What makes change successful in the NHS?

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A review of change programmes
in NHS South of England

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Executive Summary

This report presents the main lessons from a review of 15 change programmes that took place over recent years across NHS South of England (previously NHS South West, NHS South Central and NHS South East Coast). It sets out to help build understanding of what needs to happen for successful change in the NHS and how to deal with challenges in making systemic, cultural, large scale or rapid change.

The review is part of a larger piece of work led by NHS South of England that aims to support the ongoing improvement of the healthcare system. This includes a community of interest on change in the NHS and an online Catalogue of Change Programmes.

Structured to follow the NHS Change Model recently launched by the NHS Commissioning Board, the main findings of the review are summarised below.

1. Our shared purpose

The case studies confirm that a shared purpose and vision lie at the heart of successful change. The purpose of change must be clear, not just to those leading change programmes, but to anyone involved in delivering change. Leaders need to sell the benefits of the change. To do this, they need to express their vision in a way that makes it easy for stakeholders to relate it to the purpose and values of the NHS, and to their own principles and motivations.

Many staff and patients perceive a tension between reducing cost and improving quality in healthcare services. This should be discussed openly and where there are strong cost drivers, it is important to reinforce the message that this can support, not undermine service quality, as efficiency is needed for sustainable services.

Clear purpose is needed throughout change programmes, not just at the start. In particular, there is a risk that focusing on the detail of project management leads to the people involved losing sight of the overall vision, so a continuous focus on purpose helps keep the programme on the right track. Revisiting the purpose and vision is also one of the best ways of reviving change programmes that plateau or run out of steam.

2. Leadership for change

Change programmes need to be seen as legitimate and worthwhile at all levels. It is important that they receive the official backing of relevant organisations and senior leaders. At an informal level, the staff and patients you are trying to influence must buy into it. And the leaders of change programmes must wholeheartedly believe in the change themselves – as such, they should not be chosen simply on the basis of their role or experience.

Clinical leadership is a crucial ingredient for successful change programmes and should be apparent at all stages. It is invaluable both for the decent design of interventions and for the credibility of change programmes, so that clinicians will embrace the change instead of reacting against it.

In the complex healthcare system, it is often necessary to influence without hierarchical authority. It is simply not always possible to push change through in a directive way. As such, devolved leadership, which relies on inspiring and facilitating people, is often appropriate for bringing about change.

A wide range of capabilities are needed for effective leadership. These include strategic thinking, being able to communicate vision and to influence others, self awareness and resilience. Leadership development is crucial for strengthening the ability of organisations to adapt and improve, but when looking for people to lead change programmes, organisations should look at what leadership capability they already have within existing staff. Practical support may be needed to help people put their latent skills into action. These can include coaching and resources that provide advice and guidance.

3. Spread of innovation

Grass roots innovation is a powerful way of achieving change that is locally relevant and has the support and energy of staff. But predesigned innovations can successfully be applied to local contexts, so long as they have a solid evidence base and are well designed, the benefits are explained to stakeholders in a way they can understand, and they are implemented with a degree of flexibility.

Indeed, if change is to happen swiftly across the NHS, it is important that people don't feel the need to reinvent the wheel and see the value in copying or piggy-backing on existing innovations. Another important way of spreading innovation is sharing learning through peer networks, which requires a degree of collaboration that many are not used to, because of the strong competition that exists in NHS commissioning.

If organisations are ready for change, it makes a huge difference to how easily innovations and improvement can be spread. What is more, understanding how receptive or resistant organisations are likely to be to a specific change can help leaders plan the change programme and manage risk. However, this should not be seen as an excuse for inaction, as sometimes you have to push ahead with change even if the organisation is not ready.

4. Improvement methodology

A range of improvement methods can be useful for designing and managing change programmes. These are often found to be most helpful if they are followed loosely, applying the core principles rather than following them to a 't'.

Change programmes differ in how directive or emergent they are in approach. Indeed, this can vary even within the same programme, depending on the stage it is at. Emergent change, which usually goes hand-in-hand with devolved leadership, is particularly useful for achieving certain types of change, in particular: understanding what really needs to change within a complex system (avoiding 'doing the wrong things righter'); tailoring innovations so they are appropriate for local contexts; and making whole systems changes across professional and organisational boundaries.

Systems thinking is vital for effective change in complex organisations and, for these reasons, emergent change and devolved leadership are often appropriate for change in the NHS.

5. Programme delivery

Planning and project management are vital aspects of effective change programmes, although they can be most effective with a light touch. For example, devolving responsibility for delivering and measuring change can seem risky, but is a powerful way of getting people to take ownership and improving performance. In general, it is important to understand that rigorous delivery is not a question of filling in templates or trackers, but doing the right level of thinking to set outcomes and ensure they are achieved.

One of the greatest challenges in change programmes is making sure you have the time and resources necessary to achieve objectives within given timeframes. Using external consultants or programme managers can be useful, although if this is done, leaders within the organisation should make sure that the knowledge and insights gained are transferred to the organisation.

The fact that it is easy to underestimate the commitment needed to affect change is not only a question for those leading change programmes. It also has clear implications for organisations and their senior leaders. Change programmes should have formal backing and be supported properly so that they can become sustained.

But equally, leaders must be realistic about how much opportunity they will, or even should have to see through change programmes until they are fully embedded. Time constraints are a fact of life and if programme teams give too much support, it can create dependency, resulting in organisations not 'owning' the change for themselves. Further, leaders may have to be flexible with their change programmes to react to other changes in the NHS. The challenge is to hold on to the core vision of a change programme but be adaptable in how you work towards it.

6. Meaningful measurement

Measurement is important, not least to demonstrate quick wins to stakeholders, to find out what actually works and what does not, to motivate people involved in change, and to celebrate results and use this evidence to further spread innovation.

Measurement works best when it is robust, with a convincing evidence base, is closely related to clinical procedures and outcomes, and is simple and straightforward to apply. It is also very powerful when the staff concerned can generate measurement data (and even define measurements and set targets) so that they 'own' the data. The ultimate aim of measurement should be that staff use it of their own volition to understand their business and their own performance.

7. System drivers

Innovations and change cannot survive outside the system for long, so they need to be incorporated into it through the use of system drivers. There are a range of system drivers that can be used to reinforce change, including HR systems, financial incentives, strategic planning processes, information systems and organisational culture.

System drivers need to be aligned so that they collectively support the desired change. It is very difficult to achieve sustained change when people feel pulled in different directions. Equally, over-using or being overly reliant upon system drivers can backfire by giving perverse incentives. This can lead to staff 'hitting the target but missing the point'. Thus, it is important to have honest conversations about the nature of targets and incentives. They are not the be-all and end-all and may not map perfectly onto the shared purpose, but we should recognise that they are still useful.

8. Stakeholder engagement

Stakeholder engagement is crucial for change to be 'owned' by the people it concerns, and therefore for it to be sustained. But the term 'engagement' is used in different ways and it is not always clear what is meant by it.

At one end of the scale, engagement can refer to simply getting stakeholders to buy in to an initiative that has already been agreed upon and designed. But it can also refer to genuine collaboration on the design or implementation of an implementation, or even on understanding the problem in the first place. The degree of engagement that is appropriate differs according to the nature of a change programme and can also vary within a programme, depending on what stage it is at. It is important to be aware and open about what level of involvement you are offering stakeholders – what is up for grabs and what is not – as dashed expectations can be seriously demotivating and undermine good will.

A complication in engaging stakeholders is that there are different motivations for different groups. For example, among NHS staff, GPs are often found to be a difficult group to engage, as their practices can be isolated from other organisations. Many patient groups can also be hard to reach when it comes to getting their input.

Engaging with stakeholders takes time – you need to get in touch with the right people, explain the vision for change in a way that makes sense, discuss the change and listen to their concerns. But it does not necessarily need to slow down a programme, as it can be specific to certain aspects of a programme. Thus, stakeholder engagement can sometimes be carried out throughout a change programme in parallel to other activity.

Introduction

The NHS is currently facing an unprecedented efficiency drive at the same time as undergoing large scale reorganisation. To complicate these challenges, NHS expenditure is rising whilst budgets are not. Improvements in efficiency and service quality are being achieved, but as well as making sustainable improvement, the NHS needs to spread these changes more quickly and efficiently. In order to achieve this, change programmes need to be systemic and large scale in their design.

> *"Though current models of improvement and change that have emerged in health over the past decade have delivered benefits, they have also resulted in fragmentation and significant duplication of effort, with a multiplicity of different change approaches being used. If the NHS is to achieve results that are amongst the best in the world we will need a system that can significantly ramp up the pace and scale of change and innovation."*
>
> *Innovation, Health and Wealth: accelerating adoption and diffusion in the NHS*

The Quality, Innovation, Productivity and Prevention (QIPP) programme has been at the heart of much large scale systemic change in the NHS. QIPP is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector, designed to improve the quality of care the NHS delivers whilst making up to £20 billion of efficiency savings by 2014-15. NHS South of England needs to ensure that best practice in large scale organisational change is being followed if NHS organisations across the region are to achieve the challenging goals outlined by this initiative.

However, at the same time as designing and rolling out large scale change programmes, it is important to continue to enco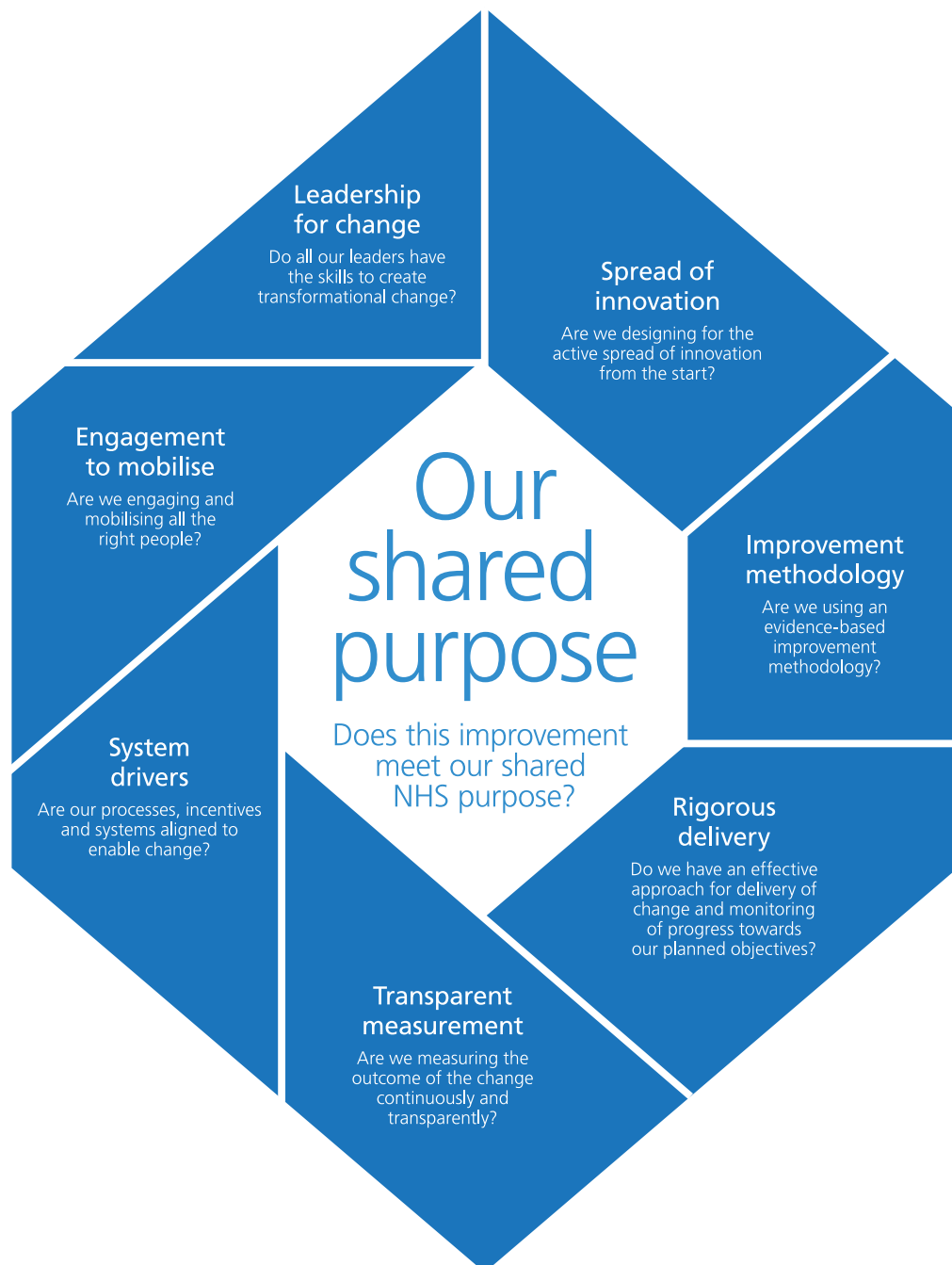urage emergent, bottom up change, as this is often where the greatest capacity for innovation lies. Related to this – and one way in which bottom-up change may develop into more systemic change – is the challenge of working across diverse groups of professionals and integrating the healthcare and social system.

It is important to continue to encourage emergent, bottom up change, as this is often where the greatest capacity for innovation lies

There is a great deal of high quality academic research on change in the NHS. NHS South of England has been involved with the NHS Academy for Large Scale Change and in helping draw up an NHS Institute model that describes the process of large scale change (Bevan et al, 2011). At the same time as we were undertaking this review, the newly formed NHS Commissioning Board developed an NHS Change Model, shown overleaf.

While they are extremely helpful in explaining core principles and elements of change, models can be very generic because they apply to so many circumstances and, as a result, can be difficult to translate into practice. Therefore, there is a need to translate existing research and models of change into practical tools for the NHS South of England context.

NHS

The NHS Change Model

Leadership for change
Do all our leaders have the skills to create transformational change?

Spread of innovation
Are we designing for the active spread of innovation from the start?

Engagement to mobilise
Are we engaging and mobilising all the right people?

Our shared purpose
Does this improvement meet our shared NHS purpose?

Improvement methodology
Are we using an evidence-based improvement methodology?

System drivers
Are our processes, incentives and systems aligned to enable change?

Rigorous delivery
Do we have an effective approach for delivery of change and monitoring of progress towards our planned objectives?

Transparent measurement
Are we measuring the outcome of the change continuously and transparently?

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A review of change programmes

Within this context, NHS South of England commissioned Roffey Park Institute to conduct a review of what improvement projects have taken place over the last few years in the region, considering what has worked well and what has not. The review was based on in-depth case study research on 15 change programmes taken from across the three old SHA regions – South West, South Central and South East Coast – and a workshop with representatives from the SHA, the NHS Institute and the case studies.[1]

The purpose of this work is to support NHS South of England to deliver large scale change by developing understanding of what approaches, models, techniques and processes have most benefit in improving NHS performance on a large scale. Following the launch of the review in July 2012, the SHA will develop a community of interest on change programmes. This will be supported by an online Catalogue of Change Programmes that will give an overview of how the programmes were designed and run, who led them, and what their impacts were. The aim is for the review and the surrounding activity to help foster collaboration and sharing of learning to support the ongoing improvement of the healthcare system.

This report presents the main lessons from the review, illustrated by case study examples and insights from the research participants. The report sets out to help build understanding of what needs to happen for successful change in the NHS and how to deal with challenges in making systemic, cultural, large scale or rapid change. We hope that it is a user friendly resource, not just for organisational development specialists in the NHS, but anyone involved in leading change in the healthcare system, be they managers or clinicians, health-care assistants or senior directors.

We have structured the report to follow the eight elements of the NHS Change Model. The model was developed independently of the review and our findings do not map onto it precisely. However, there is a lot of common ground. The case study findings confirm the importance of the broad areas described in the model and illustrate how the model can be localised and applied in practice.

The 15 case studies

Each of the 15 case studies was a change programme that had been run in the south of England within the period from 2009 to 2012. Below are brief summaries of the case studies, grouped by the old SHA regions.[2] More in-depth summaries of these and other QIPP focused change programmes will be available from September 2012 on NHS South of England's online Catalogue of Change Programmes.

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1   See Appendix 1 for a description of our approach and methods for the review.
2   The amalgamation of these three SHAs into NHS South of England took place in October 2011.

Case studies from NHS South West

Healthy Futures Programme. This was an umbrella programme for change initiatives on quality and efficiency across Bristol, North Somerset and South Gloucestershire. It helped focus on patient pathways and encouraged collaboration across acute hospital and community settings. The programme has supported a number of initiatives on prevention, maintaining independence and streamlining pathways.

Patient Access Centre. This was an initiative in Torbay Hospital to introduce a call centre for outpatient bookings, replacing a stretched system that involved nearly 400 staff with one that was run efficiently by 30 dedicated phone operators. Whilst an unpopular change initially, it was successful and resulted in estimated cost savings of £1.2 million and huge improvements in service quality for bookings.

The Rapid Improvement Programme on orthopaedic pathways was led nationally by the NHS Institute. The pathways were implemented in two pilot trusts in NHS South West, following a set process over a 12 month period. This led to improvements in quality of care and patient experience and streamlined pathways. Building on this, the SHA organised **Collaborative Commissioning events** across the region. These workshops spread the best practice developed in the pilot sites through networking and increased collaboration.

The Reablement Programme in Somerset aimed to support people to maintain their independence by finding healthcare solutions that worked for them. It took a systems approach to build a service that met demand. Significant changes were made in how patients were assessed and what services were provided. This led to improvements in efficiency, patient outcomes and staff motivation.

The Dorset **Partnership for Older People Programme (POPP)** involved a number of organisations from the NHS, the third sector and community services. It aimed to empower elderly people to take more responsibility for their health and social care, in particular by building supportive communities that enabled them to remain living in their own homes for as long as they wish. It has helped developed a preventive service focused on health promotion.

Case studies from NHS South Central

Enhanced Recovery Programme (ERP). This used a mass mobilisation approach to promote best practice in elective surgery pathways across NHS South Central. It has focused on four clinical areas: colorectal, gynaecology, orthopaedics and urology. Approaches varied at a local level, but some trusts created an ERP nurse post to help drive the programme. The programme has brought about many changes in procedures, leading to reduced length of stay and improved patient experiences and outcomes.

High Impact Pathways was a one-year programme led by the South Central SHA to reduce waiting times, in line with the Department of Health's 18 week target. The programme drew on the Lean methodology of process improvement to reduce waste and drive efficiency. The implementation was led by external management consultants. Overall, it was successful, although the implementation of Lean was patchy in parts of the organisation.

The **Small Business Research Initiative** was NHS South Central's programme to implement the Regional Innovation Fund. It defined 'problem spaces' and invited the private sector to tender for developing solutions. The programme drew on PRINCE2 project management. Its successes included a Long-Term Conditions Monitor, which used an automated telephone service to record outpatients' state of health. This has greatly increased the trusts' ability to contact patients and prevented nearly 40 emergency admissions.

Map of Medicine for best practice in GP referrals. This was a project run across south west Hampshire to reduce the number of inappropriate referrals from GPs. It used the online Map of Medicine based on NICE and other best practice. The programme developed 114 localised pathways, the highest number in the country. These pathways have also had the highest levels of GP usage in the country.

The Turnaround Project. This programme used the Rapid Spread methodology to reduce hospital acquired pressure ulcers and falls in 44 wards in Southampton. The 12 week methodology focused on spreading the use of evidence-based High Impact Actions through a week-by-week guidebook and other supporting tools, and coaching. The programme has led to 75 per cent reduction in grade 3 and 4 pressure ulcers, 62 per cent reduction in grade 2 ulcers and an estimated 50 per cent reduction in high harm falls.

Case studies from NHS South East Coast

The Enhancing Quality (EQ) programme promotes best practice in primary, secondary and community care across Kent, Surrey and Sussex. It works by accurately benchmarking clinical practice, pin-pointing variation and supporting clinical leadership to innovate and improve patient outcomes, drawing on NICE guidelines. The programme has used CQUIN mechanisms to encourage organisations to participate. A range of successes were seen in the first year, including a 15 per cent improvement for heart failure and pneumonia patients and 8 per cent for hip and knee patients.

The Normalising Birth Programme worked to reduce variation in caesarean section rates in the 11 PCTs in Kent, Surrey and Sussex. The programme worked through regular collaborative meetings where clinical leads and others involved shared learning and offered each other support. Part of the programme was to better understand variation in caesarean sections and what quality indicators should look like. The longer term benefits have yet to be realised, but the programme has led to a more robust dataset on clinical variation and developed a number of new initiatives.

The Emergency Care Programme was designed to improve patient flows and quality of care in A&E whilst reducing the number of beds used. It was implemented in the three main acute hospitals in East Kent following a service review by NHS IMAS. The programme led to various innovations, including rapid assessment practices, patient pathways and a real time dashboard on patient flows. Key outcome measures include a 28 per cent decrease in patients with a length of stay over 14 days and 97 per cent of patients treated within four hours.

Safe, Supportive and Therapeutic Care. This programme was undertaken by the Sussex Partnership Foundation Trust to improve safety and care in acute inpatient mental health units. The team collaborated with staff and patients to focus on policies, variation in practice and ward environments. The programme implemented a 7 day pathway for inpatient admissions and has led to systematic improvements in therapeutic observation, assessment and managing clinical risk.

The Sussex Dementia Partnership is a system wide collaboration between health and social care commissioners. It was set up to improve dementia services in line with the National Dementia Strategy, in particular regarding diagnosis rates, use of resources, patient experience and access to information, and to reduce inappropriate admissions and medication and length of stay. It has led to improvements in all these areas, covering secondary care, care homes and support at home.

1. Our shared purpose

Main points

- Followers need purpose and leaders need to express vision
- Perceived tensions between cost and quality drivers should be discussed openly
- Sell the benefits of the change – we're doing this for a good reason
- A clear focus on purpose is needed throughout change programmes, not just at the start. In particular, it can help projects stay on the right track and not get distracted by the detail of project management, and help revive flagging projects.

The need for purpose and vision

If change is to be embraced and properly embedded in an organisation, the people it concerns need to buy into it. Change needs to make sense and people need to see how it might bring benefit.

One way this can come about is when the need for change is supported by people's direct experience. Staff often see with their own eyes when a system doesn't work and can understand how a different approach might work better. But clearly, not everyone will share the same experiences and many people will need to be convinced of the need for change.

> *"The 'what's in it for me' is different for one of our consultants, it's different for one of our managers, it's different for a ward clerk, it's different for a nurse, and different at different sites. So we are sophisticated in understanding individual speciality service and site drivers."*
>
> *Rob Rose, Emergency Care Programme*

Change needs to make sense and people need to see how it might bring benefit

Getting people to buy in to a vision for change often isn't easy. Many people do embrace change, but it is easy to feel undermined or threatened by it, even if one accepts at a broad level that change is needed. As well as the challenge of embracing new ways of working, it can be hard to let go of the old ways. Not only do people have ingrained habits and ways of thinking; they also become skilled in familiar work and may feel that their credibility is based upon it. For example, if someone spends years honing skills in a specific procedure and is then told they should be using a completely different technique, this may cut at their sense of self worth.

Thus, the purpose of change must be clear and relate to how staff see the purpose and values of the NHS, and to their own principles and motivations.

"I had a very clear vision myself … of what a good model of therapeutic care looked like … [Our motivation] came from our experiences and our own visions … being in line with a greater objective and vision."

Kate Hunt, Safe, Supportive and Therapeutic Care

David Tappin, of the Healthy Futures Programme, described the importance of applying the principles which people profoundly believe in – best quality and best value – and talking about them at a system level. In short, it is about helping people see the relevance of the change.

"How you frame issues is very important in terms of being able to establish influence."

David Tappin, Healthy Futures Programme

This can be more complicated than it might sound. For example, the new processes designed under the Healthy Futures Programme have all been firmly based on discussions of how to provide high quality clinical service, and this has been very important for keeping clinicians, lay people and patient representatives involved. But in hindsight, some of the leaders thought there was little brand awareness of the programme outside project management teams and key stakeholder groups, and it would have benefitted if there had been more time spent on developing a public narrative for the programme.

Quality versus cost?

Whether change is driven primarily by cost or quality affects how far people buy in to it.

Make explicit links between cost efficiency and enhanced quality and emphasise the aspects of the change that are about quality

Change driven by the need for cost savings or efficiency has less natural pull than change driven by the desire to provide better patient care. Often there isn't a clear distinction between these drivers. Sometimes the original vision behind change is deflected by the need to make rapid cost savings. Sometimes better patient care is delivered when the system becomes more efficient.

"The vision overall I think has taken a bit of a battering ... We've gone from that context of trying to build a future that we would all buy into around … providing high quality health services to one which has got much more of a flavour of 'How do we do this cost effectively?'"

Chris Burton, Healthy Futures Programme

In the NHS, an organisation whose people are strongly driven by their values and commitment to patient care, it is particularly important to make explicit links between cost efficiency and enhanced quality and to emphasise the aspects of the change that are about quality over those which focus purely on cost reduction. For example, cost reductions are achieved when hospital readmissions are reduced, but much more important to most staff is the enhanced recovery represented by this reduction.

"What is really important is that it becomes self sustaining because they really want to do this … The message is [essentially] about quality and patient

experience. The more you emphasise that, the more that you engage clinicians and front line staff."

Karen Miles, Emergency Care Programme

While people *understand* the need to save money, what they *care* about are patients. While cognitive commitment is important, emotional buy-in is essential in delivering effective change. Even where the main driver is cost, this needs to be clearly linked to patient benefit to get people on board.

Drawing on service users to create vision

Vision is most likely to become shared purpose when it is created by those who will be involved in or affected by the change. These might be not only clinicians and other NHS staff, but could include politicians, the public and, in particular, service users.

Several case studies show how this approach not only builds a sense of shared purpose, but often leads to new and innovative ideas outside traditional care models. The Partnership for Older People Programme (POPP) in Dorset, for example, engaged community groups of older people to review and co-design community services from the ground up. The result is a multi-award winning service helping over 60,000 people a year, with service users still forming a majority on its strategic board to ensure that its shared vision remains at the centre of its operation.

"I want to die in my own home, thank you very much. And I want to be supported there, if necessary, towards my latter days."

Jackie Allen, Partnership for Older People Programme

Drawing on service users to create a shared vision involves genuine consultation from an early stage, and a willingness to build their views into the vision for change and to ensure that they have real influence as the change progresses.

Keep revisiting the purpose

It's easy to be deflected from the original purpose of a change programme in the face of national imperatives, or indeed from pressure within the organisation at a local level. Successful change programmes need a vision that will outlive the project. This means that you need to allow yourself time to develop the vision right at the beginning, and revisit it regularly to make sure it's still relevant and sustainable.

For example, project management systems are important and can be very helpful, but there is a danger that in focusing too much on the detail of these, people lose sight of the overarching vision. Checking in frequently with the real purpose of the change helps protect against this.

"If we allow ourselves to be driven only by the outcomes we want to see, there is a danger that we lose focus on the purpose and therefore lose it altogether. We keep going back to the purpose to check we are staying true to the methodology and not slipping back into doing things in the old way."

Ann Anderson, Reablement Programme

The best way of moving on when change programmes plateau or run out of steam is to rearticulate the vision

There is a risk in any change programme of 'plateauing' or running out of steam. The best way of moving on from this is to rearticulate the vision. By revisiting what the programme is trying to achieve, leaders can reignite the passion that unites partners and refocus energy on the process.

"There were a few occasions along the way where we had to, not rebrand, but rearticulate, or change the flavour of what we were saying so people understood what we were trying to achieve."

Tony Kelly, Normalising Birth Programme

2. Leadership for change

Main points

- Change programmes need to be seen as legitimate:
  - Officially by organisations and senior leaders
  - Informally, by the people you are trying to influence
  - In your own mind's eye as a leader.
- Clinical leadership is crucial for good design of interventions and credibility
- Devolved leadership is often appropriate for the complex healthcare system
- A wide range of capabilities are needed for effective leadership, including strategic thinking, being able to communicate vision and influence others, self awareness and resilience.
- As well as developing leaders, organisations should look at what leadership capability they already have to lead change programmes. Practical support (e.g. coaching) may be needed to help people put their latent skills into action.

Common approaches to leadership

Leadership is about forming and communicating a vision and encouraging people to join you on a journey

The concept and practice of leadership is widely discussed and written about, and many definitions and models have been developed to describe it. In this report, we use the word 'leader' to describe anyone involved in persuading or supporting others to take part in change programmes. This might include the official programme 'leads' but also senior leaders in NHS trusts and other organisations, and more junior staff who are acting as advocates and trying to encourage take-up of initiatives in their local units.

There are many ways of leading, and many leadership styles. Effective leaders are generally able to adapt their leadership style to fit the situation. Leadership can take place from the front (directive or autocratic); alongside (participative); or behind (devolved or supportive). As we discuss in Chapter 4, we can see leadership broadly as a continuum of directive to devolved leadership. But in all cases, leadership is about forming and communicating a vision and encouraging people to join you on a journey.

Getting the basics in place

What ingredients are needed for effective change leadership? Obviously the skills of individual leaders are critical. They need the ability to think strategically and must have the people skills and political awareness to be able to influence people and shape systems. But as our case studies show, there are other factors that can be equally important. These are discussed below.

Formal legitimacy

For a change programme to succeed it needs to be formally recognised as a legitimate activity for the organisation to be focusing on. Many changes require authority if they are to be adopted within a system. If there is insufficient official authority within the project team to drive change, securing senior sponsorship will help get things off the ground.

> *"It was supported as a strategy very much by the executive team backed by the chief executive, so … in a variety of arenas [it's] held up as … our strategy for our acute services."*
> *Kate Hunt, Safe, Supportive and Therapeutic Care*

In creating a new Patient Access Centre to handle outpatient bookings in one trust, for example, the continuous improvement board's sponsorship of the project was vital for getting over hurdles. In particular, it enabled the team to overcome resistance from consultants because it was chaired by the CEO and included a number of medical directors who were in favour of the change. The same trust's Director of Continuous Improvement oversaw the programme and was 'wheeled out for really difficult conversations'.

Similarly, Southampton's Map of Medicine programme was given invaluable credibility by the chief executive of the foundation trust, a charismatic and well-respected figure, who directly engaged with clinicians on the programme.

Clinical leadership

Across the board, the case studies show that clinical leadership is a crucial element of change programmes in the NHS. Clinicians' experience, knowledge and ability to talk to other clinicians in their own language lend credibility to the change. If clinical teams receive information and recommendations from clinical leads rather than managers they are much more likely to believe and act on them.

> *"It would not have even got off the ground without that. There's no way a management fad would have got to the scale that this project has without that. So that is the real key to the success without a doubt."*
> *Lucie Lleshi, Map of Medicine for GP referrals*

Clinicians often form powerful groups who can block or facilitate change and peer respect is the most effective way to unlock their support

And it's not just clinical expertise that's important. Clinical leaders can interact and influence people through formal and informal networks, building the 'informal authority' of change; credibility and legitimacy among the people you are trying to influence. Clinicians often form powerful groups who can block or facilitate change and peer respect is the most effective way to unlock their support.

> *"Orthopaedic teams are usually one of the largest teams in any acute care provider. So they've got quite a lot of authority and if, as a team, they decide not to do something then it's quite difficult to change their mindset."*
> *Deborah Thompson, Rapid Improvement Programme*

Change programmes also benefit from a genuinely collaborative process in which clinicians fully engage with diagnosing problems and designing solutions. For example, the High Impact Pathways programme used external management consultants to design and lead the change (see Chapter 5). There was some clinical involvement in the early stages of the programme, but the SHA project lead thought that in hindsight it was clearly not enough:

> *"[Greater input from clinicians would have helped] massively … Not just clinical champions because they happen to be the most interested person, but someone that has a role to drive things clinically would have made a big difference in some of the areas."*
> *Peter Loomes, High Impact Pathways*

Leadership skills

Important in any organisational context, at times of change leaders need a range of skills and attributes to set a strategic course and persuade people to join them on it. Effective change leadership isn't about telling people to change; people have to see and believe the difference. Leaders who genuinely model the behaviours that they are asking of others are crucial for the credibility of change programmes.

All leaders need strategic skills. This means being able to see the bigger picture, creating a vision based on the many elements of an often uncertain, complex, and ambiguous environment.

Having formed a vision, leaders need to be able to express it in terms of purpose. People need to understand how their work contributes to the realisation of the vision, and this means being able to relate vision to specific situations and contexts. Story telling is a powerful way to achieve this, and the best leaders often use narrative to enthuse and motivate people to become involved with the change.

Influencing skills are also an important asset. Our case studies provide many examples of how leaders have used both formal and informal networks to engage with stakeholders and build commitment to change programmes."

> *"He gets alongside people and he listens to what they're concerned about and he responds to that. And he brings people along with him and … he takes their concerns on board and he builds them into what he's doing and then he goes away and he thinks very deeply about how to get as much of what they want, combined with as much of what we want."*
> *Deborah Evans, Healthy Futures Programme*

Understanding the informal, as well as the formal networks that operate within the NHS is invaluable when seeking to influence multiple stakeholders – often those with little formal authority can be remarkably influential within a system. Recognising and using these hubs of informal power is a sophisticated and effective way of influencing across networks.

Understanding and navigating formal networks within the NHS is equally important, particularly in terms of the efficiency of project management. In one case study the SHA did

not hold contact details for all surgeons in the various specialities across the region and some hospitals were uncooperative in sharing that information, even though it was in the public domain.

Understanding the networks that operate within the NHS is invaluable when seeking to influence multiple stakeholders

Self awareness is another key component of leadership. It is necessary to know yourself in order to understand your impact on others and how you can best influence them, and to make sure you are modelling what you want others to follow. 360 feedback, as long as it is of good quality and properly debriefed, is a great help in building self awareness, as are well-managed personal feedback exercises in the context of leadership development programmes.

Practical support

It's easy to feel isolated in leadership positions, particularly when it comes to trying new things and taking risks. Setting up support networks can help here. Buddying, twinning or mentoring arrangements between leaders working on similar projects in different parts of the NHS can provide not only support and reassurance but also a useful exchange of ideas and experience which can enrich the change programme itself and reduce duplication of effort across the wider NHS. Technologies like Webex are very useful for connecting teams and individuals within change programmes and to share learning across programmes. Finding linkage with what's happening elsewhere and what support is available is a really useful first step here.

Self belief and persistence

In the course of most change programmes barriers and difficulties will arise. These are the times when leaders need to draw on their personal resources of belief and confidence – in the programme and in themselves – and of resilience and persistence. To be the right leader for a change programme you need genuinely to believe in that change and have the dedication and energy to drive it and the passion to be able to present your ideas positively and get buy-in and engagement.

At a practical level, confidence in what you are doing and your ability to lead it helps you to lead change efficiently and effectively through to completion. At a deeper level, confidence in your own ability and value helps you to recognise what things are not working well, and accept that they should be stopped or a new approach taken. Change should not be 'about' its leaders or whose idea it was. Have the courage to adopt existing change models rather than inventing your own, and to welcome and use other people's ideas. In addition, confidence in yourself is helpful in developing and using informal authority and influence.

Confidence can be nurtured in a number of ways. One is to build a 'culture of permission' in which people are not knocked down for trying out improvements that don't work, and in which appropriate challenge across traditional hierarchies is positively encouraged.

Resilience and persistence are crucial assets when barriers arise. Leaders must try not to become discouraged or give up when the going is tough. Instead, they must be consistent in their message and loyal to the core vision of the change programme. Trust the work you've done and be consistent in your approach. This doesn't mean you can't be flexible and willing

to adapt, it just means not losing sight of your core purpose and giving up.

> *"It's been important for us to remain quite focused about where we're going so that we don't lose sight of what we need to do or feel … demoralised or disempowered waiting for other parts of the service or the system to change."*
> *Theresa Dorey, Safe, Supportive and Therapeutic Care*

Accessibility and visibility

At any time, but most importantly at times of change, people need to have access to their leaders and feel that they are heard by them. Having change leaders at all levels in the hierarchy makes this a more realistic proposition in an organisation as large as the NHS, but when senior leaders make themselves personally available it is often of significant benefit in both practical and engagement terms.

What works best in leadership: key lessons

An NHS style of leadership?

Leadership in the NHS continues to evolve. For example, a coaching style of leadership seems increasingly prevalent. But it's important to recognise that no one style of leadership is appropriate in all situations, in all contexts and with all people. At the beginning of this chapter we describe a continuum of different leadership styles, from directive, or autocratic, to devolved, or supportive. The most effective leaders can adopt a mixture of styles. This is known as situational leadership, and is particularly relevant in change leadership, where resorting to one default style is likely to be limiting to success. Understanding the situation, your own preferences and influence and those of others is key to making the right choice of style at the right time.

> **No one style of leadership is appropriate in all situations. The most effective leaders can adopt a mixture of styles**

As a change programme progresses, so might the most appropriate leadership style evolve in line with the growing confidence and expertise of other people. Most often leadership style will move along the continuum from a directive to a more devolved approach, giving people the space to develop, innovate and lead their own areas.

> *"It was just trying to keep people on message, and to … keep bringing them back to what the core idea was, what the achievable situation could be, and how we could all do that … But once people started to believe, and started to see the successes, then I think actually the group itself became self-sustaining."*
> *Tony Kelly, Normalising Birth Programme*

This is not to say that there aren't appropriate moments to use a more directive style; when too little is happening, for example, or when an agenda needs to be set. This is discussed further in Chapter 4. Even when you choose to adopt a distributed or devolved approach you have to be honest about the things that are non-negotiable, acknowledging existing hierarchies but holding them lightly when you can.

Finally, a key role for change leaders in the NHS is to make links and align different strands of change programmes to make sure the project doesn't become siloed.

"Rather than looking at the project where you can say, 'This is a big pie and we're going to cut it up into deliverables' … it's more a case of … looking at the needs … and then looking at the project as mini projects alongside a clear strategy."
Julie Mooney, Partnership for Older People Programme

Selecting and developing leaders

In order to ensure that change leaders have the appropriate skills it is necessary either to recruit people with the right experience and skills or to offer support in developing their skills. It is also important that change leaders and teams managing change programmes know the NHS well enough to be able to navigate it to get the right people on board; to gain access to and cooperation from them.

Leaders who have participated in good quality, relevant development programmes report that they are extremely helpful in equipping them with many of the skills mentioned in this chapter. Coaching is also especially valued, although knowledge of what coaching is available seems not to be widespread in some areas of the NHS.

Some of the leaders within our case study programmes have participated in leadership and change management development, including the NHS Top Leaders and Aspiring Top Leaders programmes, which support people who are working across organisations and addressing the complex problems that underlie systems. Other staff attended the NHS Vanguard Programme (discontinued in March 2012) whose aim was to enable emerging leaders to deliver improvements in quality and productivity and build their leadership and improvement skills.

Change programmes can also lead to a stronger culture of improvement and enthusiasm to develop and use change management skills. For example, the High Impact Pathways programme led to the Service Improvement Skills Programme (SISK), which received a great deal of interest and had 500 participants during a three year period.

Organisations should look to the leadership capability that already exists and hold people to account for using the skills that they have developed

One lesson from the case studies is that NHS organisations should use the leadership capability that already exists. Many people go on leadership development programmes and could use their skills more, either because they don't want to commit time to supporting a change programme or because they lack the confidence to put their skills into practice. If leadership is inhibited by a lack of confidence, greater access to coaching could remedy this and be a cost effective way of harnessing leadership potential that lies dormant.

It's also important to hold people to account so that they take responsibility for using the skills that you've helped them develop and make sure that selection for learning and development programmes is appropriate. For example, selection for SISK was rigorous and participants had to prove that they could link the training directly to a project they were currently managing.

"Being sent on leadership development and project management training means nothing in itself. Because if they just go back to their world and don't do anything with it, who cares?"

Peter Loomes, High Impact Pathways

Further, it is getting the right mixture of styles and skills within a *leadership team* that is most important, rather than making sure every individual leader is adept at the full spectrum of styles. You can then bring out the most appropriate leaders for different audiences to move the programme forward in different ways. For example, some otherwise talented individuals may lack the ability to adapt their leadership style to the situation appropriately, perhaps overusing a particular style. This may be acceptable if it is supplemented by other leaders who can provide the other styles needed – for example, balancing a 'pace setting' style with 'affiliative' or 'coaching' styles (see Goleman, 2000).

Transfer knowledge to the organisation

A key legacy benefit of the High Impact Pathways programme was that the external consultants used were able to "leave skills behind", enabling others to adopt more expert roles in managing change.

Indeed, personal development in leadership and change management often seems to be overlooked as a by-product of change programmes. The individuals involved gain invaluable experience, learning to use high level change management techniques and spread innovation in ways they would not have done before.

Clearly, as argued above, people's desire for personal development should not be prioritised over organisational needs. Skills gained in leadership and management should always benefit the healthcare system. But by recognising this desire as an important driver for individuals, change programmes can tap into another source of motivation.

3. Spread of innovation

Main points

- Predesigned innovations can work if they are well designed, the benefits are explained to stakeholders and they are implemented in a flexible way.
- Don't be ashamed to copy or piggy-back on existing innovations
- Sharing learning through peer networks is an excellent way of spreading innovation
- It makes a huge difference if organisations are ready for change, but sometimes you have to push ahead with change anyway.

Designing programmes for the spread of innovation

The NHS Change Model asks specifically, "Are we designing for the active spread of innovation from the start?" Our case studies point to some instances of initial programme designs factoring in the spread of innovation and these confirm that it is important.

> *"We're really good at doing projects in the NHS, but we're not very good at embedding it and making it sustainable. And so right from the word go it's been in my objectives to make this business as usual, [to make sure] that we're not something that happens out there, as a standalone programme, but … we're integrated into commissioning, contracting, performance, clinical thinking."*
>
> *Kay Mackay, Enhancing Quality programme*

The case studies threw up various questions on designing programmes for the spread of innovation, including:

- What's the best way of spreading innovations when people have not been involved in their design?
- How can an understanding of organisational readiness for change help us in programme design?

But as well as this, a recurrent theme was more generally how innovation is seen within the NHS and how we can develop a stronger culture of innovation, so that improvement becomes a normal thing to do?

We now discuss these issues in turn.

Designing innovations upfront

While many case studies emphasised developing change programmes in a bottom-up or emergent way, there is clearly a place for using predesigned innovations. This includes those with a strongly technological solution, such as a performance dashboard like that used in the

Emergency Care Programme, or the Small Business Research Initiative, where patients were invited to use an automated telephone service to monitor their conditions.

In embedding predesigned innovations, three things are key. Firstly, the initial design should be based on robust and credible evidence. A particular strength of the Rapid Improvement Programme and Enhancing Quality programme, for example, was the solid body of evidence on which changes were based (this is discussed more in Chapter 6). Similarly, the format of the Collaborative Commissioning events was based on previous evidence that pointed to there being barriers and a lack of collaboration between commissioners and providers.

Predesigned innovations should be based on robust and credible evidence and explained to stakeholders in a way that makes sense

Secondly, predesigned interventions need to be explained to stakeholders in a way that makes clear their relevance and benefit and how this will directly affect the way they work. Messages need to focus on what is going to change and what it will mean for that service and the people involved. It's also important to use the right language and to take the time to talk to staff and help them to understand what the vision means for them. This takes time but pays off in long-term engagement with the change.

Thirdly, a degree of flexibility is needed. A predesigned tool or methodology doesn't preclude bottom-up input. It's possible to be opportunistic in developing and implementing change programmes. For example although the aim and initial structure of the Emergency Care Programme was set by senior managers, the new ways of collecting and presenting data was a bottom-up suggestion from an information analyst, and as it developed, became absolutely central to the initiative.

The Rapid Improvement Programme team felt that in terms of change management and programme delivery, the programme would have benefitted from more time being spent on its initial design, as the team had to rapidly introduce new elements as it went along. But perhaps it is too much to expect otherwise.

Indeed, it is always important to relate innovations to local contexts, not apply then wholesale. As the experience of the Sussex Dementia Partnership and Southampton's Map of Medicine shows, it is important to build in local intricacies, respecting the differences of different communities and accepting that one size will not fit all. The innovative thinking required is necessary not so much to redesign a model but to think about how best to apply it in practice.

A note of caution: successful initiatives can raise people's expectations about what can be achieved elsewhere and these may not be justified. For each change, even if you are using an existing change model, you have to 'go back to first base again' in how you apply it in its new context.

The right change at the right time

Some feel that the success of their change programmes was fortuitous, based largely on how ready people felt for change: "We've been lucky;" "Like selling sweeties to kids;" "Simply the right change at the right time." An element of timeliness is key to success in these cases.

The sense of being compelled to do something and take action at this particular time can feel like opportunism, with organisations seizing the opportunity to make a change for which appetite and energy already exists.

> "Sometimes it is just the right time and things just come together… The local authority was ready to go for it, health was ready to go for it, GP commissioners – and we involved them right from the start – were absolutely committed to this … it was just the right time… if you recognise when system drivers are aligned, it can happen."
>
> Ann Anderson, Reablement Programme

But such success is not merely fortuitous; it comes from relevant, well designed interventions being applied in alignment with wider agendas, such as QIPP. The goals of the Reablement Programme, for example, were closely aligned with the national agendas of the Transforming Community Services (TCS) programme, Quality, Innovation, Productivity and Prevention (QIPP) and with the move to clinical commissioning groups (CCGs).

In our workshop, representatives of the case studies discussed the implications of change programmes having ready followers and landing on fertile ground. There were supporters and opponents of applying the idea of organisational readiness, or how receptive organisations are to change. Some thought that you do need to understand the stage the organisation is at. This can be a predictor of how long change will take and a guide on how much work needs to be done on culture change and convincing people to embrace different approaches. Ultimately it can help you manage the risk of failure because of resistance such as 'We did this before and it didn't work'. Potentially, they thought that it might be possible to develop a tool to measure organisational readiness, similar to the NHS Institute's culture of innovation tool.

Sometimes you have to push ahead even if the organisation is not ready

However, there was a clear note of caution from others, who argued that while it is good to be opportunistic and seize the chance to work with what's there to make change, sometimes you have to do it anyway, and push ahead even if the organisation is not ready.

A culture of developing and spreading innovation

One of the most practical and efficient ways of spreading innovation is using that which already exists. "Copying is cool" might be a good slogan here.

> "The NHS is bubbling with ideas, what we have been less good at is getting those implemented and even less good at doing the spread stuff; spreading from one organisation to another remains a real challenge".
>
> Duncan Goodes, Small Business Research Initiative

The Collaborative Commissioning events run by NHS South West were a powerful way of spreading the good practice achieved in pilots. They communicated the benefits, reinforcing trusts' interest in the area and keenness to improve practices, and spread important lessons in how to achieve improvement. In doing this, they also overcame a common cultural

barrier in the NHS, which can be described as the 'Not invented here' syndrome. People often resist innovations developed elsewhere, on the grounds that contextual factors limit their relevance. Sasha Karakusevic, who led the events, explained,

> "On many indicators we're … in the top five in the country. Everybody says that's because Torbay [hospital] is specialised. But 10, 12 years ago we were average. We've learnt faster than others to move up through the league table and therefore that's a reproducible process."
>
> *Sasha Karakusevic, Collaborative Commissioning events*

Related to this, a key way of supporting small scale clinically led innovation and creativity is by building trusted networks and learning from peer experience. This can lead to widespread improvements quickly. Within this process, it is important to foster peer to peer engagement and sharing, not only to spread ideas, but also to increase a collective sense of responsibility. The Enhanced Recovery Programme (ERP), for example, aims to involve nurses closely in developing solutions, partly to capitalise on their knowledge and insight and partly to give them ownership and ensure that these crucial people are bought in to the principles of ERP, so that it is firmly embedded and sustained.

Staff need to feel that they have permission to try out new approaches

Looking within organisations, a consistent message from our case studies was that it is important to have a culture that is open to change. Staff need to feel that they have permission to try out new approaches. Often this is not the case and a cautious, risk averse blame culture stifles innovation.

> "There are an awful lot of people working in hospitals who would not speak to a consultant for fear of overstepping their permissions … Because consultants feel so powerful and so important, one consultant might say, 'I want my patients treated this way' and another consultant will come along and say, 'Don't you dare treat my patients that way' … So that then leaves the staff on the ward feeling very vulnerable – if they do the wrong thing with the wrong consultant's patients they'll get into trouble."
>
> *Geoff Watson, Enhanced Recovery Programme*

Within this environment, it is not surprising that there is often a fear of initiating change, "because if you change it and it doesn't work, you'll be blamed" (Geoff Watson). ERP has attempted to "remove that fear" and "give people permission" to make changes – and mistakes – to evaluate then and stop if they don't work. An organisational culture that gives this permission is central to what makes a healthy organisation – one that is reflective, open to change and thus adaptable.

As well as facilitating action, this permission helps self belief hugely. A culture open to change tends to be one where high performance is the norm and goals are motivating rather than discouraging. Sometimes punishing failure is not the right thing to do if you're trying to encourage innovation. Some failure must be accepted because not all new ideas will work. It's therefore better to manage risks appropriately, to accept that failure is always a possibility and that when it happens it provides the opportunity to learn.

Despite the challenges that remain, there was a sense that the NHS has been successful in developing a stronger culture of innovation.

> *"There is more receptiveness to innovation and entrepreneurship and organisations are beginning to recognise that risk taking behaviour is a good thing, provided is it informed and controlled and rational decisions are taken based on reliable evidence."*
> *Duncan Goodes, Small Business Research Initiative*

It is true that people can fear change, especially when it is seen as 'top-down' and not enough attention has been paid to communicating its benefits and implications. Sometimes people are fearful of the sheer 'newness' of a process. But it is easy to overstate this fear: POPP, for example, found its elderly service users were more ready for change than many staff.

4. Improvement methodology

Main points

- A range of improvement methods can be useful and they don't always need to be followed to a 't'.
- Directive and emergent approaches work in different situations, even within the same change programme.
- Emergent change and devolved leadership are particularly useful for:
  - Understanding what really needs to change within a complex system – avoid 'doing the wrong things righter'
  - Tailoring innovations so they are appropriate for local contexts
  - Making whole systems changes, across professional and organisational boundaries.
- Systems thinking is vital for effective change in complex organisational contexts such as healthcare.

Tools and methods used

There are a wide range of validated methods for supporting organisational change.[3] These include:

- **DEMAIC** (Define, Enthuse, Measure, Analyse, Improve, Control) – develops tailored solutions based on the needs of the organisation
- **Lean** – looks at the stages of a process to achieve things with less effort and waste
- **Mass mobilisation** – talking with stakeholders at all levels to raise awareness of issues and build motivation for change
- **PDSA** (Plan Do Study Act) – a cycle of planning, acting, evaluating and reflecting
- **PRINCE2** (PRojects IN Controlled Environments 2) – this gives seven project management processes to go through, each of which brings together 'principles' (e.g. learn from experience) and 'themes' (e.g. quality)
- **Process mapping** – mapping an entire patient journey to see where the system can be improved
- **Rapid Spread** – developed by the Department of Health, this fast approach mobilises staff to introduce specific evidence-based High Impact Actions (HIAs)
- **Stakeholder analysis** – listing all groups of people who have an interest in the service in question and prioritising them.

You can select from a wide range of methods and tools, not all of which are directly comparable. Some, like PDSA, are broad approaches to project management that can be supported by practical tools, such as dashboards to track and analyse project data. Others, such as PRINCE2, aim to guide you through all aspects of project management, and some, such as stakeholder analysis, are specific to one element.

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3   Detail on a wide range of change tools can be found on the NHS Institute's website: http://www.institute.nhs.uk

Leaders in our case studies chose methods on different grounds, including what seemed most relevant for the project, but also which they were familiar with or trained, what was generally well known and used in their organisations, and what was promoted by the DH or the NHS Institute.

Very often programme teams did not follow these methods to a 't', instead using the general principles or stages to help them order and plan their activities. In particular, a couple of programme teams used the basic structure of PRINCE2 and followed it in more detail where that was useful, but would have felt swamped if they had tried using it wholesale. Similarly, the Patient Access Centre programme used the principles of the DEMAIC model but did not rigidly adhere to it.

Using this approach helped the team realise that often they do not adequately define the problem at the outset and jump straight to solutions. Whereas,

> *"What the methodology has shown us is, look, you think you've got a problem, be clear that you have and once you've defined that, actually get others to agree … because if no-one believes there's a change necessary, you're going nowhere."*
> *Malcolm Senior, Patient Access Centre*

Other programmes took an ad hoc approach, not using any overarching method, but focusing on how they used a particular tool – the Turnaround project that used the Map of Medicine is an example of this.

There were also implicit models, where the programme teams did not consciously follow a set method but the way they worked generally reflected one of these. For example, the Dorset POPP followed a mass stakeholder model and collaborative design without being clear on the theory behind this.

Top-down and bottom-up approaches

To different degrees, change programmes can be top-down (directive) or bottom-up (devolved and emergent). An example of a mainly top-down programme is the Patient Access Centre, where the executive board set the objective of introducing a trust-wide call centre for outpatient bookings.

Devolved leadership and emergent change were common in the case studies we looked at. Here, the programme teams were more focused on creating desire for change and facilitating action than driving through a specific agenda of their own.

> *"In Dorset we took a totally different approach to the rest of the [POPP] programmes … by making everything bottom-up. Everything was focused on community and how the community could better respond, taking on a responsibility towards their own health and social care … helping people to achieve their aspiration to remain living within their own homes for as long as possible."*
> *Sue Warr, Partnership for Older People Programme*

These programmes are by nature less didactic in their approach:

"Essential to the programme is that it's not: this is what you should be doing; stop doing what you're doing and do it this way. It's: how can you adapt the way you do it to make it slicker?"
Geoff Watson, Enhanced Recovery Programme

The distinction between these two styles should not be seen as black and white. Out of necessity, change programmes are often a mixture of top-down and bottom-up. For example, the strongly emergent Collaborative Commissioning events in NHS South West brought together over 100 staff to help them lead change on orthopaedic pathways within their own trusts. But in the first instance, the programme team used leverage from the SHA senior leaders, to make it difficult for the relevant staff to decline to get involved.

> **Out of necessity, change programmes are often a mixture of top-down and bottom-up**

On the other hand, while the broad plan for Patient Access Centre was set by senior leaders, within this there was scope for staff to influence it (see Chapter 8). Similarly, in the Emergency Care Programme, the aim of improving patient flows in A&E was set at an executive level, but the programme has seen high levels of involvement and consultation. One thing that was made possible by this was the real-time dashboard, which was very much a bottom-up innovation (see Chapter 3).

In a different way, the Turnaround Project also blended top-down and bottom-up approaches. On the one hand, the High Impact Actions used to reduce pressure ulcers and falls in hospitals were based on evidence and fixed in advance. But the Rapid Spread method that was used gave responsibility to individuals across the system for deciding how they applied them.

The benefits of emergent change and devolved leadership

Devolved leadership and emergent change form part of the same approach – they rely less on directive to plan change and authority to push it through, and aim instead to create desire for change and empower people to achieve it.

Emergent change is especially helpful in the healthcare system, because service models are complex and so many organisations and professions are involved. Similarly, devolved leadership often works well because the complexity of healthcare means that a single solution won't work in all cases: innovations need to be tailored to local contexts.

> **Emergent change is especially helpful in the healthcare system, because service models are complex and so many organisations and professions are involved**

For example, the Reablement programme used a systems model to gradually "unpick all the layers of how we've always done it" and understand what really needed to change. The process was time consuming and needed a number of teams at local levels, but it meant that the programme avoided simply making the same processes more efficient, or as one leader put it, "doing the wrong things righter".

Devolved leadership is also seen to be effective where programmes don't have the authority to enforce specific changes and have to work through influence – for example, a region-wide initiative like the Enhanced Recovery Programme (ERP) that aims to encourage trusts or GPs to improve their working practices. Rather than get compliance with best practice, these programmes can affect behaviour by changing attitudes and culture (this is discussed more in Chapter 8).

However, not all programmes aimed at spreading best practice work in this way. For example, the Enhancing Quality (EQ) programme was very clear on what best practice was and measured trusts against this. Why the difference? One reason is that EQ focused on discrete practices and ERP focused on whole patient pathways, so a wider range of options were being looked at. ERP also worked with less authority with a more mixed group of staff, so a focus on energising and facilitating was more appropriate.

Systems approach

Systems thinking is vital to effective change, especially in complex organisations like the NHS that don't operate in closed systems. To improve healthcare across the board, finding solutions that work well and last, it is important to look across organisational and professional boundaries and focus on patient pathways.

To find solutions that work, it is important to look across organisational and professional boundaries and focus on patient pathways

Emergent change and devolved leadership are particularly effective for this. This is partly because they help us evaluate the system properly and avoid 'doing the wrong things righter'. It is also because of the silos of NHS hierarchies, which make it difficult to make systemic change through top-down leadership alone.

A number of the case study programmes developed a systems approach. A good example is the Sussex Dementia Partnership, which engaged with a wide range of stakeholders (see Chapter 8). Through this cross-organisational partnership, staff across the system shared learning, improved understanding of patient needs and reduced duplication of efforts. There were challenges in maintaining the partnership and getting people to work for the greater good, not just the interests of their own organisations, but the programme managed to develop solutions that were useful for the whole system.

5. Programme delivery

Main points

- Project planning and management is vital but can be most effective with a light touch

- Devolving responsibility for delivering and measuring change can seem risky, but is a powerful way of getting people to take ownership and improving performance

- Make sure you have the time and resources you need to commit to change programmes

- External programme management can be useful but make sure that the knowledge and insights gained are transferred to the organisation

- Change programmes should be supported properly so that they can bed in and become sustained. However:

  – You must be realistic about the time constraints you have

  – You may have to be flexible to react to other changes in the NHS

  – If programme teams give too much support, it can create dependency.

How structured should change programmes be?

Whether change programmes adopt a broadly top-down or bottom-up methodology has clear implications for how they are managed and delivered. In particular, this leads to structured, detailed and planned delivery, or a hands-off approach where the project team oversee delivery but devolve responsibility for learning and action to others. This raises the question: how much should change be emergent and how much should it be carefully planned upfront?

Project planning

There is a clear need for programme planning:

- Funding bids often require plans and briefs and there is a national requirement to produce annual plans

- Getting clinicians and managers to plan together helps develop a shared understanding of what needs to change and how.

Planning should be about more than filling in templates or trackers. You have to do the right level of thinking to ensure delivery, which is about setting the outcomes and ensuring they are achieved. In particular, planning should include:

- Setting outcomes that relate to the purpose

- Deciding where to put resources to achieve this, avoiding the duplication of effort

- Reviewing progress and ensuring the right work is being done

- Reporting.

But planning can be too detailed. While it is always important to be clear about the 'content' of change (what you want to achieve) you should avoid being too prescriptive about the 'process'. Change programmes often benefit when people are trusted to do things their own way. Some planning on how change is to be achieved is necessary, but if people are given a degree of control, they have a greater sense of ownership and are more motivated to make change happen.

Planning is not about filling in templates or trackers, but doing the right level of thinking to ensure delivery

In practice, this can be done by having an upfront design that is proportionate in its detail and by being flexible with ongoing planning. This will allow for movement within the overall plan and give people room to innovate and tailor aspects of a change programme for their own use.

The balance between planned and emergent change will shift naturally through the course of change programmes, as you need to get to grips with issues before planning action around them. It will also vary according to the natural styles of those leading programmes. But as a general rule, only plan as much as is necessary – planning should serve and facilitate the project, not restrict it.

Devolved management

At times, the perceived need for planning and measurement can be less about managing the project itself and more managing anxiety about the project. The benefit of loosening control and handing more responsibility to those leading or implementing change locally is that people take more ownership and really engage with the change, which helps maximise potential. But is there a danger that doing this makes programmes less accountable?

The experience from a number of our case studies was that change programmes can be devolved *and* rigorous at the same time. Indeed, when people involved in the frontline delivery are involved in agreeing what rigorous delivery looks like, projects often exceed their initial estimates of what could be achieved.

Change programmes can be devolved and rigorous at the same time

> *"Generally speaking, because communities have identified what it is that they want to deliver, need to deliver … there's not been a reason to hold people to account, because they've done what they've said they were doing to do, and then some."*
>
> Sue Warr, Partnership for Older People Programme

Successful project management systems clearly agree people's responsibilities and accountability. It is the project manager's responsibility to keep the project on track; frontline staff should be shielded from project management and compliance and freed up to concentrate on their part in delivery.

Finding the time and resources

Organisational change takes time, typically more than anticipated. Programme leaders especially need time to think, articulate and get buy-in to change, build relationships

(especially for cross organisational partnerships), facilitate activity and gather data, not forgetting that they may need to develop their leadership skills!

Finding resources is particularly challenging when clinical, management and admin staff have to continue as usual with their normal jobs at the same time. Where there was an absence of dedicated project management and administrative support, such as in the Safe, Supportive and Therapeutic Care programme, this was seen to slow down the process considerably.

> *"[I went] into this with a huge level of naivety … 'Oh yes, we'll have this sorted in a year, it will be an absolute doddle.' And I think most people with an understanding of change management would have said that 'You're bonkers, and that's not what you're going to do'. But I think the fact that people now understand that it's doable, and what's achievable in that sort of timeframe … [is] an achievement in itself."*
> *Tony Kelly, Normalising Birth programme*

So it helps to be clear at the start of a change programme what staff resources are likely to be needed to achieve the objectives. At the same time, doing this will help you gauge what can realistically be achieved in what timeframe.

External consultants

One resourcing option is to bring in external resources to help manage change programmes. This was done in some cases where the right management expertise was not available in house.

For example, on the High Impact Pathways, external consultants managed the programme at a high level to make sure it was on track. This included focusing on the key issues, identifying risks and deciding what needed to be escalated. The consultants set up a so-called 'war room' as the centre of operations, which included large visuals on the walls marking progress. Overall, Peter Loomes thought that they brought "a real professionalism and attention to detail" that was much more robust than many people had previously experienced.

But while external consultants can bring new skills, there are potential sensitivities to be aware of. In particular, they can lack, or be seen to lack, an understanding of the NHS and it can be difficult for them to fully integrate in the organisation. In the High Impact Pathways programme, this sense of "What do you know about hospitals?" combined with unease about the top-down nature of the change and the fact that people were being parachuted in, leading to feelings of being done 'to' not 'with' and difficulties in working relationships with the programme team. As a result, the programme received some push back from staff. As discussed in Chapter 2, there was a clear view that more clinical leadership would have helped avoid this.

Another important point about using external consultants is that, to get the full benefit, the skills and expertise that they bring onto a programme should be transferred to potential

leaders within the organisation, so that they can continue the consultant's work without being dependent on them.

Sustainability versus speed?

A key driver for this review was to help support "a system that can significantly ramp up the pace and scale of change and innovation".[4] One way of achieving this is to redouble efforts to spread and support change initiatives in the NHS as a whole – for example, by sharing learning and raising awareness of existing innovations, and coordinating and publicising resources and guidance.

But equally, there is pressure on individual change programmes to become more efficient and streamlined, so that they can achieve tangible benefits more quickly. Given the time needed for emergent change (see Chapter 4) there is potentially a tension here between speed and sustainability. How can this be managed?

One lesson is that, no matter how rapid change is going to be, crucial for it to be sustainable is to have a clear, shared purpose. If this means upfront stakeholder involvement and collaboration, that needs to be factored in. For example, in spreading innovations,

> *"If you do it very short term, you just get clinical disengagement, because it requires clinicians to change what they're doing and how they're doing it, and they don't do that very quickly"*
> *Kay Mackay, Enhancing Quality programme*

Secondly, one can take a mixed approach, with rapid change in some cases and a slower roll-out alongside or following this. For example, the Rapid Improvement Programme ran for an intensive 12 weeks in two pilot trusts in the south west. The principles of the delivery model were then shared with other trusts in the region through the Collaborative Commissioning events, which encouraged people to take responsibility for their own learning. This dual approach was borne of limited resources and the belief that trusts should be able to lead their own improvement programmes without being dependent on the NHS Institute's direct support. Change through the Collaborative Commissioning events was slow – about three years for proper results to show – but on the other hand, what seems to be sustained change was achieved with a light touch intervention.

Change can fail if you try to do it too rapidly, yet there is a need to create a sense of urgency

One should aim for balance rather than compromise. Change can fail if you try to do it too rapidly, yet there is a need to create a sense of urgency. The trick is to identify what are potential quick wins and what relates to a longer-term vision. Demonstrate results early on so people can see the benefits, but also stay true to the overarching objectives, working on these as thoroughly as necessary for the change to properly take root.

Keeping up with other changes

A number of leaders felt that change programmes were often not given enough time to bed in before other changes were being implemented. In short, 'give change a chance'

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4   *Innovation, Health and Wealth: accelerating adoption and diffusion in the NHS*, Department of Health, 2011.

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before you change it again. There is a strong argument for organisations holding to a course and not being erratic. Programmes must be given an appropriate level of resources and realistic timeframes to have a good chance of success. And for this, senior leaders need to be persistent and dedicated to change programmes, just like the individuals who spearhead them.

But at the same time, it is not realistic to expect that change programmes will always have time to fully bed in before they are superseded by other changes. Indeed, one could argue that, while sustainability has been the holy grail of change, we are now in an era when change is so continuous that this is less of a premium than flexibility. For example, mergers and other organisational transformation unavoidably interrupt change programmes, draining energy and diverting focus to more pressing issues.

At one level, this is simply something you have to manage as best as you can. Those leading change programmes may have to revise timelines, but ultimately, there is little they can do except persevere. It is inevitable that some momentum will be lost, so the challenge is to regain this as soon as possible.

However, change programmes may also need to adapt as they go along, so that they keep up with other changes taking place. If the organisational structures that you are trying to work with alter, you may need to try a different tack to achieve what you originally set out

Change programmes may need to adapt as they go along to keep up with other changes taking place

to do. So as well as change that is both rapid and sustained, there is a third thing to aim for: change programmes must themselves be responsive.

There is a sense that NHS staff have become more adaptable and accepting of change, in part because the need for change is so clear and partly because there has been so much organisational change that people are now used to it. Nonetheless, there are things that can be done to help make change programmes more adaptable and resilient.

Firstly, at a practical level, try not to make the change programme too reliant upon any particular person, or even specific processes, so that it is less vulnerable to personnel or organisational changes.

Secondly, stay true to the fundamental purpose of the change you are making. Recognise what are the most important things to hold on to and think laterally about the challenges that you face, looking for new opportunities to achieve your vision. Sustaining change is not about keeping things the same, but keeping them true to your aims and purpose.

Support change, avoid dependency

Finally, an important lesson on delivering change is that, while programme management teams give vital support to help make change happen, they can give so much support that frontline staff become dependent on it and don't take on responsibility for the change themselves. A balance needs to be struck so that the innovation doesn't end along with the team's involvement.

"One of the interesting questions is how much of a catalyst do you have to put in place to create change. When do you stop being a catalyst and create a sort of dependency? [In my view,] when you've got 80 per cent benefit out of the intervention, you should move on."
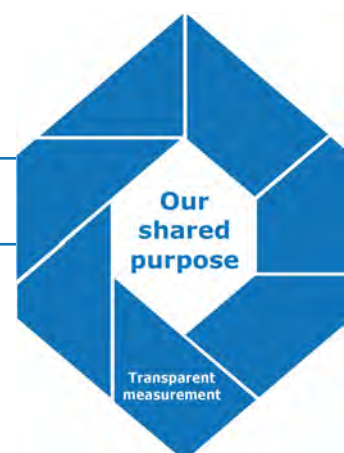
Sasha Karakusevic, Collaborative Commissioning events

6. Meaningful measurement

Main points

Measurement is important to demonstrate quick wins, to find out what works and what does not, to motivate and to celebrate results. Measurement works best when it is:

- Transparent, robust and convincing
- Clinically based and relevant
- Self produced and 'owned'
- Simple

The importance of measurement

Perhaps the most obvious use of measurement is by managers as a basis for robust performance conversations. But there are other reasons that measurement is important.

Demonstrating quick wins shows the programme's value to people delivering it and sponsors

For all programmes, but especially those with a long-term vision, it is useful to focus on demonstrating quick wins to show the programme's value to people delivering it and to sponsors. Measurement also creates motivation around the change programme. Within the Emergency Care Programme, sharing dashboard data created healthy competition amongst clinicians who were able to compare their performance to others.

> *"Staff have spontaneously taken themselves away to understand their level … Now, that tells me that we have reached a tipping point where we've got people proactively wanting to understand their own business and their own level of performance."*
>
> *Rob Rose, Emergency Care Programme*

Results and measurements can be shared across teams and across organisations. Sharing what has gone well, what hasn't and learning from the experience of others is a powerful tool for driving best practice. For example, throughout the Enhancing Quality programme, face-to-face and web-based learning events were used to facilitate this sharing.

Emergent change is grown roots up and based on stakeholder engagement. At a broad level, this requires clarity on the vision and what the outcomes might be, more than a detailed plan. However, it is also necessary to map out emergent change and make a plan. Thus, emergent change does not preclude measurement. You still need to capture what the baseline is to provide evidence of the change that takes place and its impact; equally, transparent measurement helps achieve more sustainable success, as in the words of one leader, it "reveals where we've slipped" and as such, refocuses and reenergises the change.

Measure the right things in a helpful way

Agreeing measurable objectives and target outcomes can be challenging early on, but these can be refined and evolve over time. One or two indicators, broken down quite substantially, should be used to provide an approximate measure of success.

> *"We had a lot of problems in agreeing the outcomes and what did good look like. And I bought this really long, complicated document about what the outcomes should be and how we could derive them. But we just had to discard an awful lot of them because they're just not feasible."*
> *Cathy Price, Map of Medicine for GP referrals*

But clearly, simplicity is not enough. Measurement should be robust, reliable, believable and, crucially, clinically based.

> *"Clinicians, when you show them data, most of them will say that's rubbish. 'Don't believe it, it's wrong.' But, because the data is so powerful and so clinically orientated, they come to believe it."*
> *Kay Mackay, Enhancing Quality programme*

In this programme, the data was sufficiently detailed to be able to trace individual events; for example, if a patient was held up in A&E and antibiotics were not administered. In this way it was possible to identify and rectify any weaknesses in patient care.

Targets should reinforce the purpose of the change – they should not be abstract performance indicators

Targets should reinforce the purpose of the change – they should not be abstract performance indicators. For example, in the Emergency Care programme a measure of the reductions in the number of beds used was a key target. However, it wasn't used as a measure of quality in itself. There was an appreciation that other factors would need to be considered when measuring quality of care, such as the number of readmissions.

It is for this reason that reviewing change programmes should also be broader than simply using measurement and targets. In particular, case studies or success stories are a very powerful means of reviewing, as they can illustrate what the purpose looks like in practice.

Measurement shouldn't be too onerous: there needs to be trust in the system to enable people to get on with their responsibilities, rather than a reliance on arduous processes to monitor results. A helpful assumption to take is that people will perform well, not that they won't.

Trust within change programme teams and between stakeholders is an important ingredient in organisational change, and enables teams to have difficult conversations without relationships breaking down. In order to build and maintain trust, it is often necessary to use values-based arguments rather than coercion.

> *"If we were too much the sabre rattler I think we'd diminish that trust … Our influence and ability comes, where we've had to have hard conversations …*

we've rarely had to resort to … threats we've just had to stay firm to … the core guiding principle by which we're working … Whatever our core principle is we use that rather than some commercial threat."

Richard Smale, Healthy Futures Programme

Complex measurements can stifle innovation and discourage risk taking, especially when measurements are used as a way of managing anxiety. By keeping measurements simple and transparent, staff are more likely to engage.

One of the most powerful ways of creating meaningful measurements and accountability is by involving staff in developing their own targets and even the criteria for success. For example, in the case of the *Normalising Birth programme*, the programme team saw that

"Overarching caesarean section rates have been peddled … as a surrogate marker of quality, and they're very blunt, they don't capture a lot of really valuable information".

Tony Kelly, Normalising Birth programme

Thus, the programme helped people be clearer about the reasons for variation before getting them to start making changes. Staff defined their own goals and, as a result,

"They owned the data … [We said:] it's not data that we're going to give to you that we've got from somewhere else, you will generate the data, you will just send it to us on a monthly basis, and we will recode it, and give it back to you in a very believable, transparent format. And that was brilliant because … they couldn't hide behind anything."

Tony Kelly, Normalising Birth programme

Shared responsibility for measurement may involve a loss of control but brings with it a better chance of ownership and often better results

Shared responsibility for measurement may involve a loss of control but brings with it a better chance of ownership and motivation, and often better results. The danger of people setting targets too low was not something seen on the Enhanced Recovery Programme where people set their own targets. On the contrary, as well as being a powerful way of getting staff bought in to targets, it often led to targets being increased, as staff felt that the national targets or standard benchmarks were unambitious and should be stretched. This is the sort of benefit that comes from change programmes being "managerially loose but culturally tight" (Bevan et al, 2011).

7. System drivers

Main points

- Innovations and change need to be incorporated into the system to survive
- There are a range of system drivers that can be used to reinforce change, which need to be aligned
- Overusing system drivers can backfire by giving perverse incentives
- Be honest about the nature of targets and incentives – they may not map perfectly onto our shared purpose, but can still be useful.

The use of system drivers

Change can't survive outside the system for long: one way or another, it needs to become business as usual. System levers are the obvious way of achieving this. At the most general level, it is a question of aligning all the management structures within an organisation or across the healthcare system so that they reinforce the right practices and high standards.

In their broadest sense, system drivers relate to a range of areas, including:

- HR systems – how people are managed to support change and innovation. For example, giving people the time to work on programmes; recruiting or seconding people to specific posts for change programmes; individual appraisals and rewards.
- Financial incentives
- Strategic planning processes – does the way that organisational strategy is formed take consideration of and support innovations on the ground?
- Information systems – e.g. how IT systems facilitate and draw attention to change initiatives
- Organisational culture – is the organisation used to change and innovation; is there a general mindset of continuously making improvements?

Change can't survive outside the system for long: one way or another, it needs to become business as usual

Measurement-based system drivers can be a natural extension of other types of comparison. For example, as the Enhancing Quality programme shows, a powerful way of driving best practice is to harness clinicians' desire to be seen as high performing by getting them to share their improvement activities with peers. Taking this a step further, transparency on working practices can be formalised. The EQ programme used a CQUIN (Commissioning for Quality Innovation and Improvement) mechanism to incentivise the adoption of best practice.

Financial incentives are most typically used to reinforce best practice, for example through the use of CQUINs. But they can also be used to incentivise people to take part in change initiatives. For example, in the Map of Medicine for GP referrals programme, GPs were given financial incentives to contribute to the work on developing pathways.

In almost the reverse of this, the backing of Clinical Commissioning Groups (CCGs) greatly helped raise interest in the Reablement programme:

> *"The developments in clinical commissioning have been a huge systemic driver. The CCG is really passionate about this and really keen to push forward with the implementation. And providers are more willing to put their heart and soul into it because GP commissioning is seen as the future."*
>
> *Ann Anderson, Reablement Programme*

Hit the target but miss the point

System levers, in particular financial incentives, should not be used in isolation, but should be clearly linked with the purpose and vision of the change in question. In short, they should reinforce desired change rather than become the main point.

System levers should reinforce desired change rather than become the main point

There are two main dangers. Firstly, change that is too reliant on ad hoc system drivers will probably be short lived, because attitudes and culture are not changing with it. The moment the incentive disappears, the change will be in danger of relapsing. This risk can be reduced by including the incentives within standard contract requirements.

But there is another danger that, if they are not carefully designed or are overly complex, system drivers can direct energy into the wrong things. As one of our leaders put it, it is easy to 'manage the beast feeding' and the overuse of targets and tariff incentives often result in people 'hitting the target but missing the point'.

It is easy for system drivers to become confused and get in the way of each other, making staff on the ground feel that they are being pulled in multiple directions by contradictory processes or demands. So leaders of change programmes should consider not only the system drivers they are using, but also other system drivers that may conflict with it. For example, you may have an objective to reduce activity in certain operations, but if providers are rewarded based on how many operations they do, this system is working against your plans.

Beware the carrot coloured stick

Carrot and stick are two sides of the same coin. Once incentives are established, not receiving them can be seen as punitive. A lesson here is to be honest with people and recognise the contradiction between how incentives may be intended and how people relate to them.

Equally, it is important to be clear about what specific targets mean, especially those that link cost and quality. For example, the Emergency Care Programme used the number of beds saved as a key metric *alongside* measurements on readmissions. This reinforced that the programme was not simply about saving money and that saving beds was only good so far as quality of care did not decline.

8. Stakeholder engagement

Main points

- Stakeholder engagement is crucial for change to be 'owned' by the people it concerns and thus sustained
- There are different degrees of engagement, from simply getting buy-in to collaborating on design – it is important to be aware and open about what level of involvement you are offering
- Recognise that there are different motivations for different groups: clinicians, GPs, patients etc.
- Engagement takes time but does not necessarily need to slow down a programme. It can be carried out throughout a programme in parallel to other activity.

Why engage?

In order to really understand the problem and produce realistic solutions it is important to get a view of the diversity and breadth of the different needs. In the case of the Sussex Dementia Partnership it became clear that different localities in the county had different needs. The programme manager spent time working across these different stakeholders to find common ground before establishing where to focus the work.

The importance of being sensitive to local issues was also highlighted in the Patient Access Centre case study when implementing call centre technology across hospitals and departments. The team came to an understanding that in every organisation there are different politics, personalities, issues and problems. Just adopting someone else's approach is not sufficient to engage across these differences, you have to make sure you generate enthusiasm for the idea at a local level. This principle was apparent when implementing the call centre technology.

Change that is culturally tight and managerially loose is more sustainable than the effect generated by a coercive or reward based approach

Obtaining buy-in and ownership will lead to sustained change. In the Enhanced Recovery Programme, leaders adopted a shepherding role providing direction and gentle pressure for change but leaving space for staff to create solutions. The idea is that change that is culturally tight and managerially loose is more sustainable than the effect generated by a coercive or reward based approach. The downside is that it often takes longer and may not be as effective in the shorter term.

> "There's nothing more powerful than being able to sit down with people and say, 'This is what everyone else is doing and you're not really doing as well as they are; over to you.' If they come back and say … 'How can we make it better?' 'Well here's some ideas we can help you with.' That's much more powerful than going in and saying, 'Do you know you're no good, you've got to do it differently … and we're going to put a manager in place whose responsibility is to make you do it differently'. I don't think that that's sustained change."
>
> Geoff Watson, Enhanced Recovery Programme

There are other ways to galvanise people into taking ownership. The Turnaround Project used a carefully crafted full-day event designed locally to develop collective identity, win hearts and minds and mobilise people into action. Considerable thought was given to engaging people, including nominating the Director of Nursing to introduce the event and the use of video to give a different pace to the day. The event was seen as a key factor in gaining commitment to change.

Even when the approach to change is top-down and directive, gaining buy-in is important as it enables more transactional changes in processes or systems. The Patient Access Centre project highlighted that even with a generally top-down change stakeholder involvement was needed to prevent change from stalling:

> "We want you to be part of this, we want you to engage. If you don't, you will lose the opportunity to influence the process, your job description, your working arrangements, your office."
> Nick Debney, Patient Access Centre

A benefit of engagement is that it breeds advocates

Patient involvement can act as both carrot and stick for change programmes. Improving services to patients is the main reason that people engage with change. Involving patients in the design of programmes can also be highly effective. In the Partnership for Older People programme, older people were used to help design local solutions and the POPP board felt this partnership was one of the key elements that made the project a success.

A benefit of engagement is that it breeds advocates. Clinical leaders and patients are particularly convincing along with people who can talk across specialities and executive sponsors.

> "With patient/public involvement and stakeholder management and comms … we [generally] invest heavily in that … We get good results because ultimately at the end of the process we get patients standing up as advocates, which is very powerful."
> David Tappin, Healthy Futures Programme

What do we mean by 'engagement'?

There is much talk about 'engagement', but it does not always refer to the same thing. At the two extremes, there is a clear difference between stakeholder collaboration to help define the problem and getting people to buy-in to a fixed agenda.

A truly collaborative cross-organisational change programme requires dedication. The Sussex Dementia Partnership took time and considerable effort to build, particularly in a difficult financial climate. Partners were required to be honest about their own organisational agendas and reach beyond these to the greater good, creating something larger than the individual parts.

On the other hand, once the wheels are in motion, it is harder to get buy in and people can start to feel they are being done 'to' not 'with', but here too there is the opportunity for

genuine stakeholder engagement. Involve people early and find meaningful ways of feeding back information in real time, especially when they are apprehensive or fearful of the change.

The key lesson is that it is important to be clear and open about what decisions can be shaped and what can't. The Patient Access Centre is an example of when limiting involvement and influence was legitimate and necessary. Involvement from the grass roots from the outset was an enabler of its success but so too was clarity around what people could influence and what they couldn't. Above all, beware of raising expectations too high, as making a sham of consultation seriously undermines trust (Gifford et al, 2005).

How do you engage the right people in change?

Stakeholder analysis

- Understand who has systemic and political influence. Where does the real power lie?
- Understand at what level you need to influence and why you need to influence them
    - Enablers – executive sponsor
    - People you need to involve
    - Doers – people who you need to play an active role
- Understand who will not get on board
- Understand who is against you
- Who's willing and able - who has the skills to get the change done
- Understand the distinction between power and authority (e.g. PA may not have authority but could still hold a lot of power)

On the Sussex Dementia Partnership, representatives from a wide range of the stakeholder groups sat on the quarterly meetings with the delivery board. These included ambulance, community, hospital and primary care trusts; clinical commissioning groups, local councils, charities and a care home provider forum.

Be open minded about who you should involve and don't forget those people that you don't speak to often as they are likely to be the ones you need to convince. To illustrate this, in our workshop we heard an anecdote about a discussion between two colleagues that went along the lines of:

> *"You absolutely have to involve estates in that."*
> *"In my 20 years here, I've never involved estates in anything."*
> *"Hmm. Perhaps that's why it never works."*

Shared vision and ownership

Creating a shared vision and goal is important. It can be easy to say 'Get people to own the change' but thought needs to go into answering the question 'why would they own the change?' Put simply, people will own change if they can see what's in it for them and the services they deliver and when they are asked for their help and involvement.

People will own change if they can see what's in it for their service and when they are asked for their involvement

When it comes to engagement, one size does not fit all. People at different levels and in different functions will engage at different rates and to varying degrees. Think about how to frame and reframe across different groups and take time to tailor engagement activity.

Lack of time and resource can be a barrier to certain people. In the Map of Medicine programme, the pressures on GPs of effectively running their own businesses meant they often didn't engage with the programme due to a lack of staff resources. However, several programmes found that even small amounts of money can make a huge difference in freeing people up to take part in change programmes.

Similarly, as mentioned in Chapter 1, different groups identify with a vision for change more or less strongly, depending on their position and experience. In short, some people are easier to engage than others and everyone needs to be able to clearly see the benefits.

> *"Some of them [GPs] have got really fired up … and said, 'This is great, I want to be involved,' and some would still say, 'Not interested, nothing to do with me. Why are you trying to talk to me about what you do in hospital?'"*
> *Geoff Watson, Enhanced Recovery Programme*

In the Reablement programme, senior people engaged quickly with what the programme was trying to achieve. However, the project team took time to involve those on the front line, understanding the potential barriers this group could present to the programme if not engaged sufficiently. The team ran half-day events focused on frontline staff ensuring they felt they were part of the change and contributing to it. The shadowing of early adopters by other frontline staff was particularly effective at engaging as it enabled people to draw the same conclusions through witnessing the approach.

When building a consensus for change, make a case convincing by:

- Establishing that there is a common issue that needs to be addressed
- Using evidence to convince people of the need for change – 'do your homework'
- Understanding your audience - think about the different groups and what type of evidence will resonate with them (e.g. financial case, practical case, morale case etc.)
- Showing how the change relates to better quality patient care
- Telling people what could potentially be done or if at that point, what has been planned, and sell them the benefits

Recognise and support involvement

Another thing that can help motivate stakeholders to get involved is simply giving recognition for the value of their input. For example, in the Map of Medicine case study, the chief executive of the foundation trust explicitly asked consultants for their support, asked managers to allow consultants freed-up time to work with the programme, and personally thanked those who contributed clinical input to the Map.

"It was just a simple thank you … because he knows they're doing it above and beyond their day job and I think that recognition made them feel valued and it actually made them want to do more."
Lucie Lleshi, Map of Medicine for GP referrals

Communication

Talk about the vision, why is the change needed? It helps to have a broad message but tailored communications. Personalising style and content for different audiences will help messages get through at the right time, to the right people.

It helps to have a broad message but tailored communications

Engagement is as much about listening as it about giving messages. Show empathy and don't be afraid to ask people what they need to get on board; people will tell you what engages them if you ask. Being involved in the Partnership for Older People programme was a fun experience for volunteers, it gave members a feeling they were giving something back.

Several factors were seen as key to the success of the Patient Access Centre. Firstly, it was vital to explain the goals of the project in a transparent way to stakeholders and to get their buy-in by spending time listening to them and by responding to their concerns. Secondly, relentless communication of the message and persuasion was necessary to convince people that there is a better way of doing things. People can take a while to get on board, which can make the journey lonely at first.

When planning your communication:

- Feed back regularly about progress to stakeholders. Avoid nasty surprises as change is rolled out.

- Be transparent – for example, in one trust, the status of change programmes was displayed on the wall with their progress and every week leaders 'walked the wall'. People displayed their project because it meant their progress would be seen and when there were issues people could help them achieve their goals. This created two-way accountability; people were accountable for ensuring their projects were progressing and leaders were accountable for helping the project team progress.

- Share learning – success stories to spread good practice and motivate the people leading change; and important to reflect on failures as learning points not only to improve how we work but also because if people encounter the same problems time and again then they will become disengaged.

When to engage

Engagement takes time, particularly for bottom-up emergent change. However, it doesn't necessarily have to slow down the programme, as it can be done at the same time as other activities. If possible, start engagement early, alongside getting the structures in place, and use it to inform the design. This provides valuable input to the programme and drives deeper staff engagement. But it is also important to continue to engage stakeholders as innovations are initially implemented and then rolled out.

Conclusion

Evidence on the NHS Change Model

In this report, we have compared our findings from the review of change programmes to the new NHS Change Model. At the heart of the model lies shared purpose and our research confirms that purpose and vision are crucial factors that need to be reinforced at all stages of change programmes. Focusing on them helps in all sorts of ways, including:

- Developing consensus and generating buy-in
- Making sure models, project plans and measurement are fit for purpose
- Spreading innovation
- Thinking about system drivers and making sure they are aligned
- Keeping change programmes on track and reinvigorating them when they plateau or run out of steam.

Purpose and vision are crucial factors that need to be reinforced at all stages of change programmes

Purpose and vision sometimes need to be rearticulated if programmes are starting to wander off course. They also need to be explained in different ways so that people can relate them to their own situations and see the importance of a change programme.

The review also confirms the importance of the other areas of the change model, although in some cases, the case studies lead us to a broader understanding of these areas than the specific wording of the model suggests. For example, the case studies show that just as important as measurement being transparent is that it is meaningful, clinically relevant and 'owned' by the relevant staff groups.

Part of the argument behind the NHS Model is that "if concentrated effort is given equally to all components, the sum will be greater then the individual parts" (Katherine Foreman). This was the case in all the case studies of the review. We came across change programmes where some of the categories of the NHS Change Model are only covered in a brief or general way, if at all. Most notably, some programmes followed an implicit approach but did not consciously follow a specific improvement methodology. Also, measurement of outcome measures and working to use system drivers were not always central aspects of change programmes.

But the nature of this research is that it was a review of learning, rather than a series of programme evaluations. As such, our conclusions on this are limited. Although the argument makes sense, we cannot be sure whether these programmes would have been more effective if they had covered off all elements of the model more clearly.

Using change methodologies

While most of the change programmes in our case studies followed an explicit change methodology, it is striking that they did not normally follow these methods to a 't'. Indeed, a common lesson was that methodologies should be followed in a proportionate way and programmes should not become over-reliant on them.

Models and planning are necessary, but they should only be used as far as they actually help you set direction, plan and review. Their point is to clarify what needs to be done to work towards the programme's original purpose. Don't let them become the main focus of the programme, as this can constrain innovation and even detract from what you are trying to achieve.

Models and planning are necessary, but they should only be used as far as they actually help you set direction, plan and review

Nor is it necessary to become an expert in a change methodology before you start leading a programme. Models are there primarily to help thinking, so the priority for leaders should be to internalise the principles of relevant models and apply this to practice, rather than to become a 'black belt' in the theory that lies behind the models.

Training and use of skills

Related to this, management training is an important aspect of building organisational capacity for change, but isn't a precursor for staff to lead change. Much leadership development happens through the experience of working on the ground, getting feedback and reflecting on action, and responding to this by trying different approaches.

Thus, coaching and other support, such as expert advice and toolkit-type resources, can be enough to harness the leadership potential of motivated staff. Clearly, such leadership development support needs to be accessible, which means that adequate resources must be available and well publicised.

Before training more people up in management methodologies, first look at the expertise that already exists in the organisation and make good use of it. And if management training is being used to develop expertise, we should try to ensure that it will directly benefit the organisation as well as the individual.

Be clear and honest

In an environment where staff suffer from 'change fatigue' and can be suspicious of new initiatives, it is vital to be open and clear about the intent, scope and approach of change programmes. This is not only a question of being honest, but also of explaining programmes in ways that people can understand and relate to their own positions, be they staff or patients.

It is vital to be open and clear about the intent, scope and approach of change programmes

Equally, the programme team and its sponsors must be clear about how the programme will run and what is realistic for it to achieve with the resources and timeframe it has. This openness will help build mutual trust and make sure that the programme is properly supported.

Being clear and honest is an important lesson for all aspects of change programmes, in particular:

- The drivers and purpose (e.g. cost and quality)
- Programme timescales
- How well prepared organisations are for change

- The scope of stakeholder engagement (e.g. what is 'up for grabs' and what is fixed)
- How incentives relate to the programme's aims.

Engage where you can

Stakeholder engagement is a huge facilitator of change as it helps you 'take people with you'. It makes use of on-the-ground experience, makes people feel listened to and valued, and generates a sense of ownership. In doing this, it brings cooperation, motivation and energy to change programmes, which makes the difference between success and failure.

Engage people in a meaningful way, being open about the limits of involvement and the value of their contribution

But engagement has to be appropriate and realistic. There is often a balance to be struck between involving stakeholders in decision making and making sure that change programmes align (and stay aligned) with organisational, regional or government strategy. Also, stakeholder engagement takes time and resources and there is practically a limit to what one can do.

The most important thing is to engage people in a meaningful way, being open about the limits of involvement, but also being clear about the value of their contribution.

Culture of innovation

The case studies confirm that the spread of innovation benefits from considered planning and needs time and dedication. In particular, it helps to translate innovations to the local level, explaining what they will mean for procedures and what the benefits are, and being flexible with how they are implemented to suit the particular setting.

The review also highlights the importance of developing a culture of innovation in which people feel that they have permission to try out different approaches. This can be quite challenging in the NHS, because hierarchies are strong. Another unhelpful belief that many people seem to hold is that innovations developed elsewhere won't be relevant to their setting. The message of 'copying is cool' or 'steal with pride' may help the push for replicating successful initiatives.

Learn from change

As well as replicating and spreading specific innovations and successful programmes, it is important to share broader learning about what makes change successful. Part of this is to reflect openly on what has not worked well and learn from our mistakes.

Collaboration and competition can exist alongside each other, if we are open to sharing learning and developing joint solutions

One thing that can get in the way of this is a culture of competition, which can stop people from seeing the long-term benefit of spreading best practice beyond their own units or organisations. Competition is a reality in the healthcare system and is not about to go away – indeed, it is increasingly being used to drive improvements in quality. But we need to make sure that collaboration is not forgotten within this. Collaboration and competition can exist alongside each other, if we are open to mutually beneficial opportunities to share learning and develop joint solutions.

It is our hope that this review and the surrounding activity will help foster such collaboration. Just as the review has looked back at recent change programmes, the community of interest and the online Catalogue of Change Programmes[5] will be designed to take this work forward and support the ongoing improvement of the healthcare system.

5   See introduction.

Appendix: How we did this review

The project started in March 2012 with the development of a classification framework to highlight key characteristics of NHS change programmes. This framework guided our data collection and analysis and was used to select the 15 case studies. To inform the design of the framework, we drew on our understanding of other change models, including Bridges' transition model (Bridges, 2003), the Burke-Litwin model of performance and change (Burke and Litwin 1992) and the McKinsey 7S (Peters, 2011), as well as the work of Kanter (1984), Kotter (1995), Stacey R (1996).

Emerging Model of Large-Scale Change

Joint communications were sent from NHS South of England and Roffey Park to a wide network of contacts across the region, calling for expressions of interest to take part in the review. Interested parties were contacted directly and through a 'snowball'/cascading approach (e.g. sending communications to trust directors and people overseeing clusters of change programmes).

We held 53 exploratory telephone discussions with leaders of change programmes, from which we selected the 15 case studies. We aimed for the case studies to include a broad range of change programmes, covering different clinical areas, models of change, types of intervention and geographical areas.

Face-to-face and telephone interviews were conducted for each of the case studies in April. Interviews were recorded, transcribed and analysed, with individual case study reports being written. After these had been collated, we conducted a second round of analysis, looking at themes across the case studies and comparing them against the new NHS Change Model.

Acknowledgements

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