

**The Modernisation Initiative (MI) was a four year project funded with £15 million in 2003 to radically transform stroke, kidney disease and sexual health services in Lambeth and Southwark. In January 2008, towards the end of the project, the Charity's Director of Grant Making, David Jones talked with Fran Woodard, Director of the MI, about the challenges which the Initiative faced and some of the key lessons learnt to benefit future health service modernisation projects.**

**1. David: Fran, could you describe, broadly, what the Modernisation Initiative set out to achieve and whether or not you think it achieved its goals?**

**Fran:** The Modernisation Initiative aimed to transform services within three key areas of healthcare: kidney disease, stroke and sexual health. The Charity's funding provided the health service with an opportunity to focus people's time and effort on service improvement. The three Modernisation Initiative teams identified regional, national and international best practice, looked at what works well and what does not and embedded user and patient involvement within the design, development and delivery of new models of care. This approach has created patient-focused services, which are both affordable and effective.

**2. David: Can I just pick up on that last point about affordable healthcare. What does that mean in the UK health system?**

**Fran:** There is a limited budget for the healthcare system. When commissioners look at what they are going to purchase on behalf of the local population, they have a certain amount of money and they have to look at what is required to meet all of the health needs of the local population. These are then prioritised and a decision is taken about what is actually affordable.

The Charity's money has provided the time and space to create new models of care, but most importantly, those models of care always needed to be realistically affordable for the health economy. If we had created models of care that were too expensive, they would not have been sustainable. So, over the last four years, the Modernisation Initiative has worked with commissioners to assess the viability of the models of care, ensuring that they are affordable, whilst providing high quality care, and therefore will be sustained beyond the life of the programme.

**3. David: One of the things you talked about is commissioning expertise, I wondered how important it was to have that expertise within the programme and at what stage it was introduced?**

**Fran:** I think it is hugely important and if any organisation attempts this type of project again, they should ensure that commissioners are involved from the outset.

However, what we have had to ensure it that we reflect how the commissioning works in reality. So, for example, in sexual health we part funded a commissioner because we needed to understand how the new model of care for sexual health was going to be delivered. We needed to understand what data we needed to collect about the new system, including activity and financial information, and how the contracts for sexual health services were going to be constructed in the

future. Sexual health services are commissioned as a specialist service, so we only really had to work with a single set of commissioners within each of the two Primary Care Trusts.

The commissioning of stroke services was much more complex, as its component services are commissioned by different commissioners within local health and social care organisations. As a result, we have had to influence commissioners in a very different way. So in answer to your question, it is fundamentally important to involve commissioners from the beginning, but the involvement needs to reflect the reality of commissioning.

**4. David: One of the other significant uses of the charitable funds has been around ‘buying-out’ clinical time. Please could you describe the role of ‘clinical champions’, and what have been the crucial factors in engaging clinicians?**

**Fran:** The Charity’s funding has enabled us to achieve genuine service user / patient involvement. It has also allowed clinicians to take time out from their daily work and to have the time to think about the way services are delivered to patients. The funding has freed up clinicians through back-fill or locums as appropriate. This has allowed them time to talk to patients and have a really close look at how they could provide services differently.

NHS commissioners, middle managers and clinical staff tend to have a reactive life. What the Charity gave to Lambeth and Southwark was that time out to be able to do things differently. We would not have achieved that without buying out people’s time, whether it was a session a week, two sessions a week, a day a week, or longer secondments to the Initiative.

The funding also enabled us to build a comprehensive understanding of how local health services can better respond to the needs of patients, and in preventing people from developing healthcare problems in the first place. One of the approaches to supporting health service improvement has been to pay for clinicians, managers and patients to go and look at other health systems, either within the UK or abroad. By participating in these activities together, they have been able to get to know each other, understand each others pressures, the challenges of different roles and understand why they do things currently. Initially some of these interactions were difficult, as people from different backgrounds had a range of views about how you would improve the services and improve the quality of life for patients. Whether it was going on visits or through attending conferences, patients and clinicians have been able to build real understanding of the issues and how improved services could be introduced to Lambeth and Southwark.

Where we have had clinicians who have been really inspirational, we have used those as champions and they have influenced their peers to really champion the differences.

**5. David: Did people who took part in the Initiative sometimes find it difficult to be truly innovative and imaginative about what the new models of care might look like?**

**Fran:** Absolutely. Some of the clinicians and managers have been quite seriously challenged by the opportunity to think about radical service transformation. Many people within the NHS are forced to work in a very reactive way, in very busy roles. Consequently, it is often very hard to stop and actually look and think about how you might approach things differently. In some cases, people might even feel threatened by the prospect of change, as it may challenge their autonomy, research practice, status or power. For example, some of the clinicians have trained and worked in a hospital setting all their lives and, at first, the concept of moving clinical services from the hospital into the community seemed inappropriate.

Clinicians, commissioners and managers needed to be convinced that the quality of care could be improved, rather than compromised by any re-design. However, most NHS staff, whether they be clinical or managers, truly believe in improving patient care, believing that the NHS exists to provide high quality excellent care and that is what we have always used as our currency to try and get people to work together.

Another challenge has been the differing views towards using randomised controlled trials rather than continuous quality improvement techniques to gain service transformation. We had to find ways of ensuring that people from different research and clinical perspectives were willing to listen to each other and agree a common approach.

## **6. David: In relation to the clinician - patient relationship how did clinicians and managers cope with greater patient and service user involvement?**

**Fran:** The Charity required that patient and service user involvement underpinned the programme. It has been a very important lever for this project and whilst it has been really challenging, it has been one of the biggest and the most inspiring successes that we have had.

Asking patients and service users to get meaningfully involved with the programme presented us with a range of challenges. To most of them it was a completely alien environment. They did not understand how the NHS worked, the acronyms, the language, how decisions were made etcetera. But we were determined to ensure they were effective in that environment. We ensured that they were provided with training, time, space, resources . we have paid them to actually demonstrate how seriously we valued their contribution. There are a whole host of things we have learnt - but it would be naïve to say it has not been challenging. We have ensured that patient and service user involvement has been a clear focus for every single thing we have done. No project has been allowed to exist without significant consideration of how patient and service involvement could be included.

In terms of what has been challenging, the programme has asked clinicians to give up some of their power. It has asked clinicians to talk and listen to patients in a very different way and to trust patients. Although some of the clinicians had these skills already or developed them quickly, for others it has required rethinking their relationship with patients as the expert

## **7. David: With the patients who use the kidney services, you have got quite a well defined service group. I would just be interested in your thoughts on sexual health, where you have got a very disparate and often unknown community. How have you managed to engage these people in taking part in the redesign of sexual health services?**

**Fran:** Historically in this country there is quite a fixed view of patient involvement. Luckily we are starting now to see evidence which the Modernisation Initiative has added to of how to approach meaningful participation. It is about understanding the patient grouping, the setting in which those services are delivered and also what policy drives are a priority at the time.

With the modernisation of kidney disease services, a patient chaired the Kidney Management Group. In this case we took an NHS approach and created job descriptions for him and for other patients who sat on any of our management structures.

Many of the kidney patients are long-term service users, so they are easy to access and quite interested in their care, so it has been easier to engage them with the project. The sexual health programme has been very different as you do not tend to get long-term users. They are sporadic

and transient in their use of services. In this case we have used very different methodologies, so for example, when we have sought the views of young men or sex workers, we have focused in on a specific part of the population and run focus groups, hearing about their views in safe, neutral, confidential environments - where they do not have to declare anything about which they are uncomfortable.

We have also used ~~the~~ mystery shopping a technique which most people think about in relation to department stores. We have trained service users to go out and experience the service the whole way through. This has included walking into the service's reception area, through to receiving a clinical examination. This provided us with a wealth of really powerful evaluation data. Service managers and clinicians cannot argue about data gleaned from direct patient experience; it is phenomenally powerful. In my view the ~~the~~ mystery shopper has been a fundamental driver for us to gain radical changes in our sexual health services.

With the modernisation of stroke services, we needed a different approach. Many people who have had a stroke have major communication problems and can be distressed by the impact of having a stroke, therefore it may be complex for them to become involved in service transformation. If they recover fully, many people just want to get on with their lives, but if they only achieve a partial recovery they may be left with a significant disability. The stroke programme had to engage with people at very different stages of recovery, which took considerable skill and sensitivity.

**8. David: Although, the governance arrangements were put in place before the programme started, it was not clear how they would work in practice. It was agreed that the Director would report to the Chief Executive of the local acute Foundation Trust and that a Board (including all four local NHS Chief Executives) would be established to ensure the delivery of the programme. How well did this reporting structure work?**

**Fran:** I believe these were the right management arrangements. Delivering a pan health economy project was inevitably going to create tensions as the local NHS Trusts each had their own priorities, pressures and budgets. Hospital services operate very differently to primary care services, as do those provided by the independent sector. The success in transforming services across all these boundaries requires skilled senior leadership to ensure it happens. I did not need the day-to-day support from the Chief Executives, but it has been fundamentally important that I have been able to access very senior members of the health economy when there have been challenges. This has been particularly important in relation to the commissioning of the modernised services, which required some serious conversations at executive level about organisational gains and losses. Different parts of the health service needed to pull together to ensure the tremendous gains that had been made were firmly embedded. The Programme Board was fundamentally important in providing a forum for these discussions. The participation of the Charity in the Programme Board was also beneficial, in enabling the funder to ask some difficult questions and keep the momentum of change going.

**9. David: The Trustee Board agreed an allocation of £15 million for the three projects – about £5 million each. In retrospect do you think you could have done twice as much with double the money or perhaps half as much with half the amount?**

**Fran:** Before I talk about money, I would like to mention ~~time~~ We do not tend to allow enough time to prepare for the delivery of such programmes, often because we do not directly cost it, or no

actual deliverables can be seen during this crucial phase. The Charity and the health economy originally talked about a three year project and the actual activity has been three/four years with the planning before that. Therefore, adequate time is as important as other resources. We have been involved in carrying out big changes and we need to provide the time to do that. It takes a while to get training programmes up and change people's clinical skills, establish new working practices etc.

There are a range of limiting factors to how much change you can achieve, so twice as much money would not necessarily generate twice as much change because, for instance, there are areas where there are just no clinicians to buy out as staff capacity is so tight. We need to acknowledge that NHS organisations have multiple priorities and targets to meet and therefore, if you continue to increase the amount you invest, you may get a diminishing return. We need to remember these changes are being carried out within a health economy which has many other priorities.

Sexual health was the only programme that involved a major capital refurbishment of a facility. We invested in this because we needed to get a new model of care up and running as soon as possible. Had we had half the money, we would not have been able to undertake the refurbishment and have completed such significant service changes. We chose not to do capital builds in the other programmes, because most of the service modernisation focused on how people worked rather than upgrading facilities.

**10. David: When the Charity awarded the funding, we had a very outline vision of the 'direction of travel' but it was impossible for us to ask for overly described work plans. At some stages during the early days that made the Charity feel a bit nervous and maybe some people within NHS as well. Do you think the Charity was right not to over specify what you were required you to do?**

**Fran:** My experience of large scale whole system transformation change and successful models is to not be too specific from the beginning. You need to be specific about how you are going to scope out the programme and deliver the foundation stages, but it is only after these essential processes have been crystalised that you can be in a position to describe the proposed new models of care. The Charity was right not to expect a specification of the new service model straight away. If it has done so it would have ended up with not as much creativity and less radical models of care.

Before you can get to the model of care stage, you have to test a whole series of projects to make sense of what is required. This can create an interesting tension because as a funder you need enough evidence that progress has been made and that there will be an end point to the foundation phase. During these early days running a change project can be very hard because progress can be affected by lots of external factors and there may be a lack of clarity about the direction of the programme. It is helpful to identify some simple ways of demonstrating that you are making enough progress, and then once you get further through the project you then can start to articulate the new model of care, and begin to measure the actual changes in the health economy.

**11. David: The Charity received six-monthly reports on each of the three programmes. In the early days the Charity sometimes got a bit frustrated as there was little evidence of the emerging service improvements. It took about eighteen months for the programme and models of care to be articulated. At that point relationships improved quite dramatically so perhaps we also have to learn that Trustee Boards have to take a bit of a risk as the models of care are being redesigned. Having said that, quite a clear regular reporting regime was very important to the Trustee Board even though there was very little to report in terms of improved health service delivery at the early stages. Please describe the different characteristics the reports took as the programme progressed.**

**Fran:** The reporting format has been one of the really big challenges; in terms of reporting to the Charity, the programme board and partners in the local health economy. However, it was really important that the Charity asked for regular reports because it forced us to create a clear structure for reporting. The Charity was able to provide both support and independent scrutiny. Furthermore, as the relationship developed, the Trustee Board was very flexible so if part of the programme was delayed then the Board allowed us two or three month leeway, which meant that underlying problems could be resolved properly, rather than having a quick solution

We have learnt a lot about how to structure progress reports so that they are meaningful to a variety of audiences. The other benefit of being required to submit six monthly reports to the Charity is that it reminds the health economy that this was a charity funded programme and it has a duty to, formally report back and describe how the funds had been used. It also kept the issue of sustainability high on the agenda.

**12. David: As well as wanting to support a series of transformational projects, the Trustee Board also wanted there to be national or maybe international learning arising from these programmes. To what degree do you believe the programme has succeeded in doing this?**

**Fran:** As the programme developed there has been a significant degree of regional, national, and international interest in what we have been doing in Lambeth and Southwark. We have been quite proactive about communicating what we have done and how we have approached service redesign. However, we have learned that before you could start publicising the work, it had to be relatively complete with clear evidence of the gains achieved. Frequently, we had to rein clinicians in, who wanted to broadcast our achievements, rather than holding back until that part of the project was embedded and likely to be sustained within local health services. We have been disciplined as we needed to be confident about the messages we were sending out. This has been an important piece of learning. Although our communications strategy embraced the whole programme, we have had an awful lot of interest in the user involvement work that we have done. This has included presenting at national and international events, including the December 2007 IHI conference in Florida.

The three programmes have all had different approaches so for example, the sexual health team frequently had open days or away days where people came and learnt about the sexual health model, mystery shoppers, HIV testing etc, so people from the UK and abroad came to Lambeth and Southwark to learn about what we had achieved. In terms of kidney disease, we have had lots of information sharing opportunities with other countries. The Department of Health and the NHS

Institute for Innovation and Improvement are exceptionally interested in what we have been doing. With stroke services, we have taken fourteen posters to the 2007 Stroke Forum, which is the biggest UK stroke conference.

There is a multitude of different ways of communicating and sharing our work including many different publications. We have however had to limit how much we let our teams go out to speak because otherwise it becomes extremely time consuming. It is important to note that even when the three programmes are completed in Spring 2008 the Modernisation Initiative will not go away as the work will continue within the health economy. The learning from each of the three current programmes will still be shared in future years

**13. David: We also hope to learn from the evaluation by University College London and King's College London. How useful has the evaluation been to you and what value do you think it may have been to the Trustee Board or anybody else?**

**Fran:** Evaluating a large transformational change project is very complex. Part of the challenge is that you do not actually know what and how you are going to be doing in the transformational projects at the start which makes it difficult to decide what to evaluate at the very beginning.

The Charity was right to commission the evaluation. It has been useful in giving the Trustees an independent overview of the progress that has been made. Any investment such as this should have an independent evaluation. How one actually approaches the evaluation is a very difficult question. The evaluators have done some in-depth work which has been invaluable. We have had some really good information reflected back to us through the life of the programme. For example, where we said we were going to do X and we have done Y, they have tried to explore what prompted us to change our minds.

One of the tasks we have faced though is getting everyone to understand the purpose of having the evaluation. In the early days, when we were doing lots of continuous change, it was quite hard for them to comment, and the Trustees were not necessarily hearing how changes were being made, because, they had not been fully implemented at that stage. I have learnt that evaluation is absolutely invaluable, and the correct thing to do, but it is essential that everyone understand the purpose from the outset.

**14. David: We have talked a little bit about the infrastructure that might be needed for people to embark on a transformational programme. Would you agree that some of those things cost money and some of them do not?**

**Fran:** We have mentioned before that it is vitally important to have adequate governance structures in place which mean that you have senior management buy in, and that does not actually need to have a direct cost. People will give up their time as long as you are reasonable in how much you demand of them. It is also important to remember other elements of infrastructure that anyone needs when they employ staff, such as HR, IT and all of that type of support. It is crucially important to understand where this type of support is going to come from. We had an off-site office, but that took a lot of co-ordination as you do not want staff unable to function effectively because they are unable to access IT. It is also important to remember the style in which you are asking people to work. We have been working across the whole health economy in many different organisations, so we needed to ensure that we facilitated that type of working and environment. The Modernisation Initiative team members have been very flexible, and that is part of how our office runs well.

In terms of what sort of expertise is required, there are many different ways to approach this. You need decent senior data analytical input to support people to identify clear baselines within the project, so they are able to measure the improvements made. We did not take the methodological approach of randomised control trials, but still needed to measure and provide evidence of improvement through data. We chose to have a full-time dedicated data analyst for part of the programme's lifetime. We got him to teach the staff skills and eventually we no longer needed that specific post.

As well as day to day tasks we have had to run a lot of event and conferences. I had a communications lead who supported the team using a range of communications from managing the website, to producing event and exhibition materials and generating news coverage.

We also needed business management input; somebody who has the time to spend looking at finances, so that you are accurately stating them and manages the day to day procurement and contracting. This was augmented by importing in senior health economic expertise and business acumen around financial activity and flows from service re-configurations. For example with hypertension, we needed to calculate the health economic gain over a ten-year period and in sexual health we needed to measure the potential financial gain of introducing self-care. This has been really important, as it is one of the areas that the skills and capacity are not available in the health economy. It was much more efficient to buy in senior health economic and senior business analytical skills rather than trying to do it in-house.

**15. David: There is quite a large number of people involved in each of these transformations. Has there been much cross professional and inter-professional consensus and conflict? Is it true that generally people from within the same professions have a consensus view on what needs to be done, or is it more complicated than that?**

**Fran:** I think it varies. It is certainly the experience of the three programmes that there have been some instances where single clinical professionals, or management as a whole will converge on a similar viewpoint, but that is not always the case. For example, in one of our programmes, what acute hospital teams thought therapists needed to do, was very different to what primary care thought was required. So I think that it is not just about the professional grouping, but also about the setting and the part of the pathway they are involved in.

We explored the power base and the levels of influence within each organisation, to ensure that we got clinical champions within the specialties, who were senior. We then used them to build up a peer group and to influence others. Some of that influencing has been beyond that organisation and profession. Largely we have used doctors as our key clinical leads, but that reflects who can currently actually affect change speedily within organisations. In addition, we have spent a lot of time going round talking to different people - the medical directors, the nursing directors, the heads of therapies - to ensure that we have tackled an issue from a variety of angles.

**16. David: We have focused on talking about NHS Trusts but there have been other health and social care organisations involved, not least the voluntary sector. How easy has it been to engage with the voluntary sector and what value have they added to the transformation of services?**

**Fran:** It has been absolutely crucial for the voluntary sector to be involved. Stroke had a lot of charities involved such as Connect - which works very closely with the local health sector, so it

would be somewhat naïve not to involve them in our work. Similarly, several voluntary sector providers are involved in sexual health provision locally.

In some ways it has been very easy. The voluntary sector tends to be quite collaborative, and quite focused on partnerships, and tends to be pretty good about taking risks and doing things differently. Where we have had more problems is when the voluntary sector were not represented in all of our governance structures. They were not always represented on the individual programme management groups. Nor were they represented on the overall programme board, because there was no voluntary sector representative that covered all three programmes. So sometimes there has been some tension there.

The other tension has been that the health and social care commissioners provide the funding for both the voluntary and health sector, and we have had to think about the system as a whole and how to balance both sets of providers needs. However, neither the sexual health or the stroke programmes would have been nearly as effective, without the involvement of the voluntary sector.

In relation to kidney disease, the Kidney Patients' Association, consistently at Guy's and St Thomas's and latterly at King's College Hospital, have been fundamentally important and will be a crucial element of the sustainability of the patient involvement and improvement work.

We have worked differently with different organisations, so for example, with Connect, we procured and contracted their work, which has added a different level of complexity, notably, being very careful about procurement, contracting and standing financial instructions..

**17. David: Communications and conferences have played an important role in letting people know the gains that have been made and how you have achieved them. How successful has the programme been in communicating its work and what barriers have there been?**

**Fran:** One of the biggest challenges is that we have needed communications input for a multitude of things ranging from copy writing, producing publications and posters, PR and marketing to conference skills.

It has not just been about the Initiative communicating in isolation from local partners. We have had to work closely with Guy's and St Thomas's Charity, with four different NHS Trusts and other statutory and voluntary organisations to promote their involvement. This has created tensions sometimes. The messages that the project has been trying to put across can be fundamentally different to what the Charity wants to say, or what the four NHS Trusts might want to promote; so it has been quite difficult trying to meet everyone's agendas.

The website is a really good example of how you can do some really interesting PR and marketing as well as provide a repository of information. I would not say we have got that right all the time and my advice is to make sure whoever procures a new website has an in depth understanding of web functionality. We have produced some very innovative web pages for example, but if people's browsers have not got the necessary software that supports downloads etcetera it is of less value than you might have hoped.

The other thing about communications is about corporacy - making sure we had a very clear corporate image, that our branding was right, teaching the staff how to lay things out and how to produce things. We also needed to ensure that there was an evidence base for the papers and

products people wanted to publish. Although it might not always be something you were ready to publish in that way, at the time we had to allow it to show the good work which has started, even if there wasn't quite enough evidence at that stage to provide conclusive evidence.

**18. David: But it was important for you to have your own dedicated communications resource rather than relying on the Charity's or one of the NHS Trust's communications team?**

**Fran:** Having our own dedicated resource provided greater diversity of opportunities. Having our own dedicated person has increased the range of materials produced and communications channels we could exploit to get across information out about the Initiative.

My day-to-day life has been helped by having our own communications resource. I get numerous queries and it means that I do not have to worry as everything has to go through a dedicated communications person. It means that nothing can go out without our communication lead reviewing it and ensuring that coverage is consistently on-message. Neither the Charity nor the Trust would have capacity to deliver that.

**19. David: In relation to the sustainability, your aim was to create new models of care that could be funded in the future through NHS funds. What have been the main issues around sustainability?**

**Fran:** Sustainability is a fascinating subject. I feel very strongly that we must not always attribute sustainability to money. The funding the Charity gave to the project will actually be more powerfully borne out by things that are not attributed to money. This will include behavioural changes, leadership development, process changes and training. There are a multitude of new services and approaches that do not actually cost any more money beyond the initial pump priming, because we have done it through mainstreaming the various projects. A really key message is that anyone who is considering change needs to view sustainability in a very divergent way. It is not just about money and commissioning.

Project sustainability has been a major focus of my role. Initially I found it very difficult to get agreement on how the new service models would be funded. It was only by discussing formal integration of new models of care with the Chair of the Programme Board, the then Chief Executive of Guy's and St Thomas' NHS Foundation Trust, that I managed to start to get formal agreements in place. The partner NHS Trusts have now agreed the resources and commissioning necessary to enable the new ways of working.

Senior leadership buy-in was crucial for this process, as well as clarity from the four NHS Trusts on what they were prepared to provide or commission so that services can be mainstreamed. For each new model of care we have developed in-depth sustainability plans which the project managers in conjunction with local services have owned to make them viable.

When the Modernisation Initiative began, there was a belief that it would be cash neutral, i.e. that it would have no cost after the life of the programme for the local health economy to sustain. Life has changed, politics have changed, environments have changed, and the financial situation has changed over the last five years and we knew that there were going to be some additional costs.

On reflection, I would not have ever claimed it was going to be cash neutral, because there was no evidence to suggest that it would be. It would have been more accurate to say that the changes

need to be affordable by the health community, with additional costs in some areas and savings in others.

**20. David: Looking back over the last three or four year, what do you think are the most significant achievements?**

**Fran:** For me, the work around patient and service user involvement. I have worked in service modernisation for a long time now, and the funding has brought something fundamentally different to Lambeth and Southwark. This approach will be essential for the successful delivery of the proposed transformation of End of Life services in the two boroughs. Listening to patients and service users talking about how they valued being involved in the service redesign is a testimony to everyone's hard work.

The refurbishment and opening of the Camberwell Sexual Health Centre has also been a significant achievement, not only because it is rewarding to see something tangible, but also because it signifies the huge changes that have been undertaken in improving local sexual health services. Overall, the health economy is undertaking service improvements, not just around kidney, stroke and sexual health services, but more widely. People now think about doing demand and capacity exercises, about doing Statistical Process Control charts etcetera, whereas they did not have the skills before the Modernisation Initiative. Finally, I feel very positive that my staff are now moving on to really great jobs, which reflects the skills and experience they have gained during their time with the Modernisation Initiative.