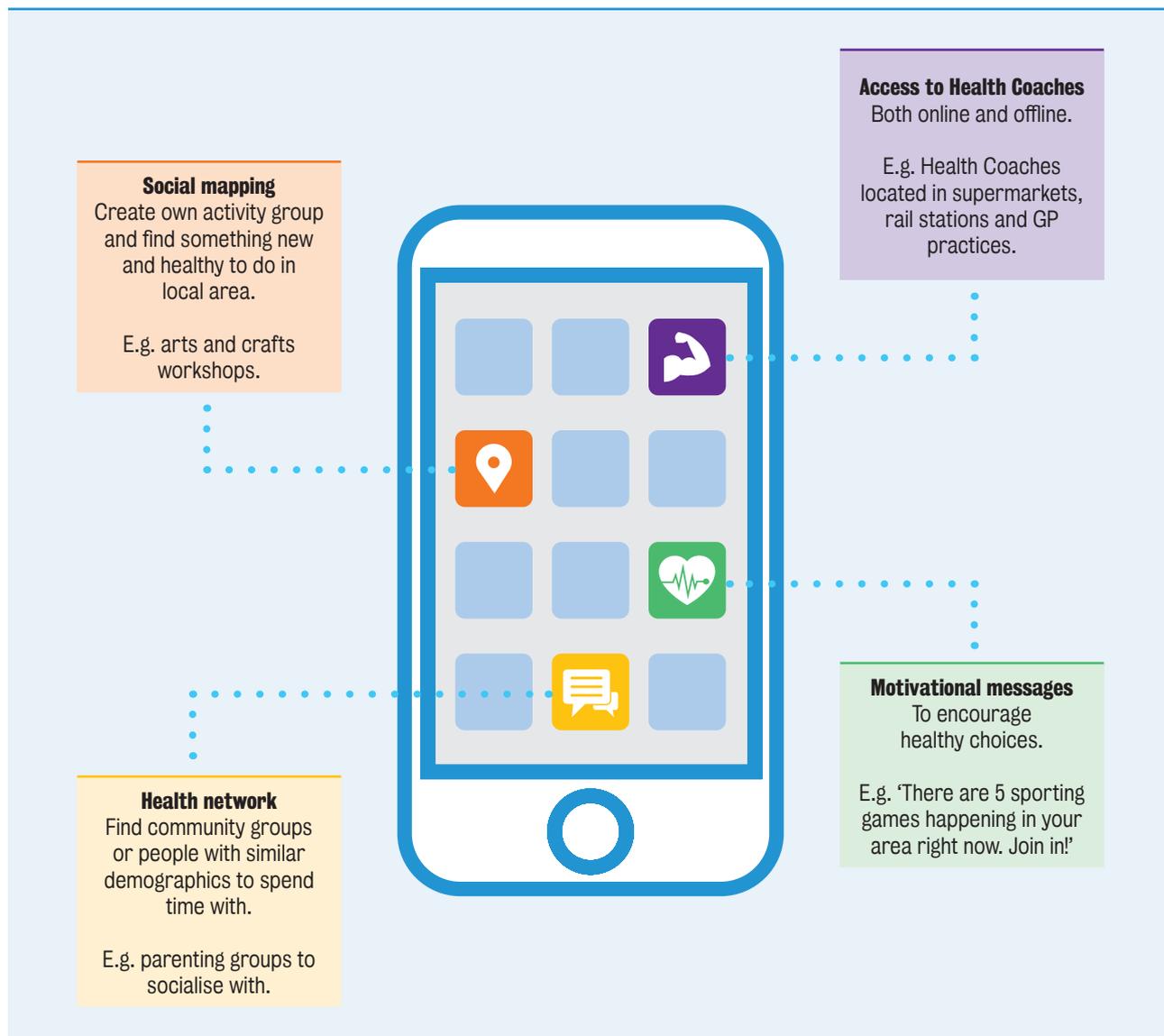


Table 2: Description of the main features of a shared health digital platform

Role	The platform will harness the power of technology to cultivate more community-based approaches to promote healthier lifestyles. It will achieve this by providing information regarding local activities, motivation, feedback and support to users, while personalising these services depending on location and individual interests.
Health network	The shared health network will have radical aims: it is intended to mobilise the entire community to connect and work for better collective health.
Motivational messages	The platform will engage users by sending facts and motivational messages tailored to them. Messages that include normative information have been found to be more persuasive, especially if the feedback is targeted. The key is to promote positive reinforcement, the importance of self-acceptance and looking after one's mind and body.
Health Coaches	The platform will provide access to Health Coaches via self-referral and allow users to find out about local Health Hubs and activities.

There already are a myriad of health-oriented apps in use, so this raises the question: what do we envisage as being different about the platform above? Through our research and personal experiences, it seems that the focus of many apps is currently self-monitoring and self-assessment, with features such as recording daily calorie intake and daily body weight. However, this may not always be conducive to a healthy outcome.

Our platform is not tracking-based but suggests a wide range of activities that people can explore. The app will promote positive behaviours without the need for constant reevaluation, and with the added benefit of in-built support. An efficient health platform should value personal autonomy and allow users to define their own goals.²⁰ Activities which are good for one person might not automatically benefit another. For example, some people may find art workshops beneficial to their wellbeing, while others may find sporting activities more effective. The platform should therefore strive for balance: instead of demanding a user's strict compliance with prescribed standards, digital monitoring should 'allow for a looser interpretation of such general rules, leaving more room for the social aspect of dining with friends or baking cookies with your kids'.²¹ This is precisely the gap that we would like to see filled, by providing individuals with the power to choose how they engage with their community and be the best version of themselves.

Finally, our platform will be customisable by health professionals. The platform will integrate GPs and other healthcare providers, allowing them to customise the information available to individuals and the local population.

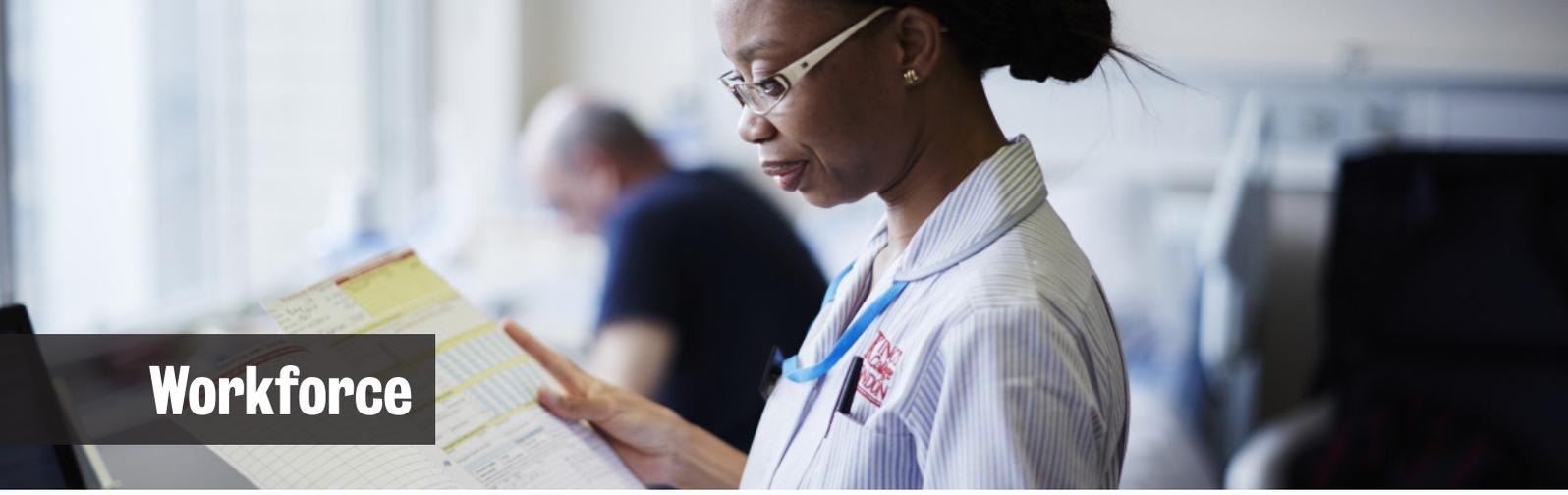
We end this section of our report with a significant case study from Australia, which encompasses part of our vision and demonstrates our model for shared health.²²

Case study: 'Hello Sunday Morning'

'Hello Sunday Morning' is an online scheme managed by Australian federal states which aims to encourage people to drink less alcohol by getting them to do more activities together – for example, on a Sunday morning. The scheme connects users to one another to arrange activities, and provides them with online access to Health Coaches, who help along the way. Research shows that nearly two-thirds of the sample reported reduced alcohol consumption following completion of the programme. The scheme's effectiveness was accredited with its uniquely innovative tools, which include 1) creation outside the clinic, 2) use of social media technology to encourage structured participation, and 3) goal setting and written records for participants, based on behavioural and engagement data.

We believe that the tools outline in the above case study could provide a creative and innovative solution for the NHS that could be tailored for current and future generations.





Workforce

Working out the glitches

The NHS is one of the world’s largest employers, with nearly 1.2 million employees in 2017. These people could be positively affected by the changes we recommend to the workforce.

Our 15-year vision involves an NHS in which the workforce has greater freedom and each staff member takes pride in working for the world’s leading healthcare provider. We aspire to a culture which allows freedom to change careers, to flex the workforce to meet demand, to work in creative ways and to address work-life balance. Moreover, our vision involves a stronger relationship between the patient population and workforce, based on mutual respect. We believe in a future in which healthcare professionals continue to ‘give 110%’ and a community-minded patient population takes greater responsibility for the use and expectations of healthcare.

The NHS is currently failing to appropriately balance the interests of the workforce with the interests of patients and policymakers, resulting in an overburdened and fragile workforce. Policy has been unable to respond swiftly enough to scale up capacity to meet growing demand. Instead, it has reinforced a culture set by efficiency targets which have stretched resources to the limit, often at the expense of staff wellbeing. These additional pressures have resulted in diminishing staff morale, retention and performance.²³

We identified three sub-themes that can improve the workforce’s freedom.

Workforce sub-themes



One step forward, no steps back: towards recognising experience and skills



A rota to encourage better living



A step in the right direction: changing patient attitudes

a) One step forward, no steps back: towards recognising experience and skills

The health and care needs of the UK population are evolving. Alongside this, medical and technological advances continue. Yet in the face of such change, the NHS clinical workforce has remained extremely traditional. The welfare of staff and review of job roles have been overlooked. The further strain on recruitment anticipated post-Brexit makes a new approach to recruitment and staff retention an even greater imperative.

Modern-day workers seldom stay in a single position throughout their life. Recognising this and providing the flexibility needed to better support staff members in transitioning between roles is key to managing burnout and morale.²⁴ However, the NHS fails to provide adequate opportunities for flexible transitioning to new roles. For example, a Band 6 hospital nurse (£26,565+) looking to transfer into community nursing would currently begin a new role as a Band 5 staff nurse (£22,128+).^{25,26} As another example, a registered paramedic with a BSc in Paramedic Science looking to transition to adult nursing would currently have to complete a two-year, full-time, graduate-entry programme. Likewise, most doctors changing specialty would be required to reapply and retrain. This situation leads to undue financial

and professional burdens, and leaves staff feeling unvalued and limited in their career choices.

The NHS's current solution to managing understaffing includes increasing overseas recruitment and expanding medical school places. However, these interventions are ineffective in improving the efficiency and productivity of the workforce.²⁷

Until the publication of Health Education England's draft report *Facing the facts, Shaping the future – a draft health and care workforce strategy for England to 2027* in September 2017,²⁸ there had been no attempt to develop an overarching workforce planning strategy for the NHS. The report acknowledges the serious gap between workforce demand and supply and the disconnect with staff planning. It also emphasises the time needed for clinical professionals to train and become active.

How might the situation be improved?

5

Recommendation

The NHS should support **re-specialisation** and offer **greater flexibility in access to career opportunities** for its staff.

The Commission encourages organisations such as Health Education England and the Royal Colleges to review the process of re-specialisation and access to career opportunities.

We envisage a future workforce comprised of healthcare professionals working in ways that are unconventional for the NHS. In our policy lab, we identified flexibility as being of paramount importance for those training in the NHS. We believe that greater career flexibility will assist in the retention of existing staff and attraction of new members, resulting in happier workers who can provide better treatment.

We believe that career pathways should be revisited, with a view to enabling greater flexibility to recognise previous experience and redefine training requirements. Particularly in the case of 'difficult-to-recruit-to' specialties, such as emergency medicine and community nursing, measures should be taken to encourage transitioning to and from them – for example,

retaining current payment bands. With many requirements set by EU regulations, such as nursing hours needing to be registered, a post-Brexit NHS may present unique opportunities to create more flexible, attractive pathways into healthcare to meet the workforce deficit.

We suggest the NHS considers more radical training programmes, such as apprenticeships based on people's abilities rather than rigid documentation of student hours. During our policy lab, such apprenticeships were suggested as a means of breaking down education barriers, improving training and providing an asset to frontline staff. The rigidity of the system should also be revisited, as many people do not have the time or money to return to university, despite being potentially valuable workers for the NHS.

b) A rota to encourage better living

As the UK's largest employer, the NHS has a duty to look after its workforce and offer a positive workplace environment. The traditional working pattern for frontline NHS staff is 12.5-hour shifts (with 1 hour 15 minutes' break), which fails to meet modern-day expectations of work-life balance. It has resulted in a stressed and fatigued workforce of people who are less able to provide the best possible treatment for patients.²⁹ For instance, today's doctors frequently work beyond their rostered hours, to the detriment of their physical and mental wellbeing, which suffers through sleep deprivation.³⁰

Exhausted workers are more likely to cause patient errors and run an increased risk of personal harm – for example, through needle-stick injuries and accidents while travelling home from shifts.³¹ Furthermore, a 2014 study showed a 30% lower mortality rate for a hospital where each nurse cared for an average of six patients and 60% of nurses had a bachelor's degree, compared with a hospital in which there was an average of eight patients for each nurse, and only 30% of nurses held a bachelor's degree.³² They concluded that staffing cuts to save money had an adverse effect on patient outcomes, and it suggests to us that hospitals which invest in staff are more likely to avoid such risks.

In countries such as Canada and Australia, doctors have the freedom to choose their working hours and even patients, and can enforce control over a healthy work-life balance and avoid detrimental circumstances. We spoke to a doctor working in general practice and A&E. They worked for

a number of years in Australia, having left the UK following burnout as a junior doctor. They confirmed that although it was the norm to work three to four days of 12-hour shifts in Australia, at least three days were then given for staff to recuperate. On asking how they maintain a work-life balance now they have returned to work in the UK, they said that they found it possible only by working as a locum GP and being able to enforce flexibility and autonomy on their own terms. This example demonstrates how opportunities abroad can be appealing for UK doctors and nurses, as they offer an escape from the working conditions of the NHS.

Focusing on the health and wellbeing of the NHS workforce and ensuring a better work-life balance for healthcare professionals is viable. It can also result in a safer service for patients.

6

Recommendation

Step up **flexible staffing** to give rota managers the power to customise and incentivise rotas according to local demand.

As part of this recommendation, trusts need to offer a more competitive alternative to locum and agency work, noting the flexibility, freedom and autonomy those roles provide.³³ The surveys conducted within our own networks reflected this sentiment, with participants prioritising flexibility, wellbeing and a healthy atmosphere as contributors to an excellent working environment.

We envisage power being delegated to consultants and senior nurses to give them greater flexibility when drawing up rotas, so they can meet the needs of their colleagues, as well as the needs of patients, more effectively. This represents a shift towards recognising that experienced healthcare professionals understand their working environment and local demands, and – to that end – are best placed to manage staffing levels. We consider that these senior professionals will best understand their staff members' welfare and are more likely to recognise when someone may be over-stretched or at risk.

While we appreciate the requirements for minimum mandatory staffing levels, we believe that creating some leeway for a better work-life balance for healthcare professionals will boost workforce

retention and attract more workers to areas facing staff shortages.

Increased flexibility for rota managers to manage demand can also improve the ability of a service to meet patient needs. For example, giving ward-based rota managers the power to authorise the advertisement of a 4-hour nurse shift to complete the morning drug round would remove significant stress on the nursing team in the morning, allowing them to focus on other areas of patient care. Moreover, such shifts may become more attractive to certain demographics, such as staff with young children who need to pick their children up from school. Likewise, in an emergency department, the ability to authorise the advertisement of short-term GP/A&E doctor shifts could clear temporary fluctuations in workload, reducing stress on the team and improving patient waiting times.

To support uptake of shifts, rota managers should be given powers to flexibly incentivise positions. For instance, conventional incentives such as enhanced rates of pay or time towards annual leave can be offered alongside unconventional, non-financial incentives such as recognition, rewards (vouchers/gift-cards/parking) or priority opportunities (training, or holiday leave such as Christmas Day).

This personalised rota management must be supported by technology, likely in the form of a mobile-enabled application which can be managed by senior staff and accessed by workers. Staff should be able to access available shifts, request shift changes/swaps with managers or other staff, and engage with incentive opportunities.

To summarise, flexible rota management allows for improved responses to local demands, resulting in a more resilient and satisfied workforce.

c) A step in the right direction: changing patient attitudes

Our 15-year vision involves a closer relationship between the patient population and workforce, based on mutual respect and better uses of limited resources. In this model, healthcare professionals continue to go above and beyond expectations to drive quality. At the same time, patients recognise the resource limitations of the NHS, take greater responsibility for the usage of services, and hold more realistic expectations. We envisage a 'community-minded' patient population, which takes a greater role and responsibility in managing

their own healthcare, through healthy living and mitigating hazardous behaviour.

A healthy lifestyle has been explored within the 'shared health' section of this report. The current sub-theme aims to explore how we can stimulate a positive social shift to bring patients' expectations in line with limited resources. Below we consider two examples arising from our policy labs and research to demonstrate the form that such interventions could take. The first example considers patient healthcare receipts, which aim to encourage efficient patient usage of health services. The second example considers a 'living' end-of-life care plan as a means of documenting health preferences to promote a more efficient workforce deployment of health services.

7

Recommendation

Support patients in using services efficiently and communicating their needs and preferences.

Patient healthcare receipts

The concept of patient healthcare receipts was a popular strategy explored in our policy labs. We felt these could help ensure that patients are directed towards the appropriate services to deal with issues such as:

- Attendance to an incorrect service (calling 999 or attending A&E for minor issues instead of a GP, Urgent Care Centre or Minor Injury Unit).
- Minor ailments better suited to self-treatment.
- Risky health behaviour (e.g. alcohol-related accidents).
- Inappropriate use of the health system (e.g. non-attendance to GP appointments).

Definition: patient healthcare receipts

These receipts use an automated messaging system to positively reinforce efficient usage of health services and offer alternative services.

This approach aims to promote the appropriate use of NHS services and highlight the cost of inappropriate use, with features such as sending an automated communication (text, email or letter)

to patients before and after healthcare attendance. This is already enforced in some areas, and with recent rapid advances in technology there is an opportunity to scale it out to clinical services across the UK. For example, on booking a GP appointment, a patient would receive a text/email encouraging them to investigate self-care treatment options and to opt out of the booked appointment if their condition appears to be self-limiting. After visiting their GP, a patient would receive another communication outlining the costs incurred by the NHS, comparisons with alternative services and suggestions for preventative care to serve as positive reinforcement for using the health service in an efficient way.

Our recommendation aims to divert inappropriate patient traffic from overburdened services such as A&E (which should be reserved for serious and life-threatening conditions) into GPs, Urgent Care Centres, Minor Injury Units or self-treatment. In doing so, each patient would receive more personalised care and the workload for staff could be distributed more appropriately and thus more manageably.

Any increased demand for community services (such as GPs and Sexual Health Centres) should be met with increased resourcing. In this way, when a patient does genuinely need NHS care, they will not be met with an unreasonable waiting time.

'Living' end-of-life care plans and 'death education'

The concept of a 'living' end-of-life care plan was another popular strategy in our policy labs. We felt proactive interventions such as these can better meet the health preferences of patients, offer a smoother deployment of key services, and avoid inappropriate attendance.

Definition: 'living' end-of-life care plan

These plans allow patients to explore and record their preferences for their care during end of life. They aim to address the current mismatch sometimes observed between patient preference and the end-of-life care they receive.

A recent report shows that the majority (over 50%) of patient deaths occur in hospital, despite this being the location that patients least often cite as their preferred place to die. The vast majority (over

85%) of patients state that they would prefer to die in their own home or in a hospice, if accessible.³⁴ Indeed, it is a familiar story when a patient who wishes to die at home is instead conveyed to A&E and takes up a bed to merely die in hospital, due to the lack of an end-of-life care plan. The patient's wishes are overlooked, and the hospital loses a bed and uses resources that could have been assigned to another patient. This situation is disadvantageous to both patients and an overstretched workforce.

We recommend a further extension of a 'living' end-of-life care plan, which aims to address the current mismatch between each patient's preferences for their death and the reality many experience. We envisage a system in which patients would have a conversation about their end-of-life care with a healthcare professional, with their preferences formally documented. The discussion should be instigated by the GP and the plan updated throughout life.

The plan would be aimed at all ages, but particularly those nearing retirement. Setting a plan would involve discussion of issues such as organ donation, appointment of a Health Power

of Attorney, resuscitation and place of death. One study found that 70% of people would feel comfortable talking about their death, but that their main reason for not doing so was a worry that other people would not want to discuss it with them.³⁵ Living end-of-life care plans could bridge this stigma-related gap and open conversations in a private, medical environment to formally record each patient's preferences. In the unfortunate event of declining health, appropriate specialist services determined by the care plan can be deployed to facilitate patients' wishes, allowing a more peaceful, dignified death without involving inappropriate services.

Our 15-year vision of a closer working relationship between the NHS workforce and patients requires a contribution from both parties. The NHS staff should better recognise and support patient preferences and encourage responsible usage of health services, while patients should use services correctly and efficiently to reduce strain on the NHS. Through this, we envisage a workforce motivated by realistic expectations and patients who have a happier, more streamlined experience of the healthcare system.





Normovation

Rethinking innovation as an everyday activity

The last two decades have witnessed ‘innovation’ becoming a buzzword across a multitude of organisations, and the NHS is no exception. However, the full potential of innovation remains unrealised in NHS practice due to an innovation pathway that is not inclusive or able to track or spread innovation efficiently. This was highlighted in one of our policy labs, where many participants emphasised the ‘conservativeness’ and linearity of the pathway. Interesting initiatives such as the *Innovation Road Map*³⁶ are **designed mainly for the development of new technology rather than a change of systems.**

Despite the impressive 30 million hits ‘NHS innovation’ receives in an online search, the Commission found that the NHS has little appetite for simple and practical innovations, such as those outlined in the case studies below, that could improve its day-to-day functioning. Indeed, ‘innovations’ are often seen as requiring highly technical proposals. While technology is indispensable, technological innovation that merely replaces manual work with automation and does not address the underlying faulty process is not true innovation.²⁷

The NHS is set to come under immense strain. The ever-increasing number of service users coupled with current financial forecasts predict a slump in NHS spending until at least 2020. The urgent need to find innovative solutions to address service delays has prompted a shift in NHS strategy to support aspiring frontline innovators via programmes such as the *NHS Innovation Accelerator* and the *NHS Clinical Entrepreneur*. Despite significant success, these initiatives only allow for a handful of professionals to innovate.

The current culture of innovation within the NHS can only be seen in pockets of success across the

country. Large parts of the umbrella organisation remain risk averse, and to us, appear closed off to innovation.

Case study: ‘The red tray’

Malnutrition in the care setting is common. Several recent reports have drawn attention to the removal of food before patients have the chance to eat it. Elderly patients at the Trauma Rehabilitation Unit at Cardiff Royal Infirmary were in danger of this, because there was no clear identification system in place for patients unable to feed themselves.³⁸ A senior staff nurse came up with the simple, low-technology solution of using a red tray for at-risk patients to serve as a visual cue that assistance was needed with eating. This simple intervention successfully identifies and supports patients at high nutritional risk. Although endorsed by the National Institute for Health and Care Excellence (NICE) as best practice, this solution has not yet been implemented in every hospital in the UK.

Case study: ‘The texting receptionist’

A receptionist at a busy HIV clinic received numerous complaints from unsatisfied patients due to the long waiting times. She came up with the simple, low-technology solution of taking patients’ phone numbers and allowing them to leave the clinic until the doctor was ready for them, at which point they were called or texted. This improved the patient satisfaction, although waiting times remained the same.

We propose the term ‘innovation’ could be expanded to include simple solutions implemented in everyday practice. Currently, innovative practices are encouraged through top-down, national programmes, wherein outputs and

success are difficult to share widely across trusts. We believe the normalisation of innovation into individuals' job roles will foster a culture that accepts innovation within the NHS. We have called this 'normovation'. The case studies above are examples of normovation: 'bottom-up' initiatives that promote any NHS employee to see potential for innovation and act on it. Normovation is the shift from an isolated episode of innovation to the integration of innovative thinking into day-to-day work life, as well as the freedom to innovate within every role.

Definition: normovation
 Normovation is the normalisation of innovation into day-to-day work life. Normovation can exist at all levels of the NHS. Both staff and patients can be encouraged and enabled to 'normovate' using NHS models and spaces promoting this inclusive approach to problem solving.

Over 15 years, we envisage that normovation could create an NHS well-equipped to explore solutions to issues as they arise, a process open to all NHS staff, regardless of position or status. To implement this, changes in NHS culture and infrastructure are needed.³⁹

Our interviews and policy lab led us to believe that this large-scale cultural shift would allow all NHS professionals and partners to facilitate the generation of simple and practical ideas and implement these successfully.

We identified three sub-themes that can help to engineer this cultural shift.



Normovation sub-themes



A clear, simplified normovation model that is accessible to all NHS staff members and patients



Fostering a normovation culture, with patients at its centre



Creating normovation spaces and champions in every NHS trust and CCG

a) A clear, simplified normovation model that is accessible to all NHS staff members and patients

The present innovation pathway of the NHS is complex, comprising multiple steps with no straightforward information on how to develop an idea. Of the 78 NHS staff members we surveyed as part of our research, an overwhelming 85% indicated they had come up with an idea to change an aspect of their workplace. However, out of the 27 cases brought to their manager's attention, 21 ideas (78%) had not yet been implemented. Most of our survey respondents said that they wanted to implement minor changes to the processes they drive, but it was not clear how they could go about it without expending more time and resources available to them at work. This highlights how the bureaucracy around the implementation of ideas in the NHS acts as a barrier to innovation.

8

Recommendation

Create a **clear, accessible normovation pathway** for all NHS staff and patients.

While it is challenging to create a uniform, accessible normovation model that can be used as a practical guideline from idea generation through to the stages of adoption and diffusion, we have attempted to in Table 3.^{40,41,42}

Table 3: The Commission’s proposed model for normovation

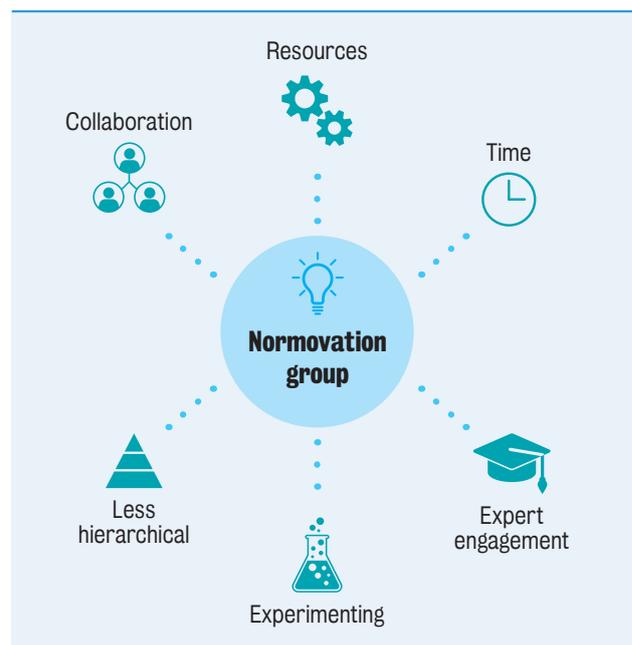
<p>Changing the structure for innovation from ‘linear’ to ‘radial’</p> <p>Current NHS innovation pathway: Linear. Proposed model: Radial. Advantages and features: Breaking down hierarchies and systems that hinder innovation. Normovation focused around individual project groups fully empowered to drive their ideas. Ready access to expert resources where project complexity demands it.</p>
<p>Normovation management platform</p> <p>Current NHS innovation pathway: No single method to track all innovations and assess their diffusion. Proposed model: Online platform where all current (and past) innovation at a trust is recorded and tracked. Advantages and features: Facilitation of collaboration across NHS organisations and with external groups. Allows employees to be introduced to the platform via e-learning and other training programmes, raising awareness of relevant project groups. Staff contribution instills a sense of involvement and a culture of innovation. Innovation software connects individuals and eases task management, thereby reducing resource barriers.</p>
<p>Risk calculator: ‘Normovating’ the evidence-gathering process</p> <p>Current NHS innovation pathway: Evidence-based model to assess innovation proposals. Proposed model: Risk-assessment model to assess innovation proposals. Advantages and features: A risk calculator to support innovators in assessing and reducing the risks associated with their ideas. Demonstration of the financial benefits and risks of an innovation. Encouragement of a cultural shift from risk adversity to risk management. Panels to review the merits of ideas and provide support to innovators.</p>
<p>Link to accelerators and smart funding</p> <p>Current NHS innovation pathway: Slow process to manoeuvre through proper channels. Proposed model: Use of partnered accelerators and smart funding. Advantages and features: Support for a hub of potential NHS normovators. Connects staff directly to ‘innovation resources’.</p>

A radial model for innovation

The current innovation pathway of the NHS is linear. A new normovation culture using a radial model (see Figure 4) can breakdown hierarchies and systems that perpetuate unnecessary red tape. Normovation can focus on individual project groups fully empowered to drive their ideas, with ready access to expert resources where project complexity demands it. Similar concepts have been proposed by prominent UK think tanks, such as NESTA,⁴³ with a keen interest in better integration of innovation in healthcare.

For example, a frontline receptionist who wishes to change an aspect of patient engagement in emergency department waiting rooms should find it easy to connect to other receptionists in the department, hospital security and other relevant personnel to form a small team. The team can test and implement necessary change, while having access to any additional expertise required.

Figure 4: The radial pathway for normovation in the NHS



A normovation management platform

The NHS currently has no universal method to track all innovations and assess their diffusion. An online platform where current (and past) innovation in a trust is tracked and recorded could facilitate collaboration across NHS organisations and with external groups. Employees can be introduced to the platform via e-learning and other training programmes, raising awareness of relevant project groups. They can choose to contribute, thereby instilling a sense of involvement and culture of innovation. By facilitating connections and easing task management, the platform can also address the concerns raised in our survey that there is currently a lack of resource to turn new ideas into reality.

Potential challenges to the success of the online normovation system include the time and resources required to keep it up to date and the development of a mechanism to connect potential collaborators. These challenges can be overcome with appropriate technology to track project progress in real-time, and algorithms to connect projects and individuals based on common features. Service suites with such features are already in use by private organisations prioritising open innovation.

Definition: open innovation

A process focused on equal collaboration which recognises that an idea can come from anywhere, whether it be a manager or service user.

Risk calculator: 'normovating' the evidence-gathering process

In the NHS, professionals are taught to 'follow the evidence'. Over the last few decades, evidence-based practice has been accepted as the way to achieve the delivery of the best possible care in the health service. Our interviews with prize-winning NHS innovators revealed that the amount of evidence provided to support an innovation project is strongly considered in measuring its effectiveness. However, innovation is 'new' by definition, and a lack of existing evidence can be a barrier for many NHS innovators.

A one-size-fits-all approach doesn't work for innovation. We envision that a 'risk calculator' can be used by anyone to determine the potential

of a 'normovation' to be successful. The tool identifies, evaluates and prioritises the risks for an innovation to achieve its purpose, and identifies the expected outcomes. Similar to a patient risk calculator, we expect it to take into account factors such as financial gain, predicted expenditures, and desired users (such as staff or patients), and set parameters that are unique to that circumstance. The difference is that it goes above and beyond measuring the risk for one individual: it estimates risk for a whole normovation process.

While this is quite a futuristic approach, data can be collected now, with a checklist as a precursor to a more complex risk assessment, prompting an innovator to further consider the design and desired purpose of their normovation. This gives transparency to stakeholders as an innovator embarks on the normovation pathway. Information collected now can later be used to generate predictive data that inform future normovations, and could in turn be used to design a more complex risk calculator.

This type of normovation risk calculator would support a radial pathway, as opposed to a linear one, because a new innovative practice or idea of any magnitude could use it at any stage of development. In the previous case study examples – the 'red tray' and 'texting receptionist' – such a risk calculator could be used at any point in the normovating process as a checklist to inform the normovators and evaluate progress, and would one day potentially demonstrate the projected risk and potentially high financial gain.

The use of a risk calculator encourages a cultural shift from risk adversity to risk management.

Links to accelerators and smart funding

Normovators of ideas selected for development should be given support to develop them through accelerators partnered with NHS England. The NHS should look to expand partnerships with local accelerators, to allow for a hub of potential NHS normovators to be developed. If the NHS had a partnership with an accelerator that allowed flexibility of staff hours to work on an innovative project (similar to Google or the King's Digital Lab), then staff would have the time to think creatively. The NHS could also look to acquire innovative start-ups as an investment opportunity, and as a way of increasing in-house capability.

This would be more cost-effective in the long term, rather than paying to use an established service annually when charges are at a premium.

b) Fostering a normovation culture with patients at its centre

Patients have been at the heart of the NHS for 70 years. Recently, there has been a call for an increase in patient involvement in innovation and research. Our survey of healthcare professionals showed that often when they received patient feedback or service user participation, they were aware of the information being fed back into the system, but they did not regularly experience any indication of follow-up. It is clear there is a feedback process, but we want to ensure it functions as a feedback *loop*.

9

Recommendation

Embed a **cultural shift** by involving patients in the practice of **normovation** from start to finish, in a movement towards **open innovation**.

In our policy lab last year, it was agreed that a requirement of health innovation is a focus on service users' needs, and that the innovation process should therefore have patient involvement at its heart. Such involvement can already be seen in the 'open innovation' movement, which is focused on equal collaboration and recognises that an idea can come from anywhere, whether it be manager or service user.⁴⁴

A user-driven example by Charles Leadbeater illustrates this kind of approach: cyclists who required a sturdier, lighter frame for mountain biking designed a new bike by amalgamating different parts to meet their needs. Mountain biking now represents a major sport in the cycling industry.

Organisations such as NESTA endorse open innovation to reach a wider range of people and generate better, cost-effective ideas. NESTA implemented the 'São Paulo: Open Innovation in Health' collaborative project in Brazil, to find ways to make health innovation cheaper, faster, more democratic and more responsive to real-world needs, with notable results.⁴⁵ However, we do not believe this form of innovation is possible in the NHS yet, because patient feedback is not seen as

an intrinsic part of the innovation and improvement process.

Digital platforms can support stakeholders, customers and managers in contributing to innovation. For example, the Crowdcity programme has been utilised in NHS Dorset with positive results.⁴⁶ We envisage that the shared health digital platform described earlier in this report could include features to support collaboration on innovation and to collect and use patient feedback effectively.

From here, it is our vision that avenues created through a normovation model allow ideas from patients to be captured and utilised to improve services instinctively and with minimal prompting. Improving a patient's ability to input into NHS services means their direct involvement is more transparent, and therefore encourages patients to get more involved and share responsibility for their care. Previous work by David Albury, Director of the not-for-profit Innovation Unit, has also shown that patients and carers can be instrumental in creating traction for an innovation.⁴⁷ Hopefully in the future, patients could be instrumental in not only generating ideas through open feedback links, but also in sharing and spreading innovation. In a world that is increasingly driven by digital technology and social media, this could one day be a viable possibility.

c) Creating normovation spaces and champions in every NHS Trust and Clinical Commissioning Group

In response to the Sir John Bell's *Life Sciences Industrial Strategy* report of August 2017, Simon Stevens announced the introduction of digital innovation hubs.⁴⁸ We believe this milestone is a key step in the right direction; however, solutions sourced from non-digital forms of innovation are also impactful. With this in mind, we make our final recommendation:

10

Recommendation

Trusts and Clinical Commissioning Groups (CCGs) should issue **physical spaces** and **champions for normovation**.

The integration of 'normovation spaces' in hospital trusts would give greater visibility to frontline

clinical developers and allow them to connect with other relevant professionals to explore ideas. This would embed the necessary cultural change within the service by actively fostering innovative thinking and practice within the workplace. An example is given in the case study below.⁴⁹

Case study: Guy's & St Thomas' NHS Foundation Trust's 'Bright Ideas Fund'

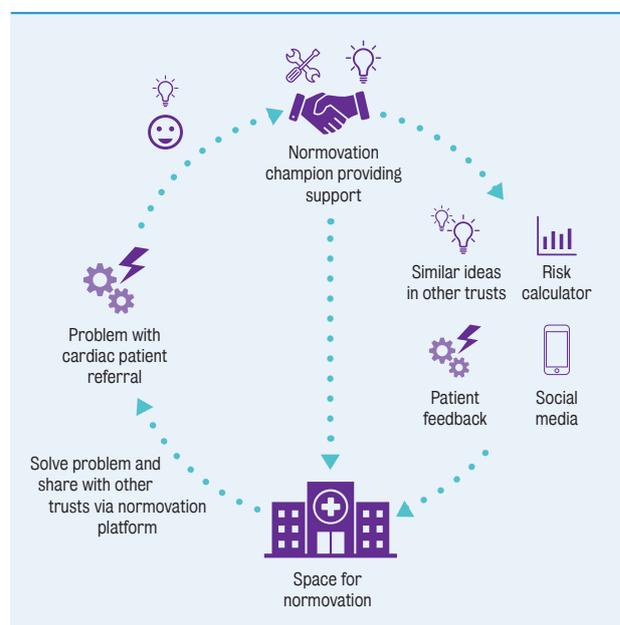
The 'Bright Ideas fund' has been embedded since 2014 by Guy's & St Thomas' Charity and Guy's & St Thomas' NHS Foundation Trust. It aims to invest in developing innovative ideas, proof-of-concept projects and spin-out opportunities with commercial potential that originate from the trust. Successful innovative outputs include 'Desperate Debra' and 'Myotrace'. The Desperate Debra project culminated in the development of a manikin to help prevent foetal impacted head syndrome. The manikin allows clinicians to confirm the presentation and position of the baby's head during labour, as well as simulate a realistic mother and baby for practising delivery techniques during training.⁵⁰

To better engage staff and provide an integrated approach to innovative practice, we call for the introduction of 'Normovation Champions'. These champions could actively encourage innovative thinking and lead development, similar to the clinical research approach commonly used by specialist consultants. Involving the most senior clinicians as Normovation Champions allows for a true grassroots shift towards commonplace normovation.

To increase the engagement of clinicians as champions and the clinical workforce as normovators, we believe normovation should be given the same academic recognition as clinical research in the scientific community, and incentivised in a similar way. Just as clinical research strives to contribute to better patient outcomes, so too does normovation – but it is not always recognised academically. Building upon the gradual shift that is already occurring at a medical school level with the introduction of Quality Improvement Projects, this recognition should be extended across all clinical disciplines and hierarchies.

While innovation can involve novel (often digital) invention, there is also room for innovation that evolves how the NHS functions. Importantly, normovation is not a one-off solution: it is an adaptive system allowing for continuous, real-time change in line with the shifting needs of its users. This is done by engaging normovators with diverse skill sets who opt for solutions and methods of evaluation that are not pre-determined, but are instead tailored to suit the problems being solved. Normovation provides frontline staff with the freedom and flexibility to improve their working place.

Figure 5: The pathway to implement an innovative practice (e.g. a new approach to cardiac patient referrals)



Conclusion

The NHS is part of the fabric of British society. Since its inception, the public have strongly supported the principles on which it was founded, and despite the challenges it may face, they believe we must do everything we can to maintain it. This Commission agrees, and through this project has provided a vision for how to take our NHS to even greater heights by 2033.

As a group of young people, we see an NHS challenged by the uncertainty that Brexit brings, the resource demands caused by an aging population with increasingly complex and numerous conditions, and the expansion of

technology into everyday life. Our 15-year vision calls for an NHS with the freedom to be flexible, freedom to be inclusive and freedom to innovate in the face of this adversity. This is underpinned by a common vision shared by patients, the public, politicians and the healthcare workforce. We imagine a stronger NHS in which patient needs are balanced with workforce welfare, and in which shared ownership of healthcare is a genuine reality. Patients will have the freedom to access health resources and networks, the workforce will have the freedom to work with flexibility and free from undue expectations, and the culture will encourage and support innovation. This is the future we want for our NHS.

Epilogue

At the start of this report, the reader was asked to keep in mind the story of Becky and Margaret. To conclude, we now return to their story, in an alternative future we believe is possible for the NHS, if our agenda is successfully implemented:

As the rain beats down against the window, Becky prepares to leave for the hospital. A sense of joy fills her, knowing she is going to the place to which she has dedicated so many years, where she feels appreciated in a thriving working environment. It is with excitement that she thinks about seeing Margaret there today. Margaret, a neighbour for many years, has been more like an aunt to Becky.

Becky thinks back to 15 years ago, and the transformation in both herself and Margaret feels inspiring. She feels they have both been embraced by a healthcare system seeking to constantly improve under strain. Becky had realised nursing was the right option for her when she saw the difference a Health Champion made to Margaret, who was struggling with her weight.

As Becky embarked upon her nursing training, her feeling of certainty grew as she heard staff speak about the fulfilling working conditions that would await her. Still Margaret continued to improve her wellbeing, having been referred to a Health Coach, after the Health Champion supporting her realised she had some deeper issues with feeling low.

Upon beginning her nursing career, Becky quickly felt the reality of the working conditions she had looked forward to. The flexibility of the rota helped her to retain her work-life balance. She felt community nursing would be an area she might like to go into, and was excited by the ease with which she would be able to make that transition. She had met up with Margaret recently, who had been successfully maintaining her weight and mood and decided to train as a Health Coach herself.

Becky had received training on how to put forward ideas for improvement within her NHS trust, and used the online platform to submit them. When Becky's ideas were seen by other wards and implemented, she felt grateful her contribution had been valued.

Becky considered becoming a Normovation Champion. When she was given this responsibility, she felt she was being the best possible nurse she could be. As patients were supported to understand the implications and costs of their care, Becky thought of Margaret when she saw patients with preventable illnesses and felt hope they could achieve change. On the day Becky decided to apply for a community nursing role, she received a phone call from Margaret. Margaret was now a Health Coach and explained she would be coming to the hospital to discuss and promote the role to staff; she would see Becky on the ward. As Becky grabs her umbrella, knowing she will see Margaret today in her new role, she reflects on both their journeys through the health system and feels a sense of pride.

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For a full list of the policy lab participants and those who were interviewed, please see the Annex available online.

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