

Improving local healthcare

**Modernisation Initiative**  
**Executive Summary**

1. This report describes and evaluates the Modernisation Initiative (MI), a system-wide transformational change programme working across the health economy in the London Boroughs of Lambeth and Southwark to modernise local health services. The MI was a partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT), King's College Hospital NHS Foundation Trust (KCH), Lambeth Primary Care Trust, Southwark Health and Social Care, community groups, patient groups and the independent and voluntary sector.
2. The MI was funded by Guy's and St Thomas' Charity (the Charity), which made a decision in 2000 to invest a substantial sum of money to enable significant service improvement in certain areas of health care locally. The aim was to make a 'big difference' to the delivery of health care in those areas, in terms of: tangible change, as represented by novel services, service options or modes of delivery; cultural change, as reflected in behaviour, relationships and balance of power between healthcare organisations, staff and patients; and measurable improvements in the quality of care. The improvements were expected to extend across the whole care pathway; cover all relevant patient populations; have an impact that extended beyond the immediate locality; and be sustained into the future beyond the funded period.
3. An independent evaluation was commissioned by the Charity through competitive tendering. The Charity's requirements of the independent evaluation were that: it should provide insights about progress to support the implementation of the MI; illuminate the evolving relationship between the MI and the local health system; generate learning about the relationship between context and process in service transformation; provide an account of the impact of the initiative in relation to its objectives; and explore the implications for the Charity's approach to funding future initiatives.
4. The design of the evaluation had to take account of the fact that each of the three MI projects had many objectives and multiple work streams operating within and across the local health care system and community at a variety of levels, and that these different initiatives were likely to change organically with time. The approach taken was one of 'realistic evaluation', which uses a variety of methods (mainly but not exclusively qualitative) to explore the interplay between context, mechanism and outcome. This approach allowed us to provide formative feedback to project teams and the MI as a whole, as well as drawing summative lessons at a more abstract level, both for the Charity and for research and policy more generally.
5. A total of £15 million was provided to fund modernisation projects in three areas of service provision – for stroke, kidney and sexual health. The projects received start-up funding to work up plans for service improvement, followed by further tranches of investment to support implementation for a further three year period. The project funding ended in March 2008.
6. In terms of working methods, the MI was heavily influenced by the concepts of redesign pervading thinking about service modernisation in the UK and US in the early 2000s. An eclectic mix of approaches was drawn on, including re-engineering, total quality management and lean thinking, all of

which share: a focus on the patient or customer and the quality of their experience; an emphasis on the patient process or pathway rather than on departments or tasks; and a commitment to improving efficiency and clinical excellence; and strong, distributed leadership throughout the programme. The MI was designed to provide a breathing space for improvement, enabling dispassionate analysis of problems with existing services and sustained attention to finding solutions in a neutral, collaborative space protected from the pressures of usual business in the NHS.

7. Through a process of extensive consultation and analysis of information, the MI project teams identified a wide range of problems with current provision in relation to the planning, recipients, providers and pathways of care in each of the three areas. Existing services were experienced as, variably, inaccessible, inconsistent, staff-centred, designed around a medical model of disease, culturally naïve, disjointed, hierarchical, and inefficient. The vision for transformation was that services should become more accessible, evidence-based, patient-centred, designed around a holistic model of illness and risk, culturally congruent, integrated, collaborative, and efficient.
8. Shared strategies for achieving this vision across the MI project teams incorporated multiple interacting strands of activity, which are grouped here for the purpose of analysis into six principle “mechanisms of change”: integrating services across providers; finding and using evidence; involving users in modernisation work; supporting self-care; developing the workforce; extending the range of services. Within each of the above approaches, teams adopted different strategies. For example ‘integrating services across providers’ was variously addressed through (a) creating boundary-spanning roles; (b) developing shared guidelines and protocols; (c) implementing shared IT systems and common data sets; and (d) developing networks and supporting networking.
9. A fundamental premise of the MI was that the benefits and improvements it brought about should be sustainable. It was anticipated early on that the frontloaded effort and responsibility invested by the MI would incrementally shift into the local health economy, as the skills developed and changes planned and implemented were adopted and embedded in mainstream services. The approaches taken by the MI and partner organisations to achieving sustainability were sophisticated, diverse, executed with considerable skill, and informed by evidence from the successes and failures of previous projects elsewhere. These approaches included a combination of: proactive planning to help anticipate and address risks to sustainability; close partnership working with commissioners to coordinate with their commissioning and strategic plans; retaining transformational capacity within partner organisations by embedding staff skills; mainstreaming new ways of working by aligning with existing service drivers, routinising practice, transferring responsibility to providers and minimizing dependence on additional resources; providing evidence of potential costs and benefits; and working at many levels to achieve deep rooted cultural shifts that would be self-reinforcing.
10. The three MI projects encountered a variety of challenges in their efforts to bring about change. Much of this variation was explicable in terms of the very different contexts of the three project areas regarding the organizational structure and culture of existing services, the nature of the conditions being dealt with and their trajectories over time, the characteristics and circumstances of the patient groups involved and the aspirations of patients, users and staff. Comparison of different experiences within and between projects enables the identification of ‘enabling’ and ‘constraining’ factors for each mechanism that appeared to influence the outcomes within the MI and might have more general currency as predictors of success. Overall, the experience of the MI suggests that:
  - a. Efforts to integrate services across providers are more likely to succeed where: there is an infrastructure that supports and rewards inter-organisational working; strong alignment of values and standards; integration is seen as ‘socio-technical’ rather than driven by ICT; and there is an enabling policy context
  - b. Efforts to find and use evidence are more likely to succeed where: evidence is easy to collect, widely understood, uncontested and timely; valid and reliable performance metrics exist and there is the capacity to collect and interpret them; data are seen as authentic, representative and timely; and teams undertake proactive visits to capture learning from systems in action elsewhere

- c. Involving users in modernisation work is more likely to succeed where: there is a stable cohort of fit, motivated users with key skills and capabilities and an infrastructure for supporting and training them, and creative partnerships between users and staff
  - d. Efforts to support self care are more likely to succeed where: the physical environment and general culture supports autonomous, questioning users; the self-care potential of users is high; the idea of self care is successfully marketed; and the self-care routine is freestanding
  - e. Efforts to develop the workforce are more likely to succeed where: there is a wide pool of potential staff with a good balance of change management skills; a bold and proactive strategy for developing the workforce; staff are keen to change and new roles and responsibilities accepted by others; training is appropriate and endorsed by professional bodies; and there are opportunities for 'double loop learning' in the organisation
  - f. Efforts to extend the range of services are more likely to succeed where: new services meet users' needs and are easily introduced and routinised; extended services are feasible and adequately resourced; there is user input to service [re]design; clear information is available to users; and partnerships with other providers are characterised by mutual support and respect
11. As a major, system-wide, one-off intervention, there was no 'control' site available for comparison to see what would have happened over the same period without the MI. In assessing its impact, therefore, it is not possible to apportion responsibility for what was achieved between the MI and other forces acting locally or as a result of national policy initiatives. Nevertheless it is certainly the case that significant improvements were achieved in all three project areas during the period of MI funding. These included: a wide range of qualitative improvements to existing services that enhanced effectiveness, convenience, availability, access, coordination, support, information, flexibility, appropriateness or choice; and some substantive elements of new service provision and changes to the ethos of care. In Kidney, the main shift was towards a more de-institutionalised approach to care, with priority given to designing services to fit better with people's lives, rather than orienting care around the main treatment options. In Stroke, the modernised service was also significantly more patient-centred than before, but with a different emphasis, in that the changes were more about streamlining and coordination to ensure that all patients received the right care at the right stage in the right way. In Sexual Health, the nature of the change was different again, reflecting a strategic focus on making things better through changing the image of sexual health services and the relationship of users to their own care. In all three areas, changes were made right across the care pathway and most, though not all, of the changes applied throughout the local system, that is, they encompassed all relevant providers in both acute and community services and were relevant, in principle at least, for all patients and carers. Overall, then, a 'big difference' had certainly been achieved by the time the MI ended, in terms of both the nature and extent of change within all three project areas. On this basis the MI can be accounted a significant success.
12. The ambition of the MI was always that its impact would be greater than the sum of its parts. While resources and activities were focused around the three MI project areas, and on services within the local patch, it was hoped and expected that the scale of the enterprise and the partnership working engendered at all levels would have broader beneficial effects on the local health economy as a whole, and would also filter outwards to influence thinking and practice at a wider level. There was recognition among stakeholders that a broader change did indeed take place across the local area as a result of the MI's focus on cross-organisational working and the structural support and expertise it had provided. This change was manifest in: new habits of co-operation; a longer and more ambitious view of doing what was right for the patient as opposed to what was right for the organisation in the short term; a thirst and capacity for further transformation; and a much more sophisticated understanding of the role of money and other facilitators and obstacles when setting about whole system change.
13. From the start, the MI project teams worked hard to disseminate their learning in and beyond south east London and to secure a high profile for their work nationally and internationally. A key resource for this purpose was the MI website. Other activities included: local conferences, open days and exchange visits; production and dissemination of a wide range of resources, including toolkits and information leaflets; articles in academic journals; and workshops, papers and posters at a range of high profile national and international conferences. These efforts were undoubtedly effective in generating wide

awareness of and interest in the MI's experience and achievements. There were several examples of MI tools and approaches being adopted elsewhere and some significant impacts on national policymaking with regard to aspects of the improved local services that were recognised to be now 'leading the field'.

14. The MI represented a significant development in the Charity's approach to grant making and its relations with its beneficiary organisations. The collective journey made by all partners during the course of the MI resulted in widespread appreciation of the Charity's role in providing flexible and strategic support for largescale transformative service improvement. The strongest indication of this change of focus is that such collaborative partnerships with organisations across the local health economy have become an established and significant element in the Charity's portfolio of support.
15. By April 2008, significant gains had been made at all levels. The critical question, recognised as such by the Charity from the start, was whether these would be maintained after the MI funding ended. In the event, the multi-stranded strategies to ensure sustainability had, in many respects, already delivered and the gains made were as secure as any element of service provision can be in a dynamically changing health service. In areas where decisions about the future were constrained by the need for information not yet available, agreements were in place for continued interim funding. And for each of the relatively few issues still outstanding there were clear plans, with named individuals taking responsibility and explicit timetables for action.
16. The MI approach was a new departure for everyone involved, in terms of the collaboration between the Charity and its beneficiary partners, and many practical and relational issues had to be worked out from first principles. While the approach itself was based on established current thinking about quality improvement, there was nevertheless a need to persuade some stakeholders that the MI's goals were safe and appropriate and its ways of working were robust and able to deliver. In these circumstances, building trust between and among parties was the most critical challenge faced by the MI and its most crucial asset once achieved. The turning point on trust was reached through a combination of means including sorting out governance and accountability, developing a common language and understanding about where the MI aimed to get to, learning how to work together and seeing and hearing about good things happening as a result of the MI's efforts, which confirmed its worth.
17. The experience of the MI produced significant learning for anyone contemplating future initiatives of this sort, either locally or elsewhere. Key points associated with various aspects of the MI's overall design include the following:
  - a. In development work of this kind, irrespective of the overall scale of investment, progress can not be equated with smooth or predictable spending, and planned timetables for spending therefore have to be flexible, since the pace of spending is necessarily determined by the development of ideas and the capacity of the NHS to cope with change. There are risks inherent in more creative approaches to using charitable funds to stimulate innovation and change that need to be accepted. Tight accountability is unlikely to reduce the risks and can be dysfunctional for projects.
  - b. Service transformation through behaviour change does take a long time – perhaps invariably longer than anticipated. While, clearly, planning for such initiatives cannot be entirely open-ended, any set period of years is unlikely to be precisely right. Timetables may need to be reviewed and revised during the life of a project and funders and other stakeholders should expect, and have strategies to accommodate, 'ragged' rather than neat endings. In planning for such work, its 'projectness' should be played down where possible, with emphasis placed instead on its linkage into a more continuous long term process.
  - c. A top level cross-organisational Board provides an essential and effective element of project governance and leadership, acting as a crucible for improving relations between those organisations and thereby amplifying the benefit of transformational projects for the wider health economy. The governance structure might be strengthened by including wider representation from the public and service users and relevant voluntary sector organisations. Project connections with other levels of management and service commissioners are also very important and need to be considered from the beginning.

- d. In complex projects with diverse stakeholders, considerable attention may be needed to finding a common language and format for shared understanding and communication. In this case, the 'models of care' provided a much needed identity of purpose and helped significantly in building trust.
- e. The application of generic principles of redesign and quality improvement, together with outstanding leadership and customised mechanisms of change adapted to suit the particular situation is a powerful combination for bringing about change. Creative and sophisticated involvement of service users is a particularly powerful source of inspiration and energy for all stakeholders, which can provide extra momentum for the change process.
- f. Different types of information and evidence are required at different stages of transformational work. Not everything can be, or needs to be, measured and monitored. Rather, evaluation effort should be focused where it will be most useful and perhaps specifically where information about impact, costs and benefits is needed to ensure sustainability.

Major progress can be made in ensuring that gains are sustained, but this demands intensive effort, imagination, communication and negotiating skills and visionary leadership. Different types of change require very different strategies to ensure they are maintained, and all stakeholders, not just those involved directly in the project work, have important roles to play.