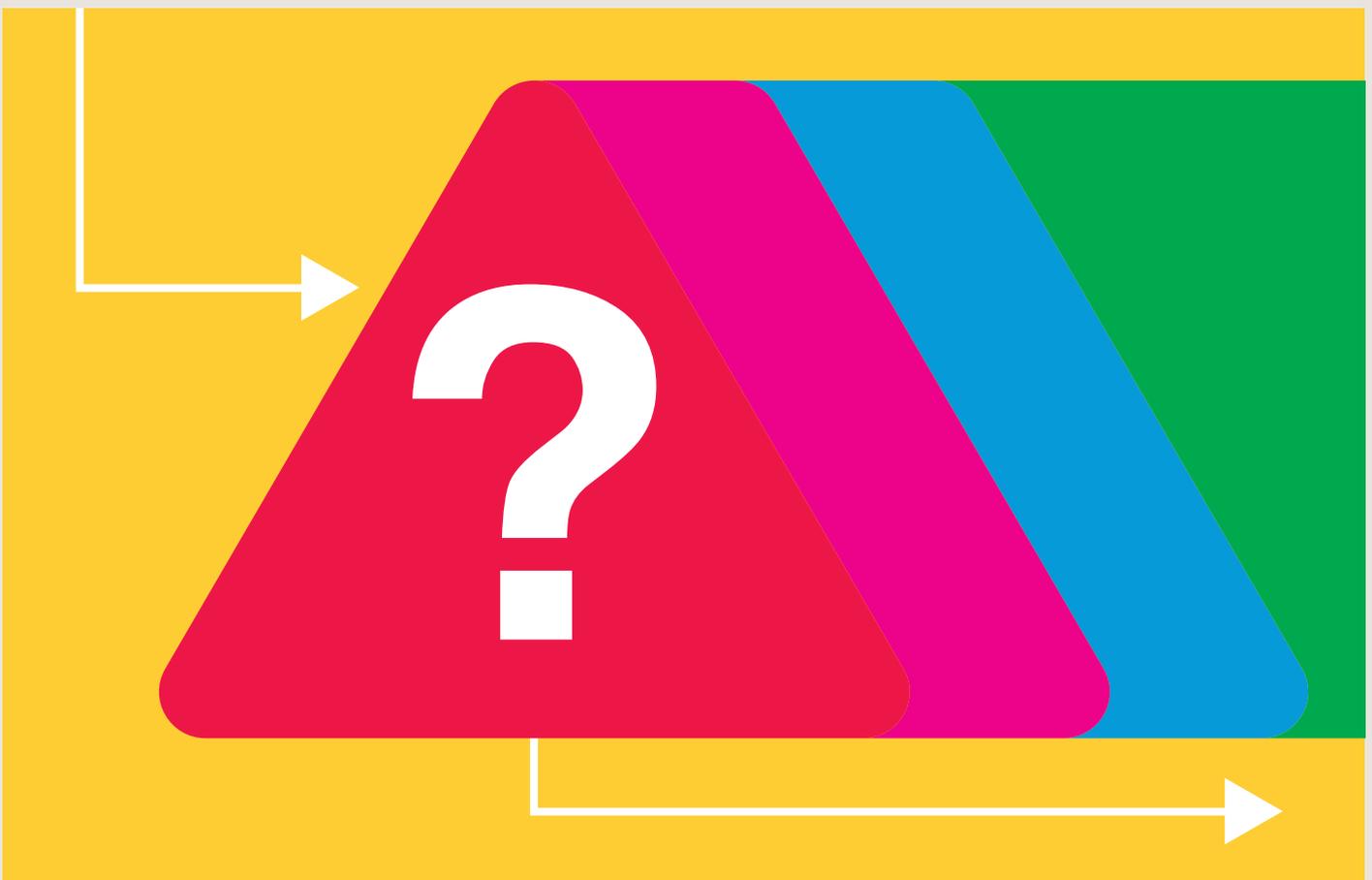


# Constructive comfort: accelerating change in the NHS

*Clare Allcock, Felicity Dormon, Richard Taunt and Jennifer Dixon*



## About this report

To improve quality and efficiency and move to new models of care the NHS must change at a pace and scale not previously seen.

This report identifies key factors needed for successful change and explores why they are not consistently present in the NHS. It sets out how national bodies can help make successful change more likely, in part by boosting the support provided to organisations and focusing on NHS staff leading change. It draws on the following workstreams:

1. Workshops focusing on what helps and hinders change in the NHS. The workshops involved commissioners, leaders in quality improvement and people who had participated in Health Foundation leadership programmes.
2. Interviews about how change happens and what could be done differently. We spoke to clinicians, academics, improvement leaders, commissioners, managers and leaders in national bodies.
3. Health Foundation experience of funding, researching, supporting and evaluating improvement projects.
4. Specific analysis of provider transformation, based on interviews with senior leaders from a range of acute providers. This is available as a supplement to this report: *Transformational change in NHS providers*. See [www.health.org.uk/acceleratingchange](http://www.health.org.uk/acceleratingchange)
5. A scan of available empirical evidence about the barriers to making change in the NHS: *What's getting in the way: barriers to improvement in the NHS*. See [www.health.org.uk/publications/what-s-getting-in-the-way](http://www.health.org.uk/publications/what-s-getting-in-the-way)

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# Executive summary

With demand rising and resources significantly constrained, the need for the NHS in England to make fundamental changes over the coming years is well recognised. The task is to improve the health of the population and the quality of care available, while at the same time increasing the health service's productivity levels to 2-3% per year for the foreseeable future, a feat never previously achieved in the NHS.

To achieve this will involve doing everyday work more effectively right across the NHS, and simultaneously developing new models of care and improving health. There is much agreement on the broad models; the *NHS five year forward view* gives a succinct summary. The bigger question now is how to make changes to day-to-day work, and develop the new models, at the speed and scale now needed.

The NHS is able to change its administrative structures significantly, as successive structural reorganisations have shown. But more complex change is now needed at the front line of service delivery. This includes the boundaries with other sectors (such as social care) and needs to involve individuals more in co-creating improvements. This is a far more challenging task than structural reform alone; the nature of health and care delivery is more complex, risky and high profile. In addition, those in national bodies\* who design overarching strategies for change are a long way from the front line and from people receiving care, with successive reforms over the past 20 years reducing their direct role in service delivery.

Given the acute short- and medium-term challenges facing the NHS, what would constitute a 'best shot' at accelerating the needed changes? The answer must be action on a number of fronts.

Several important fronts are not discussed in this report: investment in new technology and science to produce innovations that accelerate change; how to work better with patients, individuals and wider populations to co-create health policy and health care delivery more effectively; and wider policy to make more impactful links between different parts of the public sector and the public and private sector.

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\* By 'national bodies' we mean those statutory and non-statutory bodies that collectively manage the health service in England: for example the Department of Health, NHS England, the Care Quality Commission, the Trust Development Authority, Monitor, the General Medical Council and royal colleges.

The focus here is more modest but no less challenging: how best to design national policy on the NHS to accelerate improvements to health care?

In this report, we argue that national bodies' efforts to effect change follow three broad types of approach:

- **Type 1: 'Prod organisations.'** This approach aims to direct, prod or nudge providers of care from the outside. Familiar tools here include: legislation; targets; command and performance management; payment (currency and price) incentives; regulation; and competition. This approach could be loosely termed a 'deficit management' or 'compliance' approach to improving performance reliant upon 'extrinsic motivation' for change.
- **Type 2: 'Proactive support.'** This approach focuses on enabling organisations more directly to make the changes needed. In the past, prods have been described as offering 'constructive discomfort' for change. By contrast, proactive support efforts offer 'constructive comfort'. This could be loosely termed an 'asset management' or 'commitment' approach to improving performance, reliant upon 'intrinsic motivation' of staff to make the right changes.
- **Type 3: 'People-focused.'** This approach includes both prods and proactive support, targeting NHS staff rather than organisations, as well as actions to inspire, engage and involve staff. Approaches include using policy mechanisms such as education and training, national contracts, professional regulation and clinical standards.

Given that speed of change is now critical, the questions on the table include:

- Is there currently the right **balance** between the three types of approach: prod organisations, proactive support and people-focused?
- Are current efforts in each of the approaches **individually** potent enough? If not, how could they be developed to achieve a better blend now and in the future?
- In the future, how can all three approaches be developed **together** most effectively to accelerate needed change?

This report draws upon relevant literature, testimony from professionals working on the front line and leaders in national bodies, and on the Health Foundation's experience of funding improvement programmes in providers for more than a decade. We identify the factors for successful change at local level (in and between providers of care), and make initial suggestions as to what national bodies might do to support providers to create these conditions more effectively. To support this work, we commissioned an analysis of how acute trusts have turned around their performance and a scan of available empirical evidence about the barriers to making change in the NHS. These documents are published separately (see [www.health.org.uk/acceleratingchange](http://www.health.org.uk/acceleratingchange)).

Our findings show that there is broad consensus on the components of good change. We have identified the following seven success factors for change at any level of the health system, but particularly locally in organisations:

- Committed and respected **leadership** that engages staff
- A **culture** hospitable to, and supportive of, change
- **Management practices** that ensure execution and implementation
- **Capabilities and skills** to identify and solve problems
- **Data and analytics** that measure and communicate impact
- **Resources and support** for change
- An **enabling environment** which supports and drives change.

These seven factors are not consistently present in the NHS – meaning efforts to improve services and make changes are more difficult than they need to be. Our analysis identifies particular barriers to change in four areas: **recognition** of the need to change, having the **motivation** to change, **headspace** to make change happen, and the **capability** to execute change.

We ask if the current blend of national approaches is aligned to support the needed change in local organisations. For example, are national bodies:

- supporting **recognition of the need for change** when chief executives of trusts in special measures risk removal, while their consultants are more likely to receive clinical excellence awards than be dismissed?
- creating an environment in which there is sufficient **motivation to change** when foundation trusts (FTs) are pressured to put their short-term financial success ahead of the creation of a sustainable future for their local health economy?
- creating the **headspace to make change happen** when dips in performance are accompanied by multiple demands for assurance, but limited offers of support?
- building and supporting **capability for change** when every reduction in managers is celebrated by politicians, making change ever harder?

We conclude that the national ‘proactive support’ approach holds significant potential to accelerate change, and there needs to be much more thinking about action in this space than has been the case to date.

Investment in the proactive support approach means a commitment to developing the medium-term capacity, skills and resilience of NHS providers, not just focusing on the need for short-term ‘payback’. However, some actions may also deliver a short-term return on investment; suggestions here include breakthrough series collaboratives and twinning of developed robust organisations with weaker ones, as suggested by the Dalton review.

To invest in a proactive support approach more fully and coherently will require a shift in mindset not only towards the medium term, but also towards a view that NHS providers are part of an overall ‘system’ – not a set of autonomous units – which it is legitimate to support. There also needs to be an understanding that the prod approach can, at most, produce only very partial change relative to the totality of what is now needed.

We conclude that national bodies now need to take the following action:

- **Immediately develop a shared view of how change happens in the NHS and what national bodies should do to catalyse it.** This should be developed with leaders of front line services in an ongoing way and inform all national activity.
- **Develop the current blend of organisational levers (‘prods organisations’) to best support change.** In particular, increasing coherence and redefining national measures for local success, moving from a narrow view based on short-term performance to include the conditions for successful change and resilience.
- **Invest far more in support for change (‘proactive support’), starting with a coherent improvement strategy for the NHS in England.** This should be a five- to 10-year strategy and address the seven factors for successful change outlined in this report. This strategy should include concrete suggestions for how proactive support can make improvements in the short term (within a year), as well as how regional support will develop over the medium to long term.
- **Focus action on people who work in the NHS (‘people-focused’).** Policy of all types should start with how it will support individual frontline staff to improve care. A great deal more work is needed with all current stakeholders to establish how the current staff-focused type policies can be developed and aligned to support change, as well as how these blend with the organisational prods and supportive approaches outlined above.

Only by working on these actions can the NHS’s aspiration to harness the ‘renewable energy’ and the intrinsic motivation of staff be realised to improve the health and health care of all into the future.

# Introduction

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## Box 1: What do we mean by change?

Change can be small and incremental, for example on a ward, or large and involve altering services completely across an area – both are needed to meet the challenges the NHS faces.

In this document we use ‘change’ and ‘improvement’ interchangeably. We use ‘continuous improvement’ to describe small-scale incremental changes – which can, over time, produce significantly different services. We use ‘transformation’ to describe large-scale change across an organisation, or multiple organisations in a local health economy or region.

For the NHS in England to be sustainable within the likely resources available in the coming years, its task is to do every day work much better while simultaneously developing new models of care and improving health. There is much agreement on the broad models – the *NHS five year forward view* (Forward View) gives a succinct summary.<sup>1</sup> The bigger question is how to make the changes at the speed and scale now needed.

The legacy of previous initiatives looms large: ‘Our vision will require significant transformation in the way in which care is delivered in the future’ is not a line from 2015, but from 2009.<sup>2</sup> Is this time any different?

The NHS is able to change its administrative structures significantly, as successive structural reorganisations have shown. But more complex change is now needed at the front line of service delivery.

The focus in this report is: how best to design national policy on the NHS to accelerate improvements to service delivery in health care?

To answer this question, we start from the experience of staff involved in making change happen in the NHS. We identify the conditions for successful change at local level (in and between providers of care), and make initial suggestions as to what national bodies might do to support providers to create these conditions more effectively. In doing so, we draw upon relevant literature, testimony from professionals working on the front line and leaders in national bodies, as well as the Health Foundation’s experience of funding improvement programmes in the NHS for more than a decade. We also commissioned an analysis of how acute trusts have turned around their performance and a scan of empirical evidence about the barriers to making change in the NHS.\* For more detail of the contributing workstreams, see annex C.

This report is aimed at those working in national bodies in England, including the Department of Health, arm’s length bodies, royal colleges and professional regulators. It focuses on how the NHS can strengthen its ability to change, and specifically how national policy can support and catalyse this.

While this report is focused on the NHS in England, we have had input from people working across the UK and internationally, who encounter many of the same challenges.

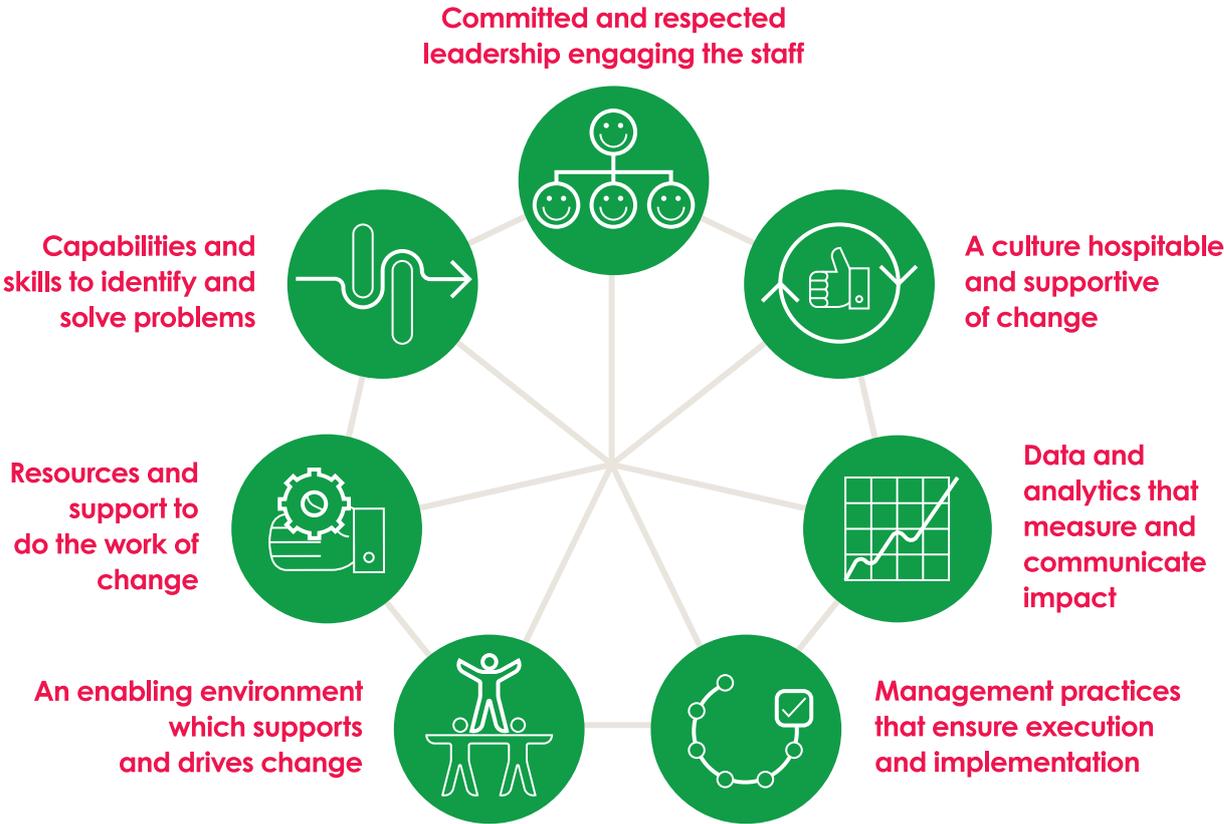
\* These documents are published separately to this report – see [www.health.org.uk/acceleratingchange](http://www.health.org.uk/acceleratingchange)

# What does successful change look like?

There is a significant literature on how successful change happens. Examples include Pettigrew’s work on managing change conducted during the 1980s,<sup>3</sup> more recent international case studies of quality improvement,<sup>4</sup> collaborative work to develop the NHS Change Model,<sup>5</sup> and the Health Foundation’s own work on improving quality in health care.<sup>6,7</sup> Familiar themes arise, both within health and the wider management literature.

Building on this body of work, and via conversations with commissioners, providers, system leaders and those working in improvement, we have identified seven success factors for change relevant to the NHS (see figure 1). These success factors are not new, but summarise what is recognised as important in delivering successful change in the NHS. Annex B maps these success factors to other change models.

Figure 1: Seven success factors for change in the NHS



The seven success factors are:

- **Committed and respected leadership that engages staff.** Leadership – particularly the ability to engage people with a clear vision for change, centred on patients – is arguably the most important factor for achieving successful change. Leadership needs to be collective and distributed throughout different levels of an organisation, with leaders facilitating collaboration and sparking enthusiasm.<sup>6,8,9</sup>
- **A culture hospitable to, and supportive of, change.** A healthy culture (‘the way things are done around here’), harnessing the commitment staff have to patient care<sup>10</sup> and engaging clinical staff in change<sup>6</sup> is vital to making successful change.<sup>11</sup> This means co-produced organisational values used in decision making, a positive attitude to risk taking, staff feeling valued<sup>12,13</sup> and active engagement of patients.<sup>14</sup>
- **Management practices that ensure rigorous execution and implementation.** Successful change cannot be delivered without effective operational management. This means both getting ‘the basics’ of management right through processes, governance and accountability;<sup>15</sup> and expert management of change<sup>16</sup> through a strategic approach, achievable expectations and a focus on execution.
- **Data and analytics that measure and communicate impact.** Detailed, timely data and information are needed at all levels of the system – as well as staff with the skills to interpret them. Information allows frontline staff to understand and improve their care, boards to connect with their organisations, commissioners to know what their populations are experiencing and build the case for change, and national bodies to understand quality over the whole health service.
- **Capabilities and skills to identify and solve problems.** At least three types of capability are needed to deliver change: ‘technical’ skills such as project management, clinical pathway design, change management or using practical quality improvement methodologies; ‘interpersonal’ skills such as good communication, conflict management and negotiation; and ‘learning’ skills including collective reflection and debate.<sup>17</sup>
- **Resources and support for change.** The majority of organisations or health economies committed to change have dedicated teams, in addition to frontline time dedicated to change.<sup>18</sup> Adequately resourcing change means investment, but increases the likelihood of success, leading to greater efficiency and better outcomes in the long term. Practical support for change also matters, including providing expertise, coaching, peer support and facilitation of discussions.<sup>19</sup>
- **An enabling environment which supports and drives change.** The environment is a set of factors influencing change beyond the direct control of the unit making changes.<sup>20</sup> For a clinical team, this will include supportive organisation-wide policies or national standards. For organisations or health economies, this will include strong local relationships, explicit permission from national bodies and politicians to take risks and learn from mistakes, and a set of national policies, for example financial incentives, which help not hinder change.

These success factors have relevance to all levels of the NHS system, from continuous improvement within a ward to transformation across a whole health economy. Box 2 sets out examples relating to acute providers. The relative emphasis of different factors will depend on the context and level of change being attempted.<sup>20</sup> This is explored in further detail in annex B.

*‘Most senior people can deliver the tangibles; it’s the ability of CEOs to deliver on relationships that separates the more successful leaders from the rest and, of course, usually if you get this right the other deliverables fall into place.’* Acute trust chief executive

These seven success factors, while they may be well known, are not widely present in the NHS, and previous efforts to improve or transform services have had mixed results. Why?

### **Box 2: Examples of the seven success factors from acute providers**

Providers engaged in whole-organisational change spoke of the challenges of delivering change, as well as the importance of our seven success factors for change:<sup>21</sup>

- **Committed and respected leadership engaging the staff:** Frimley Park Hospital NHS Foundation Trust has managed to maintain and improve its performance through a sustained focus on continuous improvement, championed by a long-standing chief executive with strong relationships with staff. He is highly visible within the organisation, going into A&E every morning and at the end of the day, and is prepared to stand firm when changes may be unpopular, for instance bringing in seven-day consultant-delivered services.
- **Management practices that ensure rigorous execution and implementation:** Basildon and Thurrock University Hospitals NHS Foundation Trust created a new divisional structure to make clinical directors clearly accountable for care. A firm approach was taken towards underperformance, and sustained management focus was applied to understanding and resolving problems.
- **A culture hospitable to, and supportive of, change:** At Frimley Park, clinicians are part of the hospital’s management team. The chief executive actively looks for staff who will ‘go the extra mile’ and participates in consultant recruitment. The culture of innovation is evident in performance and working practices, such as five-hour theatre sessions, and a pathology service that has been described as ‘by far the most productive and highest quality in the country’.
- **Data and analytics that measure and communicate impact:** The use of data and diagnostics at Poole Hospital NHS Foundation Trust was critical for building understanding of the trust’s financial problems (which still continue). The leadership accepted that data quality would be challenged, but this led to improvements in the data and subsequent recognition of the financial problems.
- **Resources and support for change:** Change efforts in Nottingham University Hospitals NHS Trust have been boosted by appointing an internal transformation team of around 20 people. The trust has also made use of external consultants for performance analysis and as extra skills/capacity for specific projects.
- **Capability and skills to identify and solve problems:** Nottingham has a standard range of tools and improvement techniques that are taught in development programmes and these have become the ‘way we do things’, also providing a common language for improvement efforts. There is widespread participation in skills development programmes with an expectation that clinical staff, including senior doctors, attend workshops to strengthen their skills and confidence in leading improvement activities.
- **An enabling environment supporting the right kind of change:** At Basildon and Thurrock, the new leadership team was given headroom to make improvements by regulators and clinical commissioning groups. The relationship throughout was broadly supportive and inspections were felt to provide helpful insights into problems.

# Why is change so hard?

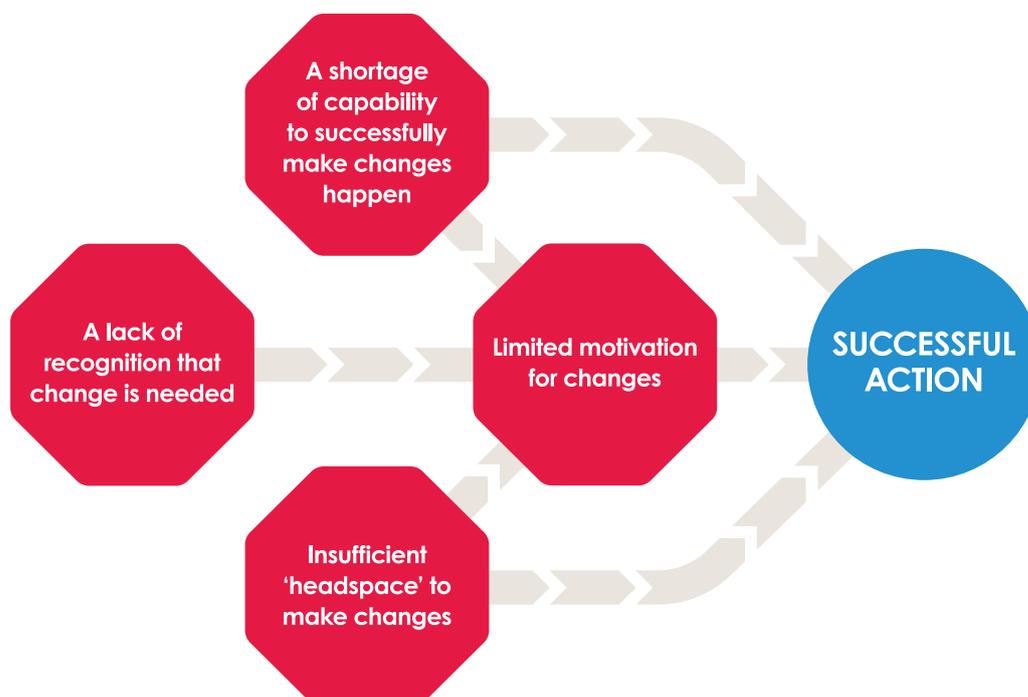
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While they are widely recognised, the seven success factors for change are not consistently present in the NHS; good health economies are often the result of serendipity and outstanding individuals, achieving excellence despite the system they exist in, not because of it. Box 3 on page 13 provides an example of the challenges involved in making change.

Our interviewees highlighted to us 'know-do' gaps across the health system, where staff (particularly in provider organisations) know things could be better, but lack the ability or agency to do something about it. Our analysis identified four key barriers to change:\*

- **Recognition** of the need to change
- Having the **motivation** to change
- **Headspace** to make change happen
- **Capability**: having the right skills.

Figure 3: Four barriers to making change in the NHS



\* These factors map across to existing work on understanding behaviour change, for example, Mitchie et al's work which sets out a helpful framework for understanding and designing interventions for behaviour change ('COM-B' – Capability, Opportunity and Motivation contributing to Behaviour), [www.implementationscience.com/content/pdf/1748-5908-6-42.pdf](http://www.implementationscience.com/content/pdf/1748-5908-6-42.pdf)

### Box 3: Success factors for change in clinical teams: Safer Clinical Systems

The Health Foundation's Safer Clinical Systems programme ran over two phases between 2008 and 2014. The programme adapted tools for systems analysis and the safety case technique from other industries and applied them to frontline clinical care. It sought to identify proactively potential safety breaches, enabling teams to build better, safer health care systems.

The independent evaluation of the programme highlighted difficulties experienced against all of our seven success factors for change.<sup>22</sup>

- **Committed and respected leadership that engages staff:** Lack of leadership from consultants and other senior staff in taking charge of problems or standardising their practices was a barrier to progress in improving patient safety.
- **A culture hospitable to, and supportive of, change:** The efforts made to improve pathways revealed wider system issues implicated in hazards identified at the point of care. Typically, these problems were 'symptoms of deep organisational pathologies with long histories and complex dynamics' – and outside the control of project teams.
- **Management practices that ensure execution and implementation:** Greater attention was needed on purposeful process design and clarity of accountability. During the course of the programme there was often ambiguity about whose job it was to do what and processes for ensuring that tasks were actioned were weak.
- **Data and analytics that measure and communicate impact:** There was a considerable skills gap in measurement design and data collection and interpretation, with a need for frontline teams to have better access to these skills.
- **Capabilities and skills to identify and solve problems:** Realising the potential of ideas and insights generated by frontline teams often required substantial time and support from operational managers skilled in process diagnosis and design, as well as the wider skills needed to achieve complex change.
- **Resources and support for change:** Supporting staff at the front line to understand and improve the processes of care that they typically know best was a critical ingredient of sustainable improvement. This addresses issues that can be resolved at the front line and unearths problems that need to be understood and addressed elsewhere. Operational and senior managers would benefit from skills and time to do this, meaning embedded capacity to improve support systems in addition to clinical care.
- **An enabling environment supporting the right kind of change:** The rigour of analysis required to come to a proper diagnosis of safety problems felt counter-cultural, with many staff struggling to find the time to prioritise mapping the processes of care and associated risks. This highlights the risk that organisations continue to rush to take action assuming that they know the solution, rather than take the time needed to really understand the problems they are seeking to address.

### Recognising the need to change

Problems can be so entrenched that staff accept them as inevitable instead of believing that they can be changed.<sup>23</sup> Conversely, convincing staff there is a real problem to be addressed is a challenge in many improvement efforts.<sup>6,24</sup> In some cases this may reflect previous experience of poorly designed or unsuccessful changes, and in others a lack of comparative information on quality and performance. Despite the availability of benchmarking data, many people we spoke to reported that they lacked sufficient information to pinpoint the action needed.

Gaps between the perceptions of boards and their organisations impede senior recognition of the need for change – boards consistently rate their organisations better than frontline staff. For instance, in 2014, 84% of executives felt that their organisation was characterised by openness and honesty, while only 31% of nurses felt the same.<sup>25</sup>

*'Clinicians and others may argue that the problem being targeted... is not really a problem, that it is not a problem "around here" or that there are many more important problems to be addressed before this one.'*<sup>6</sup>

### **Motivation to make changes**

To deliver change, staff need the motivation to overcome the difficulties and challenges intrinsic to it. Most NHS staff are committed to giving high quality care to patients;<sup>10</sup> however there are factors that inhibit and reduce their ability to make the changes or improvements to services that they want to. Much of this relates to 'value', both:

- how much individual members of staff feel valued and enabled to act
- how much value is attached to improvement activity over and above the 'day job'.

Improvement, especially on a large scale, requires discretionary effort – and this means staff need to feel valued and supported. Time and again during this work we heard about the pressure that staff working in the NHS are under and the damage this does to their energy and motivation for change.<sup>10,13</sup> Levels of work-related stress are rising in the NHS<sup>26</sup> and bullying levels are around 20%,<sup>27</sup> higher than in many other industries.<sup>28</sup>

*'What messages do you hear when you are feeling stressed and bullied? How does "we need to save more money" come across?'* Senior clinician, mental health trust

Staff feeling valued is linked to the leadership they experience. Our analysis showed that a continuing perception of a 'command and control' culture in the NHS and a pervasive 'heroic' leadership style<sup>29</sup> were highlighted by many as disempowering and unengaging.

Providers, commissioners and practitioners frequently experience a disconnect between words (enabling) and actions (controlling) from leaders at all levels of the system. While phrases such as 'collaborative leadership', 'innovation' and 'taking risks to improve services' are prevalent, they are often in stark contrast to behaviours which are short-term and unduly focused on control.

*'Have to be quite bold to do things without permission – because of the previously tight rein on the system'* Commissioner

Fears of risk and resulting blame can seem to be ingrained in the culture of the NHS.<sup>30</sup> Yet to make change happen, risks are necessary and learning from difficulties is part of developing the right solution. This fear of failure exists even in staff groups with apparent job security.

*'...CCG palpably feels the pressure of the Secretary of State Monday morning delivery meetings, area teams are on the phone by Tuesday demanding action.'* Commissioner

The high turnover of leaders can have a strong negative effect on organisations,<sup>31</sup> and those that are struggling suffer particularly: in 2013, 50% of the 24 trusts in special measures had chief executives who had been in post for less than a year.<sup>32</sup> People we spoke to described a set of unrelenting pressures facing health care leaders, including pressure on performance, feeling unsupported by the system in which they work and beaten down by negative local media and political attention.

Politics, both national and local, was mentioned particularly as decreasing motivation for change. Political interference in change efforts, even those with a strong clinical case can sap staff motivation and make staff less likely to attempt future changes.

Improvement work also needs to be valued for people to want to get involved. Work on improving services often lacks both ‘hard’ rewards such as promotion, and ‘soft’ rewards like recognition from peers, support to effect change and time to do the work. Those we spoke to contrasted improvement with clinical academic work, which is seen as a valid use of clinical time, whereas working on improvement in service delivery is often perceived as ‘management’ and so of lower value. There was also a perception that professional bodies had insufficient focus on service improvement.

*‘Professional attitudes and training is a real barrier to an improving mindset – clinicians see “the system” as not themselves and not their responsibility.’ Improvement leader*

### **Headspace to make change happen**

We were consistently told that the available headspace – the capacity to think beyond the day to day and work on making changes – was insufficient to meet the challenges facing the NHS. This can be conceived in terms of the ability of individuals to split their time between the ‘two jobs’ of health care set out by Batalden and Davidoff: ‘everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it.’<sup>33</sup>

The NHS obviously places a strong focus on ‘doing the work’. Pressure from the centre on the delivery of targets in the short-term means ‘fire-fighting’ is often prioritised over local ambitions to improve and change services. Many at the front line feel that they have too many competing priorities, with associated undue effort in ‘feeding the beast’ through metrics and plans to account for their performance.

This is compounded by a perceived lack of understanding, particularly from national bodies and politicians, of the complexities, time and resources it takes to achieve sustainable change, resulting in unrealistic demands and timescales being placed on staff operating in frontline care (also an issue in local improvement efforts).<sup>6</sup>

*‘The pressure created by failing the A&E target in the last month, along with our local acute provider’s focus on achieving FT status means our transformation plans get put on the back burner.’ Commissioner*

Management capacity was often linked to headspace, with commissioners in particular feeling the tightening management resource limit is detracting from their ability to support change. Overall, NHS management resource is decreasing; there has been an 18% reduction in managers since 2010.<sup>34</sup> The need to strengthen skills for good operational management was also highlighted. A number of those we spoke to pointed to the lack, since the abolition of strategic health authorities, of capacity at a regional or health economy-wide level to support the development of skills, and broker consensus for change and help drive implementation of change.<sup>35</sup>

Headspace can be decreased further by the lack of standardised operational processes across the NHS, particularly among providers.<sup>23</sup> Poor management processes and unclear lines of accountability detract from the ability of organisations to perform reliably and efficiently<sup>36,37</sup> which wastes time that could be focused on improvement.

### Capability to deliver change

A lack of the necessary capabilities to deliver the changes now needed in the NHS was consistently identified to us, particularly with regard to formal quality improvement skills, management and data analytics. This not only means that change, when attempted, is less likely to succeed, but also diminishes staff motivation to make further changes.

*‘There is a need to think seriously about time – everything is done on the margins and at the weekend – if we are serious about this then it needs a team of four people.’ Academic safety expert*

Even where staff working in provider organisations have been trained in practical improvement skills, such as Lean, or using ‘plan, do, study, act’ cycles, they often lack understanding or confidence in the practical application of tools, particularly how to match their ambition to the context in which they are working.<sup>19,38</sup>

*‘There is a lack of skills and knowledge of improvement – therefore improvement work is not seen as “real” work.’ Improvement practitioner*

There are numerous organisations in the NHS, both national (such as NHS Improving Quality) and local (such as Academic Health Science Networks) which seek to develop improvement capabilities. However, many of the people we spoke to experience this support as confused, both in the approach taken in poorly performing organisations, as well as providing limited help for organisations with middle-ranking performance. The various roles of national bodies in improvement were generally thought to be unclear, and there seemed to be no clear strategy for building capability across the NHS in England in the medium term.

There is a shortage of high quality candidates for senior management and leadership roles.<sup>32</sup> This can partly be explained because of the stresses of such jobs, and the cuts which have reduced the strength of middle management. Historic underinvestment in management and leadership development across all levels of staff in the NHS also contributes, as does a lack of succession planning. For instance, nurses are unlikely to receive training in management before being appointed as a ward sister – a role managing around 20 staff.<sup>39</sup>

*‘[Analytical capacity is] not invested in - most of analytical capability has focused on reporting upwards.’ Improvement practitioner*

A lack of analytical capability has been attributed to insufficient data being available to understand the services provided, further hampered by poor IT systems.<sup>24</sup> Individuals also often lack confidence in dealing with information and data,<sup>24</sup> or are not able to access the analytical capacity and capability that they need to support them. This poses questions around how the NHS can build skills and capability in this area.

*‘Not enough people in NHS “speak geek” – need to translate data analysis into something meaningful for frontline staff to engage with.’ Local improvement analyst*

# How do national bodies support change?

4

The change now needed in the NHS is overwhelmingly local and overwhelmingly the responsibility of frontline providers of care. National bodies are a long way from the front line. Despite recent policies to devolve power, England's health service remains centralised, and national bodies still have a pervasive influence on local services. They can employ three broad types of approach to effect change:

- **Type 1: 'Prod organisations'**. These types of approaches direct, prod or nudge providers to make changes. For example: targets, directives and performance management; regulation; use of competition; contracting; and setting payment incentives. Currently, the priorities of many local organisations are set by prods: national 'must dos' – waiting times targets and the regulatory regime for providers (for example, on poor performers), or the CCG assurance framework in commissioning. In the past, some of these levers have been described as providing 'constructive discomfort' to the NHS,<sup>40</sup> driving better performance. In the service some can also be perceived as being part of a 'deficit management' approach to improving performance – where deficiencies are pointed out and the service nudged (or more) towards ameliorating them. Useful suggestions to develop the blend of prod approaches have been made in a recent report by the King's Fund.<sup>41</sup>
- **Type 2: 'Proactive support'**. These types of approaches directly or indirectly support providers and commissioners to make changes. In contrast to prods, proactive support could be described as providing 'constructive comfort' – put simply: where support leads to improved performance. In turn, this could be considered as an 'asset management' approach to improving performance – supporting existing assets. In helping providers accelerate new models of care and improve productivity, national efforts in the past have included the funding of the NHS Modernisation Agency and NHS Institute for Innovation and Improvement and, more recently, NHS Improving Quality, the NHS Leadership Academy, Academic Health Science Networks and strategic clinical networks (currently under review). There are also examples of networks of NHS organisations coming together to support improvement and change – for example the Advancing Quality Alliance<sup>42</sup> in the north west of England and the fledgling UK Improvement Alliance. More recent initiatives such as the Integrated Care Pioneers also employ a range of largely support type approaches, starting with identifying the needs of local NHS sites, providing flexible direct support and giving permission to make changes (see box 4 overleaf).<sup>43</sup>

- **Type 3: ‘People-focused’.** People-focused approaches influence the actions of staff directly. The NHS workforce of 1.4m people is employed by hundreds of separate local organisations. However, national bodies have a strong influence on their day-to-day working through mechanisms such as national contracts, professional regulation, leadership, clinical standards and revalidation.

Previous national efforts to support change have had mixed success. Where successful, they have often blended all three types of approach – with performance management, support and alignment of the way staff work – for example, to improve care for people with cancer<sup>44</sup> and cardiovascular disease,<sup>45</sup> or for broad groups of services such as A&E. Many of these efforts could be thought of as making up an overall strategy for improving the quality of care, as outlined in 2008 by Leatherman and Sutherland.<sup>46</sup>

However, the current blend of national approaches is not aligned to support the needed change in local organisations. For example, are national bodies:

- supporting **recognition of the need for change** when chief executives of trusts in special measures risk removal, while their consultants are more likely to receive clinical excellence awards than be dismissed?
- creating an environment in which there is sufficient **motivation to change** when FTs are pressured to put their short-term financial success ahead of the creation of a sustainable future for their local health economy?<sup>47</sup>
- creating the **headspace to make change happen** when dips in performance are accompanied by multiple demands for assurance, but limited offers of support?
- building and supporting **capability for change** when every reduction in managers is celebrated by politicians, making change ever harder?

*‘We need a different message from the system; the real message at the moment is not transformation.’ Acute trust chief executive*

#### **Box 4: Integrated Care Pioneers – a national programme working to support local areas in overcoming barriers to change**

The Integrated Care Pioneer programme is an example of a concerted effort from the centre to support local innovation. There is a central mandate to try out new ways of working, with explicit permission and moral support from national bodies, alongside access to national expertise and very modest sums to allow cross-programme networking and learning.

*‘We became part of the pioneer programme as “the badge” opens doors and gives us air cover to do what we want to do.’ Commissioner*

Pioneers are given flexibility in ‘the rules’ set by the national bodies. They have also benefitted from a light central reporting requirement and a realistic recognition of the time taken to make change. Those involved are positive about the programme and the risks and changes it has allowed them to start making.

*‘One of the real benefits of being a pioneer has been the access to a senior national sponsor and leadership mentor. This practical central support has been invaluable in helping to unblock barriers and facilitate difficult local discussions.’ Commissioner*

# Discussion: How can national bodies accelerate change?

5

What will it take to deliver change at the speed and scale now needed and articulated in the Forward View? It needs a realistic assessment of the scale of the task, and honest acknowledgement that if change isn't the top priority for the NHS, it will happen too slowly, if at all.

Crucially, it needs the recognition from national bodies that using the current set of policy approaches is likely to be insufficient. Instead, it is clear from the frontline testimony in this report that there needs to be some fundamental thinking about the overall balance of the three types of approach (type 1: prods; type 2: proactive support; and type 3: people-focused) in the NHS in England, and the coherence within and between each type of approach.

To help with this thinking, it might be useful to test some of the following propositions put up for argument:

- Prods are important and have had the most focus in policy terms. However, taken together at a local level they have, at most, 10% impact in improving overall, rather than targeted area, performance of providers of care – including commissioning.
- Proactive support has potentially far higher relative impact in improving local performance and there is not enough of it, or hard thinking about support.
- Proactive support can be targeted to specific interventions, or can be more generic (such as boosting operational management skills or stability of leadership). A focus on context is particularly important as, if improving performance can be described as 'intervention + context = outcome',<sup>11</sup> context is almost everything.
- People-focused approaches can be very potent, yet are significantly under-examined. Policy thinking relies too much on a theory of decentralisation (for example, through FTs being able to determine their own pay) rather than reality (hardly any FTs do so).

These propositions need debating not just between 'system leaders' but also with experienced providers of care. This is because the debate about the potency and relative strength of the levers and support is not an ideological or theoretical one, but is a debate largely resting on experience of what helps to accelerate performance at the front line.

If what counts is what works, greater testimony about what works is needed from the front line.<sup>48</sup>

The debate should be iterative and ongoing – not designed to unfreeze existing approaches to delivering care only to refreeze them after review,<sup>49</sup> but to recognise that, in the future, ‘permanent slush’ is desirable.<sup>50</sup> The results may be uncomfortable and may go against the grain of what has been the broad direction of reform for the past 20 years – the move to greater autonomy by individual provider units. But the debate needs to continue if ‘best shot’ policy is to be designed now to speed improvement towards transformation over the next five to 10 years. Without this ongoing debate, there is a real risk that the Forward View remains a well-articulated vision and nothing more.

We suggest four areas for action by national bodies:

- **Immediately develop a shared view of how change happens in the NHS and what national bodies should do to catalyse it.** This should be developed with leaders of front line services in an ongoing way and inform all national activity.
- **Develop the current blend of organisational levers (‘prods and supports’) to best support change.** In particular, increasing coherence and redefining national measures for local success, moving from a narrow view based on short-term performance to include the conditions for successful change and resilience.
- **Invest far more in support for change (‘proactive support’), starting with a coherent improvement strategy for the NHS in England.** This should be a five- to 10-year strategy and address the seven success factors for change outlined in this report. This strategy should include concrete suggestions for how proactive support can make improvements in the short term (within a year), as well as how regional support will develop over the medium to long term.
- **Focus action on people who work in the NHS (‘people-focused’).** Policy of all types should start with how it will support individual frontline staff to improve care. A great deal more work is needed with all current stakeholders to establish how the current staff-focused type policies can be developed and aligned to support change, as well as how these blend with the prods and supportive approaches outlined above.

Below we discuss each of these areas for action and provide recommendations for what national bodies should do to address them.

### **A shared view of how change happens in the NHS and what national bodies should do to catalyse it**

To support change most effectively, national policy must be based on a clear understanding of how successful change happens at the front line. While national bodies may have a unified vision on what needs to change in the local NHS, they do not yet have a common understanding of how they can support change across all parts of the performance spectrum.

Currently, national bodies have multiple and competing assumptions about, and methodologies for, how they support and drive local change. What is needed is a single theory of change with explicit agreed assumptions that can be tested and which underpin the activities of all national bodies.

The design of the theory matters – it must be collective and be co-produced with the NHS, working with staff and leaders who have a track record in frontline delivery. This could build on the work of the NHS Change Model<sup>5</sup> and the seven success factors for change identified in this report.

However, more important than the design is that the theory becomes ‘live’: iterated as thinking develops, and used as the blueprint for all national action supporting change. This goes well beyond a dry academic task; the Forward View’s ‘theory of change’ should be as debated and discussed in 2015 as its vision was in 2014.

**Recommendation:** National bodies should collectively develop a single model of change. This work needs to be live and ongoing and co-produced with experienced frontline providers of care. The actions of national bodies should then be aligned with it.

### **Develop the current blend of organisational levers (‘prod organisations’) to best support change**

Over the past two decades, the broad focus of national policy has been on designing the right blend of policies to nudge providers of health care to improve, whether this is through an approach based on hierarchy (such as targets) or incentives (such as introducing tariffs). There is potential to refine these levers, for example, through the development of more sophisticated payment currencies or regulatory approaches.

Two tasks are now needed. First, the blend of these prods needs to be developed to be more coherent to achieve the agreed theory of change. Second, the measures national bodies use to define success for organisations in the NHS need to be broadened. At present, there is a mismatch between what the centre prioritises (predominantly focused on short-term performance) and the priorities of organisations and health economies that adapt and succeed over the long term (whose priorities include capability for improvement, change and resilience). The current set of incentives mean that a trust chief executive who puts building an improvement culture ahead of waiting time performance would be likely to be risking their career.

To support organisations to change and improve, national bodies should judge success using a wider set of criteria. These could include performance but also look at capability for change, patient and staff experience, and the extent to which actions benefit the local health economy (see figure 5 overleaf). The Care Quality Commission’s (CQC) ‘well led’ domain in their inspection framework is a step in the right direction, but remains a small part of the overall performance regime. This new definition of success must be agreed and aligned across all national bodies, and designed with local stakeholders including those representing patients and the public.

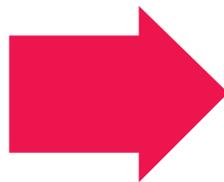
The forthcoming election and potential new government mean new priorities, and an opportunity to redefine what success looks like for the NHS.

**Recommendation:** National bodies should develop more coherent actions, aligned with an agreed theory of change. The performance frameworks owned by Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should be developed by moving to one framework for providers. This framework should be aligned with commissioning expectations; with equal parity given to performance across a health economy and capability for improvement, as well as short-term performance (see figure 5).

Figure 5: The shift needed in how the NHS defines success

## Defining success...

From...



To...



This new definition of success will need to be accompanied by different relationships and conversations between national and local organisations. Changing what success looks like involves difficult decisions – for instance trading-off central assurance on short-term performance against local time and space to make changes. These trade-offs need to be addressed and made explicit rather than avoided.

While national targets are likely to be here to stay, a far more nuanced approach to performance could be taken.

**Recommendation:** National bodies should introduce transparent ‘improvement zones’ for those transforming their health economies: where expectations of performance are adapted to create headroom for the duration of a period of change. Such an approach could be used to accelerate change in the Forward View ‘vanguard’ sites.

Improvement zones could be used across the performance spectrum. Health economies could set out the changes that they plan to make and how long it will take: and then account for both performance and ability to change over time.

**Invest far more in support for change (‘proactive support’), starting with a coherent improvement strategy for the NHS**

The NHS in England needs on-the-ground support: expertise on the issues and changes local areas are grappling with, alongside moral support for taking risks and making changes.<sup>51</sup> The support can be direct on specific issues (for example, managing waiting times), or more generic such as strengthening management and frontline capability in ‘quality improvement’ skills (for example: Lean; or plan, do, study, act cycles).

The NHS has had an inconsistent approach to such proactive support. For example, there has been an unhappy set of national bodies set up with this aim in mind, only to be abolished soon after birth: the NHS Modernisation Agency (established 2001, abolished 2006); its successor the NHS Institute for Innovation and Improvement (established 2005, closed 2013); the NHS University (launched 2003, abolished 2005); and the National Patient Safety Agency (established 2001, abolished 2012). ‘National support teams’ were a core part of the national service frameworks of the 2000s, and new nationally supported collaboratives (such as that for safety) continue to be designed to help deliver improvement in specific areas. A review of two main national entities for proactive support – NHS Improving Quality and the NHS Leadership Academy – is currently underway.

The reason for this unstable and confused history may be that the whole area of supportive approaches is poorly understood. Or, more likely, that it is contested in at least three respects:

- The nature of support (which is poorly understood).
- Its impact, particularly in the short term (a weak and mixed evidence base).
- Fundamentally, whether NHS support to NHS providers is legitimate (whether or not providers should be autonomous entities surviving through their own talents and choices and sourcing their own support privately).

At the root of this last point lies some ideological preferences. For example, there are competing views as to whether the NHS represents a form of ‘mega-chain’, a ‘system’ or a set of autonomous, competing providers.<sup>52</sup> However, we know that, designed well and in receptive contexts, linking up teams from multiple providers to work in a structured way to learn and improve together can improve quality.<sup>53</sup>

This collection of past experience and ‘meta-policy’ uncertainty leaves us with a deeply messy picture at a crucial point in the NHS’s history: there isn’t a clear articulation of what the collective support ‘offer’ from national bodies should be, let alone what it is now or what each body should do. In constructing a way forward, there are three dimensions to consider.

The first dimension is **timescale**: proactive support cannot be only about building capability for improvement and wider change in the medium term, although this should be an element. There must be some short-term gains, given the need for speed and to justify investment at a time of financial squeeze. The following support approaches might provide this progress:

- a. Group/network organised effort such as a breakthrough collaborative series<sup>54</sup> across England or a region on a targeted topic, such as developing integrated care, or improving the flow of patients through A&E. This approach has been used with effect in England more than a decade ago<sup>53</sup> but efforts, experience and skills were disrupted by the turbulence in national improvement bodies at the time.
- b. Buddying of high performing, well-developed providers with poorer performers for the medium term (as suggested in the *Dalton review*<sup>55</sup> and beginning to happen, for example in Northumbria and Cumbria).
- c. Central teams with significant skills in a particular area (such as in A&E care via the NHS Emergency Care Intensive Support Team) helping those needing to improve performance in targeted areas.

Since local organisational context is so important in helping or hindering change, it may be that suggestion (b) is more likely to produce sustainable results.

The second dimension is **geography**: the extent to which supportive approaches to organisations can really be provided at a national level in a country the size of England. National bodies can provide direction, galvanise effort across the country, and (in theory) influence other national bodies developing prods. A national body could also have responsibility for monitoring progress of improvement capability in providers. This national function could map, link and foster support activity in areas, such as primary care, traditionally overlooked by improvement support; not directly supplying support but ensuring its provision.

But understanding the capabilities and local contexts of providers thoroughly enough to provide support and challenge, cultivating efforts for the medium term and understanding progress (which may not easily be measureable), will need knowledge much closer to the ground. It may be that support is best organised at a regional level – whether on an existing administrative footprint such as an Academic Health Science Network, or a network of providers/commissioners in a region voluntarily coming together to provide critical mass and funding for support, as is happening in the north west of England.<sup>42</sup> In whatever shape or form, regional entities should be helped to build the infrastructure that they need locally to support improvement.

The third dimension is **provider performance**: the nature and organisation of support for providers in different parts of the spectrum of performance from poor to excellent. Related questions here include the extent to which Monitor and the Trust Development Authority should play a role in improvement – in ‘failure’, ‘pre-failure’ or at better levels of performance? Why does the role of NICE largely stop at defining high quality care, with minimal support from national bodies to put NICE guidance into practice?

**Recommendation:** National bodies should develop an NHS improvement strategy for England, based on an agreed view on supporting change, and with a clear description of the role of national bodies collectively and individually.

Such a national improvement strategy could encompass support for:

- **Individuals, focused around the continuous improvement of services.** To make a difference in the long term, improvement skills should be part of clinical and non-clinical training. In the shorter term, capacity building in organisations is needed, as well as mechanisms for people to network and learn from each other across boundaries.
- **Organisations, both providers and commissioners, focused on developing capability.** Support is needed that focuses on improving operational management ‘basics’: communications and people management, implementing good governance and appropriate processes. Access to those with skills in engagement, analytics and change management can helpfully inform change that organisations are leading, as can access to collaborative efforts to catalyse change in areas of common difficulty. To help organisations understand where they are in building their capability to change, they may focus their resources; a diagnostic measuring and linking success factors for change and quality of care could be helpfully developed (starting from the seven success factors identified in this report).
- **Local health economies, focused on transformational change.** Those developing new models of care or reconfiguring would benefit from senior peer support, continued moral support from national bodies, and access to a trusted external facilitator or ‘honest broker’ to build consensus among partners and drive change.

### **Focus efforts on people who work in the NHS (‘people-focused’)**

Through organisational prods, national policy seeks to improve care by focusing on organisations. For example, this focus is seen in the description of future models of care as ‘multi-specialty community providers’ or ‘viable smaller hospitals’.<sup>1</sup>

While organisational mechanisms have an important role to play, the importance of staff can be overlooked. Successful change rests upon the ability of staff to work together to agree a common goal and take action – whether they be porters, clinicians, middle managers or senior leaders. This has two main implications for national policy.

First, any form of national policy needs to be grounded in an understanding of the pressures faced by NHS staff. At present, there is no systematic way for NHS staff or organisations to provide real input into, or feedback on, the cumulative effect of national policies.

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**Recommendation:** The Department of Health, as steward of the system, should conduct a transparent annual exercise with frontline staff to understand and communicate the costs and benefits of collective national policy. National bodies can then take action to remove expectations that are not aligned with their collective vision.

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Staff working on the front line know more than national policy makers about the challenges of delivery and what will improve patient care. When they use this understanding to make a difference, the results can be transformational. For example, more than 400,000 staff have signed up to the #hellomynameis campaign for more compassionate care,<sup>56</sup> led by Dr Kate Grainger, a hospital consultant and patient.

National bodies need to ensure that they involve frontline staff, in addition to patients, service users and the public, in the design of all policy. This means having far greater intelligence about how national actions affect people on the front line, and finding ways to design policy with them. They need to go beyond consulting on finished products, or involving only representative bodies. This process takes time and effort to do properly. It could involve using intelligence gathered via existing regional tiers of the system, greater use of digital communications, or asking organisations to allow staff time to contribute to a better health system.

In thinking about change, national bodies could play closer attention to their role in shaping the environment staff operate in. This ranges from the role of the Department of Health (via NHS Employers) in setting national contracts, to the role of professional regulators and the royal colleges in overseeing professional standards and education.

The approach by national bodies has often been to concentrate on prods to organisations, staying away from issues which affect NHS staff directly. Prods and people-focused approaches are commonly designed separately, and can lack clarity as to how they relate. The past five years have seen significant changes both to systems of regulating organisations (through changes to the Care Quality Commission) and doctors (through the introduction of revalidation), yet how these two systems are designed to complement and support each other is unclear. Likewise, the Forward View and its planning guidance focus on organisational policy changes, with little to say about policy on people who work in the NHS.

This matters: some aspects of staff members' professional lives are set centrally, and have the potential to either support or undermine change. For example, financial reward and continuous professional development.

This is well beyond the reach of organisational policies or prods, but not national influence on professional attitudes and working environments. For example, the Doctors' and Dentists' Review Body has recommended amendments to clinical excellence awards, linking them much more closely to consultant performance and commitment to the NHS.<sup>57</sup> Policy changes like this can alter the expectations and culture around improving services and staff members' roles in change.

While we lack the evidence to be able to judge the relative impact of people-focused approaches, such as a well-designed change to the consultants' contract, compared to the further development of prods (organisational policies), what is clear is that both approaches are needed, and must be aligned.

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**Recommendation:** National bodies should undertake a comprehensive review of how all policies affecting individual staff can contribute to supporting change, and how they can be aligned with organisational policy and support. This needs to ensure the role of education and training, national staff contracts, clinical excellence awards, revalidation, professional leadership and regulation all support the needed change.

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To achieve change at the pace and scale now needed in the NHS requires much careful thinking about the mechanisms employed to effect change.

In this report we have focused how best to design national policy on the NHS to accelerate improvements to health care. We have argued that there are three broad types of approach to achieving this change:

- **Type 1: ‘Prod organisations.’** Prods – which include policies commonly termed ‘system reform’ levers – need to be developed into a more coherent and intelligent blend. But even so, the overall impact on frontline care may be indirect, partial and weak.
- **Type 2: ‘Proactive support.’** Proactive support – which involves providing more direct support to providers – is currently ill-thought through and has been markedly inconsistent over time. Yet, arguably, it has the potential to have far greater impact than prods.
- **Type 3: ‘People-focused.’** People-focused approaches – more direct mechanisms to affect the behaviour of frontline professionals – are potent but also have not been developed in a comprehensive or coherent way.

Furthermore, how these three broad types of approach combine in order to be greater than the sum of their parts is also under-examined.

Everyone stresses the need for change, while continuing to use broadly the same national mechanisms as in previous years to try to make local change happen. Unless this is addressed, the speed of change in frontline care will not be sufficient for the NHS to meet the challenges it faces or to secure the high quality care that the population expects.

Theory and ideology on the one hand, and empirical evidence on the other, are not going to provide answers to optimum design of the above three approaches – the issues are too complex for that. Furthermore, any such design will need to be iterative and adapt over time. We suggest that any strategy for improvement work is built upon close and continuing work both with providers with a track record of providing high-quality care, with providers who are well developed and resilient organisations, and of course the populations they serve.

Taking the approach set out in this document is not the whole solution – technology, working with patients and working with other sectors will still need to be addressed. However it would represent a significant step towards successful change and a sustainable NHS.

# Annex A: The seven success factors and other change models

The table on pages 30–31 maps various models for successful change in health care against the seven success factors identified in our work. It does not aim to provide a comprehensive view of the literature, rather to show similarities and the range of models previously developed.

The models included are:

1. **NHS Change Model:** A collectively developed model for successful change in the NHS.<sup>5</sup>
2. **Kotter's eight stages for successful change:** a widely used framework for organisational change, developed as stages to go through for those leading the change.<sup>16</sup>
3. **Overcoming challenges to improving quality:** a synthesis of the learning from a number of significant Health Foundation funded programmes.<sup>6</sup>
4. **A systematic narrative review of quality improvement models in health care:** produced for Health Improvement Scotland, identified 'necessary but not sufficient' conditions for success.<sup>58</sup>
5. **High reliability organisations evidence scan:** factors common to high reliability organisations collated from the literature.<sup>36</sup>
6. **Improvement collaboratives in health care evidence scan:** factors for successful learning collaboratives distilled from the literature.<sup>53</sup>
7. **Pettigrew's eight factors of receptive contexts for change:** from a study of eight 'high change' district health authorities in the 1980s.<sup>3</sup>
8. **Organising for quality: the improvement journeys of leading hospitals in Europe and the United States:** the study looked in detail at 12 quality improvement programmes.<sup>4</sup>

## Mapping the seven success factors to other change models

	1. NHS Change Model	2. Kotter's eight stages for successful change	3. <i>Overcoming challenges to improving quality</i>	4. <i>A systematic narrative review of quality improvement models in health care</i>
<b>Committed and respected leadership engaging the staff</b>	Leadership for change Engagement to mobilise	Create Urgency Create a vision for change	Leadership. Convincing people that there is a problem. Convincing people that the solution chosen is the right one.	The active engagement of health professionals, especially doctors
<b>Management practices that ensure execution and implementation</b>	Rigorous delivery Spread of innovation	Form a powerful coalition Build on the change	Excess ambitions and 'projectness'. Considering the side effects of change.	Sustained managerial focus and attention; the use of multi-faceted interventions
<b>Capabilities &amp; skills to identify and solve problems</b>	Improvement methodology	Create short term wins	The organisational context, culture and capacities.	Substantial investment in training and development
<b>Data &amp; analytics that measure and communicate impact</b>	Transparent measurement		Getting data collection and monitoring systems right.	The availability of robust and timely data through supported IT systems
<b>Resources &amp; support to do the work of transformation</b>		Form a powerful coalition	Securing sustainability.	Provision of the practical and human resources to enable quality improvement
<b>A culture hospitable and supportive of change</b>	Our shared purpose	Anchor the change in corporate culture	The organisational context, culture and capacities. Tribalism and lack of staff engagement.	
<b>An enabling environment which support and drive the right kind of change</b>	System drivers	Remove obstacles to change	Balancing carrots and sticks – harnessing commitment through incentives and potential sanctions	Coordinated action at all levels of the health care system

## Mapping the seven success factors to other change models (continued)

	<i>5. High reliability organisations evidence scan</i>	<i>6. Improvement collaboratives in health care evidence scan</i>	<i>7. Pettigrew's eight factors of receptive contexts for change</i>	<i>8. Organising for quality: the improvement journeys of leading hospitals in Europe and the United States</i>
<b>Committed and respected leadership engaging the staff</b>	Highly trained and well-rewarded staff	Get buy in from senior leaders	Key people leading change Simplicity and clarity of goals	Addressing the politics and negotiating the buy-in Inspiring, energising and mobilising people
<b>Management practices that ensure execution and implementation</b>	Redundancy of processes continuous improvement flexibility to deal with change	Set clear goals that team members buy into and are accountable for. Provide standardised change interventions but allow for tailoring to the local context and needs.	Quality and coherence of policy	Structuring, planning and coordinating quality efforts
<b>Capabilities &amp; skills to identify and solve problems</b>	Highly trained and well-rewarded staff	Include organisational coaching in addition to collaborative learning sessions.	Change agenda and its locale	Creating and nurturing a learning process to support continual improvement
<b>Data &amp; analytics that measure and communicate impact</b>	Regular checks	Ensure there is an appropriate IT infrastructure for collating data and sharing good practice. Use simple measurement tools.		Designing ... technological systems supportive of quality efforts
<b>Resources &amp; support to do the work of transformation</b>	Highly trained and well-rewarded staff	Ensure organisational support, appropriate resourcing and enough time for changes to embed.		Designing physical infrastructures ... supportive of quality efforts
<b>A culture hospitable and supportive of change</b>	Learning culture Creative ways to cope with errors Positive safety culture	Include organisations that volunteer rather than making participation mandatory.	Managerial clinical relations Supportive organisational culture	Giving 'quality' a shared, collective meaning, value and significance within the organisation
<b>An enabling environment which support and drive the right kind of change</b>	Complex high risk environments Consequences of error would be serious	Focus on topics where there is established good practice and a large gap between current and ideal performance.	Environmental pressure Cooperative inter-organisational networks	Outer context – market, technology, political / regulatory environment, social / cultural environment

# Annex B: The seven success factors at different levels of the NHS

The seven success factors at different levels of the NHS

	Leadership	Culture	Management practices	Data & analytics
Clinical team	Clinicians take improving their service seriously, and engage others in improvement	Constructive team relationships and joint working, including with managers	Explicit and clear processes for doing business  Clear accountability for delivering change	Timely information on the team's performance, with comparisons to similar teams
Provider	Committed and courageous leaders provide a clear patient-centred vision  Leaders convince staff change is possible and to be involved in change efforts	Staff feel valued by their peers and management  Improving services seen as part of the day job	Good governance and operational management  A strategic approach to organisational change	Information on the organisation's quality, cost and patient experience available throughout organisation, and how this relates to others
Local health economy/ commissioner	Clinical and organisational leaders successful in engaging the public and local politicians  Constructive relationships between organisations	Valued staff in organisations  Organisations open to working together  Willingness to try, fail, and try again	Quality of cross-organisation joint working  Effective governance and managements of change efforts	Information to allow benchmarking of performance and prioritisation of areas to focus on
National	Priority, and leadership with a strong clinical component	Successful link between change attempted and professional values  Support from professional opinion leaders	Time to pilot and engage when designing new initiatives  Effective programme management	Sufficiently detailed information on quality and performance available

**The seven success factors at different levels of the NHS (continued)**

	<b>Capabilities &amp; skills</b>	<b>Resources &amp; support</b>	<b>An enabling environment</b>
<b>Clinical team</b>	Team capability in improvement skills and project management	Time set aside for improvement, and access to improvement expertise / coaching	Organisational incentives and priorities align with improvement activity
<b>Provider</b>	Mix of improvement skills, project management, management and leadership skills	High quality resources for change management	Constructive relationships with regulators  Commissioners engaged with, and supportive of, change
<b>Local health economy/ commissioner</b>	System capability in change management and engaging staff and patients	'Air cover' from national organisations to innovate  Enough people with dedicated time to support change  Access to external support as necessary	Economic context of local health economy  Supportive local politics  Flexibility in payment structures  A navigable health care geography
<b>National</b>	Capability needed assessed and addressed  Appropriate skills available to national programme	Sufficient resource available to support change  Practical support available to deliver the change	National politics amenable to change  Other public services cooperative in making any necessary changes

# Annex C: Methodology

There were five strands of work that contributed to this report and its conclusions:

- **Workshops** with commissioners, leaders in quality improvement and people who had participated in Health Foundation leadership programmes. The workshops focused on what is important in change in health and what gets in the way. The four workshops were:
  - a roundtable session with commissioners, focusing on the challenges of leading large-scale change across a health economy
  - a roundtable session with system leaders, focusing on the roles of the different national bodies in improvement, and how the current health system supports change and improvement
  - a workshop with members of the UK Improvement Alliance, concentrating on what an improvement support offer should look like, and the systemic issues preventing sustainable change from happening consistently
  - a session with Health Foundation alumni on effective change, focused on moving away from action plans to more improvement-focused system management.
- **Interviews** with more than 40 system leaders, clinicians, academics, improvement leaders, commissioners and managers. In the interviews we discussed change and what could be done differently. In addition, we conducted a set of structured surveys with a panel of improvement practitioners – people with practical experience of leading improvement projects in the NHS.
- **A review of Health Foundation experience** of funding and evaluating improvement projects. Particularly relevant to our work has been the previously commissioned review of Health Foundation improvement projects *Overcoming challenges to improving quality*,<sup>6</sup> in addition to more recent project evaluations,<sup>22</sup> evidence scans,<sup>36</sup> research on context<sup>20</sup> and thinking on implementing change.<sup>7</sup>

- Specific **analysis of provider transformation**, based on interviews with senior leaders from a range of acute providers. McKinsey Hospital Institute led this work and spoke to senior trust leaders, including people working in community and mental health trusts, alongside a number of McKinsey staff with experience of supporting change in health services. This is published as a supplement to this report. See: [www.health.org.uk/acceleratingchange](http://www.health.org.uk/acceleratingchange).
- A scan of empirical **evidence** about the barriers to change in the NHS, prepared by the Evidence Centre. A total of 73 studies about the NHS were analysed, plus more than 100 studies from other countries were looked at, as a comparison. Most studies in the NHS were small scale, based in a hospital context and published within the past five years.

The seven factors for successful change were identified through synthesis of key frameworks from the existing literature, Health Foundation experience on successful change and interviews as part of the project. We then tested the success factors through further discussions and workshops.

We developed a picture of the many barriers to successful change through the different strands of work outlined above. This information was collated, and synthesised/organised through iterative discussions within the project team, continually coming back to the underlying reasons behind barriers encountered in change initiatives. We have aimed to give equal weight to the various sources of opinion and experience in our evidence gathering. The resulting barriers to change were then tested through our ongoing conversations and against Health Foundation experience.

Finally, our conclusions and recommendations were developed through careful consideration of what national bodies could do to support accelerated change in the NHS.

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