NHS Modernisation:
Making it mainstream
March 2003
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1.0 Foreword

I am pleased to provide a foreword to the research report *Local modernisation: making it mainstream*.

The catalyst for the research was a national meeting organised by the NHS Modernisation Agency during 2002. This was attended by 450 PCT and Trust Board Directors with responsibility for modernisation. The questions that the participants asked most frequently were “how should we organise locally to support modernisation?” and “what do we need to do to spread improvement across our organisation or community?”

As a result, the Modernisation Agency commissioned Matrix MHA to undertake some “speed” research. Our aim was to gather information about what was working in local modernisation and to make advice available to NHS teams as quickly as possible. Despite the speed and limited scope of the research process, it has produced rich results which are useful for local leaders, Strategic Health Authorities and the Modernisation Agency.

This research represents the start of a process to build a powerful body of knowledge about “what works” in local modernisation and the components of effective modernisation support systems. We hope that this knowledge can be applied to help accelerate the improvement process in local organisations and communities.

Over the past few years, the NHS has begun to create the knowledge and skills necessary to improve health and social care on a colossal scale. If we were to put into practice everything we know and link it to purposeful leadership for improvement and effective support systems, we could create a system which performs at a level way beyond NHS Plan targets. No-one would have to wait unnecessarily. Patients could drive their own care in ways they are comfortable with. Improvement of health and healthcare could be an integral part of everything we do.

To enable this to happen, we need to move to a new phase of healthcare improvement. Many of our existing modernisation programmes and projects have demonstrated outstanding results for patients. However, in the next phase we have to focus on the tougher goal of demonstrating the ability to “mainstream” improvement work; moving beyond projects to embed it into all that we do. The organisation and communities featured in the research embody this new way of thinking, unleashing the energy and creativity of their staff to make a real difference for patients.

The challenges are significant but the prize is massive.

Thank you to all who took part in the research.

Helen Bevan
Redesign Director
NHS Modernisation Agency
March 2003
2.0 Executive summary

2.1 The aim of the report

This report is the product of a rapid review undertaken by Matrix MHA\(^1\) for the Modernisation Agency (MA) examining local modernisation within the NHS.

Sustained change in healthcare practice depends in part on the commitment of individuals to do things differently\(^2\). Modernising the NHS will not happen overnight and requires commitment from different levels. To involve individuals and to take forward the modernisation agenda, local organisations have developed different support structures. Some of these are focused to develop particular service improvement in a narrow field whereas some of them are designed to look at the whole system, across several local organisations. The aim of the review has been to identify the local change support systems that local change leaders and teams have used to close the performance gap. Local change support systems have been described by the MA as follows\(^3\):

> Local decision-making leads to local action to improve. This requires the creation and maintenance of local change support systems that provide easy access to resources and tools that local change leaders and teams can use to close the performance gap.

This report forms part of the MA's review of current modernisation support systems, *Healthcare Improvement Next Steps*, which aims to:

- develop a vision and direction for healthcare improvement in the next phase;
- increase the coherence of national and local modernisation efforts;
- identify financial flows related to modernisation;
- create partnership agreements between the MA and Strategic Health Authorities;
- improve human resource systems within the MA; and
- formalise the discipline of improvement for health and social care.

We have identified a "migration" in local NHS modernisation from a nationally driven and piecemeal approach to a locally driven and mainstream approach. This migration has three broad phases:

- phase one: nationally driven with a programme focus;
- phase two: locally driven with a programme and project focus; and
- phase three: locally driven with a mainstream focus.

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\(^1\) Matrix MHA is the trading name of Matrix Research and Consultancy Ltd.

\(^2\) Research into Practice Programme Summary report No 1, July 2002: *From scepticism to support – what are the influencing factors? Modernisation Agency*

The report focuses on the latter two phases of this migration and divides findings into two stages:

1. **Establishing modernisation** – utilising a traditional model of change management to assess how modernisation can be successfully introduced and developed in an organisation.
2. **Mainstreaming modernisation** - identifies common themes that will help an organisation to mainstream modernisation by embedding processes and structures to support modernisation at the local level.

We do not seek to present this as representing a complete or in any way linear process, as there is likely to be a degree of overlap between these two stages.

### 2.2 Establishing modernisation

The two stage approach to establishing and developing the modernisation agenda in local health communities sees the development of project and programme based modernisation initiatives as an important precursor to more fundamental mainstreaming, characterised by the sustained integration of modernisation into organisational systems and culture.

When thinking about establishing modernisation within local organisations, the model that we used\(^4\) conceptualised the change process as a series of elements:

- **recognition** that external events or internal circumstances require a change to take place;
- the **start of the change process** where the need for change is translated into a desire for change;
- **diagnosis** involving reviewing the present state and identifying the preferred future state;
- **preparing and planning for implementation** which takes account of things identified during diagnosis which will need to be done in order to realise the change in reality;
- **implementation**; and
- **reviewing** which will be ongoing and ensure that there are feedback mechanisms and reward systems in place that will monitor and reinforce desired new behaviours.

However, this is not to suggest that the process of establishing modernisation is strictly linear. A key message from interviewees participating in the review has been that local change support systems vary according to local context and therefore the way that they are developed, implemented and combined varies from area to area.

Our research suggests that in order for the need for change to be recognised and the change process to start there is a need for:

- clear leadership that is focused on the needs of the patient;

• multi-professional teams appropriately supported and incorporating clearly delineated responsibilities;
• organisational structures to support modernisation, underpinned by protected time; and
• partnership working.

Our rapid review identified diagnosis of the problem, prior to developing and implementing a change plan, as often being a relatively weak area in the change management cycle. In many of the organisations that we spoke to we were not able to identify an explicit process of diagnosis preceding the implementation of a change plan. Three themes that we did find in organisations that had successfully incorporated a diagnostic element to their modernisation programme were that they had:

• established clear aims and objectives for the modernisation programme;
• adopted a bottom up approach to supporting this process; and
• offered protected time for diagnosis.

A range of local change support systems were identified for planning, preparing and implementing change, many building on the good practice set out by the Modernisation Agency in their Improvement Leaders’ Guides. The central themes identified from the stakeholder interviews focused upon:

• strong project management skills;
• the utilisation of methods including process redesign and whole systems working;
• the ability to deliver ‘quick wins’;
• the development of peer networks; and
• effective communication systems for the dissemination of good practice.

Evidence of effective practice generated by the review process for use by those implementing change can usefully be shared with a wider audience to encourage the spread of effective practice to other parts of the organisation or the wider local health community. The three themes identified by respondents as helping review and spread were:

• setting clear targets;
• providing effective monitoring; and
• developing systems for local support and development, including local forums and collaboratives.

2.3 Mainstreaming modernisation

A number of respondents highlighted the limitations of a project and programme-based approach to modernisation and stressed the need to ensure that the modernisation agenda was ‘mainstreamed’ across local organisations. This can be identified as the second phase in the local modernisation process and we identified various roles and structures that local organisations have put in place to embed and sustain local modernisation within the mainstream of service delivery.
Approaches to mainstreaming modernisation have been grouped together around a number of key issues:

1. **Workforce and skills development**

Issues included:
- developing in-house capacity to deliver modernisation;
- putting in place and accessing a range of training to develop appropriate skills;
- creating specific mainstream roles with a remit for taking forward the modernisation agenda as part of mainstream practice;
- recognising the key role middle management plays in turning the vision of an executive team into reality and ensuring frontline views are fed up through the organisation;
- making modernisation part of all staff’s job descriptions; and
- including modernisation with clinical division’s and directorate’s responsibilities.

2. **Strategic and policy**

Issues included:
- clear links with organisational strategy to turn modernisation from a short-term to a long-term goal; and
- placing modernisation and service improvement as a regular item in trust board meetings to help sustain change and make modernisation mainstream;

3. **Communications and partnership**

Issues included:
- constantly placing the patient at the centre of care to help organisations see the significance of contributions made by other organisations to a process;
- the importance of recognising achievements and celebrating success in making modernisation relevant to mainstream work; and
- recognising that investment in IT and knowledge management is important to ensure the dissemination of knowledge.

2.4 **Conclusions: Taking modernisation forward**

A number of factors are likely to be key in taking the modernisation agenda forward in the coming months and years.

The NHS Plan promises radical change in healthcare over the next ten years and this will almost certainly entail a move from transactional to transformational change. However, in our discussions with interviewees, it was often apparent that while members of the Modernisation Agency (MA) and strategic health authority (SHA) modernisation leads tended to focus on achieving transformational change, the extent to which transformational change was achieved at trust and PCT level varied. One of the key challenges to devolving the modernisation agenda will therefore be to encourage transformational change within and across local organisations. For this to occur a number of issues need to be considered:
change will need to rely to an extent on bottom-up learning and feedback if sustainable, transformational change processes are to be created;
organisational cultures supportive of change will continue to be important and will need to be developed further;
staff, patient and carer involvement is complex and challenging, but crucial for delivering transformational change;
inter-agency working between the range of national, regional and local organisations involved in modernisation needs to be simplified;
inter-agency working within local health communities needs to be extended to engage more effectively with other parts of the local public sector that are facing similar challenges and seeking to develop similar solutions; and
performance management and service improvement will have to be brought together effectively to establish a ‘performance improvement’ approach, where a creative tension emerges between performance management and modernisation and encourages transformational change.

Key to all of the success factors set out above will be the presence of strong local leadership. To date the MA has taken a major leadership role in taking forward the modernisation agenda, through national teams, programmes and collaboratives. In the future, the main leadership role for mainstreaming modernisation will come from SHAs, trusts and PCTs with support from the MA. Mainstreaming modernisation will only be possible if local leadership is effective, and this requires:

the presence of a range of leadership roles including the commitment of Chief Executives and senior managers, as well as clinical leadership;
change leaders with a good understanding of organisational development and different strategies for organisational change; and
front line staff being given the freedom and authority to make changes to their services.
3.0 Introduction

This report is the product of a rapid review undertaken by Matrix MHA for the Modernisation Agency (MA) examining local modernisation within the NHS.

Sustained change in healthcare practice depends in part on the commitment of individuals to do things differently\(^5\). Modernising the NHS will not happen overnight and requires commitment from different levels. To involve individuals and to take forward the modernisation agenda, local organisations have developed different support structures. Some of these are focused to develop particular service improvements in a narrow field whereas some of them are designed to look at the whole system, across several local organisations. Modernisation project teams, Modernisation Boards, networks, learning sets and regular forums are coming together to exchange ideas and disseminate good practice. These are becoming increasingly important in changing the way organisations work together, involve staff in activities and keep pace with public expectations, best practice research and developments in IM&T.

Modernisation and service improvement is at the heart of developing patient centred care and is closely related to the clinical governance agenda. Therefore it is important to measure success in modernisation and service improvement in terms of clinical outcomes, not just service efficiency, to ensure delivered change will ultimately respond to the needs of patients, service users and carers to deliver improvements in their experience of services.

3.1 Aim, objectives and methodology

The aim of the review has been to identify the local change support systems that local change leaders and teams can use to close the performance gap. Local change support systems have been described by the MA as follows\(^6\):

*Local decision-making leads to local action to improve. This requires the creation and maintenance of local change support systems that provide easy access to resources and tools that local change leaders and teams can use to close the performance gap.*

The key objectives of the project were to:

- identify local change support systems that are easy to access and that close the performance gap;
- describe the process of creating and maintaining such systems; and
- identify the potential for replicating such systems across local NHS communities.

The basis of this review has been a series of interviews\(^7\), undertaken predominantly by telephone, with a range of practitioners and improvement leaders in local health communities and

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\(^5\) Research into Practice Programme Summary report No 1, July 2002: From scepticism to support – what are the influencing factors? Modernisation Agency


\(^7\) A small number of interviews were face-to-face interviews
within the MA. Interviews were undertaken over a three-month period between December 2002
and February 2003. Relevant national and local literature was also reviewed and a small number
of interviews were undertaken with individuals from other parts of the public and private sectors to
examine comparative approaches to local modernisation issues.

In most cases the work reported here is ongoing and the effectiveness of the implemented
support structures has not been formally evaluated. Within the time frame and scale of this rapid
review, the ability of the research team to systematically verify the effectiveness of local change
support systems and practices has been limited and emphasis has been given to individual
organisations’ own evaluation of the effectiveness of the implemented support systems. The
methodology used, is discussed in more detail in Appendix Two.

3.2 The local modernisation agenda

There is a danger in a report of this nature of ‘reinventing the wheel’ and therefore it is important
to place this review within the context of the continuing development of local organisations, the
Strategic Health Authorities (SHAs) and the MA.

The MA defines NHS modernisation as making improvements which patients can sense, touch
and feel. This is said to involve three strands:
- renewal – making good the years of under-investment and ‘making do’;
- redesign – changing the way that services are delivered to make them work better for
  patients and staff; and
- respect – re-instilling in the service a sense of respect and pride in achievement.

The wider modernisation agenda increasingly acknowledges that local organisations should
become the champions of change. The NHS Plan set out a vision of a health service fit for the
21st century that is predicated upon the need to change the way care is delivered, with
increased investment accompanied by reform.

As a part of the implementation of The NHS Plan, Shifting the Balance of Power, led to the
establishment of new structures to support this change process. One of the key elements of the
plan includes empowering frontline staff and patients in the NHS to encourage a culture that
puts patient's need before the organisation’s needs. Locally based primary care trusts (PCTs)
have been given the key role of running the NHS and improving health in their areas. This has
also led to the establishment of Strategic Health Authorities. Modernisation of healthcare
requires a fundamental examination of how services are organised and delivered. In recent
years local organisations have made increasing progress in developing and modernising the
way services are provided to deliver better care for patients. The modernisation agenda is
increasingly seen as an integral part of the wider organisational framework, instead of an ‘add-on’
to existing workloads. Increasingly, the modernisation agenda has been built into
organisational structures. It has become integral to the way things are being done throughout
organisations instead of being delivered as a series of detached projects that have little
relevance to the way overall care is delivered.

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8 Modernisation Agency Business Plan 2002/03
9 http://www.doh.gov.uk/shiftingthebalance/index.htm
The SHAs act as representatives of local healthcare improvement by representing local organisations and pulling improvement together in their geographical area. Bringing together service redesign with performance management, SHAs utilise systems and processes such as Local Delivery Plans to develop a whole systems approach to service development.

The MA will also have an on-going remit in continuing research and innovation, building improvement skills and knowledge, and supporting organisations.

Local organisations are responsible for how they organise and run things and for all implementation. The Modernisation Agency should ensure that they support the implementation in a way that works for people locally and in a way that ensures that key policy initiatives are implemented effectively so that people can get maximum benefit out of it.

Interviewee from the Modernisation Agency

This report forms part of the MA's review of current modernisation support systems, Healthcare Improvement Next Steps, which aims to:

- develop a vision and direction for healthcare improvement in the next phase;
- increase the coherence of national and local modernisation efforts;
- identify financial flows related to modernisation;
- create partnership agreements between the MA and Strategic Health Authorities;
- improve human resource systems within the MA; and
- formalise the discipline of improvement for health and social care.

Throughout this report we have made references to the most well known modernisation programmes. These national programmes have supplied energy, focus and a mechanism for working in more interactive and successful ways toward improvement across the health and social care continuum. More information on individual programmes can be found in the MA web site www.modern.nhs.uk.

In presenting our findings we have identified a "migration" in local NHS modernisation from a nationally driven and project-based approach to a locally driven and mainstream approach. This migration can be seen to have three broad phases:

- phase one: nationally driven with a programme focus;
- phase two: locally driven with a programme and project focus; and
- phase three: locally driven with a mainstream focus.

Our research findings suggest that moving to phase two and phase three does not negate the need for phase one type support for local teams. National programmes and support systems from the MA will need to continue to play and important role. However, as NHS organisations migrate to phase three, the nature of the support that local teams need from the MA will change.

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10 Research into Practice Programme Summary report No 1, July 2002: From scepticism to support – what are the influencing factors? Modernisation Agency
We have sought to focus on the latter two phases of this migration, identifying common themes and approaches as well as specific examples of modernisation practice. We have presented these in the following two stages:

1. **Establishing modernisation** – utilising a traditional model of change management to assess how modernisation can be successfully introduced and developed in an organisation.

2. **Mainstreaming modernisation** - identifies common themes that will help an organisation to mainstream modernisation by embedding processes and structures to support modernisation at the local level.

We do not seek to present this as representing a complete or in any way linear process, as there is likely to be a degree of overlap between these two stages.

These two sections link through to the five case studies in Appendix One as well as making reference to additional interviews carried out to support this project. A concluding section sets out key issues for the future development of the modernisation agenda.
4.0 Establishing modernisation

The two stage approach to establishing and developing the modernisation agenda in local health communities sees the development of project and programme based modernisation initiatives as an important precursor to more fundamental mainstreaming, characterised by the sustained integration of modernisation into organisational systems and culture.

When undertaking the review we used a conceptual model of the change management process to help us understand the contribution local change support systems made to the change management process. The model that we used\(^\text{11}\) conceptualises the change process as a series of elements:

- **recognition** that external events or internal circumstances require a change to take place;
- the **start of the change process** involves translating the need for change into a desire for change, deciding who will manage the change and, where an external change agent is introduced, establishing a workable and effective change relationship;
- **diagnosis** involves reviewing the present state and identifying the preferred future state;
- **preparing and planning for implementation** takes account of things identified during diagnosis which will need to be done in order to realise the change in reality;
- whatever has been planned needs to be **implemented**; and
- **reviewing** and monitoring will be ongoing and consolidation will ensure that there are feedback mechanisms and reward systems in place that will monitor and reinforce desired new behaviours.

This model is represented diagrammatically in Figure 2 and has points of interface with the Model for Making Modernisation Mainstream, developed by the Modernisation Agency, which seeks to show the links between different elements of the change process across the health system\(^\text{12}\).

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Figure 1: Model of change

This model should not be taken as suggesting that change is a rational, linear process. However, conceptualising the change management process in terms of a series of discreet stages facilitates the task of understanding and describing a complex process. The authors of the model also emphasise the importance of ‘people issues’, in change management, namely:

- power, leadership and stakeholder management;
- communication;
- training and development;
- motivating others to change; and
- support for others to help them manage their personal transitions.

We have also taken these issues into account when identifying local change support systems.

We have grouped local change support systems according to the elements of the model of change to which they are most relevant. However, these approaches should not be understood as a mutually exclusive set of categories. Many of the support systems have relevance to more than one stage of the change management process. A key message from interviewees participating in the review has been that local change support systems vary according to local context and that therefore the way that they are developed, implemented and combined varies from area to area.

The case studies referred to within the text can be found in Appendix One.

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4.1 Recognition of the need for change and start of the change process

Our research suggests that recognition of the need for change and the start of the change process requires:

- clear leadership that is focused on the needs of the patient;
- multi professional teams appropriately supported and incorporating clearly delineated responsibilities;
- organisational structures to support modernisation underpinned by protected time; and
- partnership working.

Whilst all of these are likely to be found both in change management literature and in much of the work of the MA to date, the confirmation of their importance by respondents is an important validation of their applicability within the NHS and provides additional detail for those concerned with their implementation.

1. Clear leadership that is focused on the needs of the patient

*Clear leadership from Chief Executives and other Board Directors is necessary to set the change agenda and to generate and maintain momentum*

When speaking to local organisations it was clear that leadership from senior levels of the organisation was critical to the start of the change process. Often, the ‘modernisation lead’ was a Chief Executive or a specific Director of Modernisation. In some organisations without a specific Director of Modernisation role, another Director would take on the role. Key to the role of modernisation lead was working with the organisation to help it recognise the need for change and translating that recognition into the start of the change process. However, the modernisation lead continued to play an important role in later stages of the change process, maintaining momentum and acting as a champion for the acquisition of key resources required to make the change process work, such as time and expertise. Respondents believed that the modernisation lead should be a resource and/or conduit for their organisation and be able to identify appropriate knowledge or put people in touch with appropriate examples of good practice. It was seen to be important that the role holder was allowed flexibility in doing this. It was also seen to be important that the corporate modernisation lead was able to provide ‘hands-on’ help to individual project teams. Where recognition of the need for change came from practitioners within an organisation, a senior corporate modernisation lead was still crucial for generating momentum.

See Case Study 1 and 2 for examples
Patient and carer involvement is a powerful catalyst for change

The importance of patient and carer involvement in change management is well documented. Many of the organisations that we spoke to had set up structures and processes for involving patients and carers and ensuring that change was led by an understanding of patient, carer and wider population needs.

See Case Study 4 for an example

2. Multi professional teams appropriately supported and incorporating clearly delineated responsibilities

Where a group is established to take forward the modernisation agenda, the creation of a diverse team is important

Some respondents saw avoidance of boards, steering groups or project teams consisting entirely of one profession as a key feature of project-based approaches to modernisation. Team members from a range of backgrounds were seen to bring different perspectives, knowledge and skills.

The start of the change process came with the formation of an interest group. They were a group of like-minded individuals and as a team they involved a range of working styles: blue sky thinkers and doers.

Director of Planning and Service Development at a PCT

One of the critical success factors was that the team was created to include a mixture of people who had good knowledge of the local health community.

Director of the Modernisation Team at a local Health Community

Effective change management needs the identification and support of three distinct roles: a clinical lead, a managerial lead and a project manager

Respondents suggested that successful change management often requires the identification of three distinct roles: a clinical lead, a managerial lead and a change agent / project manager.

- the role of the clinical lead is to provide clinical leadership and act as a ‘champion of change’ engaging with clinical colleagues and selling the change to them;
- the role of the manager is to focus on the content of change, make decisions, remove barriers, free resources and lead the team; and
- the role of the change agent is to bring the project team together, facilitate the team, develop a common view of the issues being tackled, provide expertise (e.g. knowledge

See Case Studies 1 and 2 for examples

and understanding of change management tools and models of change) and provide important skills (e.g. patient involvement and workforce redesign).

These three roles need appropriate support varying from allocated time to undertake modernisation work to project management training. In practice, these different roles were not always fulfilled by different individuals. For example, the clinical lead might have also been the managerial lead.

Leaders need support to develop their skills as transformational leaders

Many local organisations have focused on the ‘people skills’ essential for embedding modernisation within organisations and have accessed leadership training for their senior staff, ranging from Chief Executives to general managers and heads of departments.

Lots of new PCT Chief Executives have had support through the National Primary Care Trust Development Programme which was established following “Shifting the Balance of Power” to provide organisational support to PCTs. The SHA corporate development team has also helped to develop leadership skills [and] is seeing results in terms of Chief Executives becoming more receptive to change tools such as process re-engineering.

Executive Director of Modernisation at a Strategic Health Authority

3. Organisational structures to support modernisation underpinned by protected time

Project boards or steering groups can help to support and co-ordinate local change management projects.

Project boards or steering groups ensured clear direction to modernisation activities and contributed to overall organisational learning. The structure and function of such boards varied. Generally, where a project board was established it co-ordinated modernisation projects and received regular progress reports from individual projects. In some areas a specific project or programme manager was appointed to support projects and report to the board.

The involvement of the Chief Executive of the organisation concerned was seen as important.

The Local Change to the Patients Programme Board is chaired by the Chief Executive.
The Board receives monthly reports from project facilitators and clinical champions.

Head of Modernisation at an NHS Trust

Project boards have representation (including clinicians) from participating organisations. Generally the ones that have the commitment/participation of the Chief Executive are more successful ones.

Head of Modernisation at a Strategic Health Authority
Away days give organisational members an opportunity to reflect on performance and direction and discuss the need for change.

For many organisations, the catalyst for change was some form of away day, often involving a range of staff from different levels within the organisation and led by the organisation’s Chief Executive or a Director with responsibility for modernisation. Away days were seen as a means of generating time away from work to reflect on performance and direction, and engage in the creative thinking necessary to start the process of setting out an alternative vision of how the organisation might develop over time.

4. Partnership Working

Collaboration between organisations within the local health community can ensure the effective co-ordination of local modernisation work

In some areas joint boards or steering groups covering several organisations within a local health community have been established. For instance, collaboration between PCTs and Social Services might be seen as a way to develop a whole systems (see below) approach to local modernisation. Issues to be considered when engaging patients include identifying sufficient resources, managing expectations and sustaining interest and involvement.
4.2 Diagnosis

Our rapid review identified diagnosis of the problem, prior to developing and implementing a change plan, as often being a relatively weak area in the change management cycle. In many of the organisations that we spoke to we were not able to identify an explicit process of diagnosis preceding the implementation of a change plan. Three themes that we did find in organisations that had successfully incorporated a diagnostic element to their modernisation programme were that they had:

- established clear aims and objectives for the modernisation programme;
- adopted a bottom up approach to supporting this process; and
- offered protected time for diagnosis.

A key element of diagnosis is to base it within a longer term and clearly defined strategy

Underpinning much of the thinking around increasing the sustainability of modernisation within organisations was the importance of taking a long-term perspective.

*Much of the modernisation that is required relies on long-term strategies being in place. For example if a modernisation programme concluded that patients details should be collected only once during the patient journey you would need a common IM&T system with, say, Social Services. This needs long term planning in order to deliver required outcomes at an operational level.*

Director of Modernisation at a Strategic Health Authority

Some of those involved in the review highlighted the danger of short-term performance management demands encouraging a view that modernisation can be postponed in favour of meeting performance targets, with the result that more fundamental types of change did not happen. However it was suggested that there will come a point of realisation that many targets will not be reached without significant service improvement or redesign, and that this realisation may facilitate the merger of the performance management and modernisation agendas. Several organisations had developed either trust-wide or local health community wide modernisation strategies or plans. These strategies and plans outlined the aims and objectives of improvement work and often linked very closely with the NHS Plan targets.

‘Bottom-up’ involvement in identifying problems and solutions will improve the quality of local modernisation

Often local modernisation was started from the top down, with a transformational leader such as a chief executive setting out the modernisation agenda. Change management is always likely to need a certain amount of top-down, central direction. However where local organisations had succeeded in
involving practitioners they reported that this improved the understanding of the problem, the relevance of proposed solutions and the likelihood of sustaining and spreading local modernisation.

**Protected time is important to give key individuals the space to analyse the current situation and develop a vision of the desired end state**

Many people that we talked to identified the importance of protected time for key individuals taking forward the modernisation agenda. Protected time was seen as particularly important where the aim was to achieve transformational or step change. However, there were few specific examples of the types of strategies that an organisation might adopt to ensure that protected time was put in place. Many of the interviewees highlighted that providing protected time from normal duties was often problematic considering the high workloads of individuals and the fact that some of the key individuals were part of several modernisation groups. Even though there would have been the funding and willingness to provide cover arrangements, in practice it was not always possible to find individuals to cover for example clinical staff.

*Lack of time is often the biggest hindrance to local modernisation. Time is needed for reflection, diagnosis, and making sure that all the key people get involved. Often we waste time because we don’t make time for these critical tasks early in the change process. As a result, teams who have undertaken insufficient diagnosis etc. waste time trying to implement inappropriate changes that are not going to work. One of the most important roles of leaders is enabling time to be freed up for these tasks*

Individual at the Modernisation Agency.

### 4.3 Planning for, preparing and implementing change

A range of local change support systems were identified for planning, preparing and implementing change, many building on the good practice set out by the Modernisation Agency in their Leadership Guides. The central themes identified from the stakeholder interviews focused upon:

- strong project management skills;
- the utilisation of methods including process redesign and whole systems working;
- the ability to deliver ‘quick wins’;
- the development of peer networks; and
- effective communication systems for the dissemination of good practice.

**Project management systems are crucial to the effective delivery of modernisation projects and project management is an important skill for local change agents**

Good project management was seen as crucial, not only to project-based approaches to modernisation, but more generally as an important skill for local change agents. While the need
For good project management skills is widely accepted, embedding such skills across a whole organisation was seen by some as a challenge.

Some clinical staff have also been seconded to the project teams. They are given training in project management, working in different projects, and then they go back to their normal working places with an increased skill base.

Head of Modernisation at an NHS Trust

Different organisations used different project management systems. PRINCE 2 (Projects In a Controlled Environment) was favoured by some organisations who not only ensured that project teams were trained in PRINCE 2 methodology, but trained key individuals across the organisation and local health community to use the methodology so that modernisation work could be supported more effectively.

**Process re-design is a vital tool for planning and implementing local change**

Many of the organisations that we spoke to had used some kind of process re-design as a tool for planning and implementing change. Specific approaches used included:

- process-mapping and critical path analysis;
- supply and demand modelling;
- capacity planning; and
- integrated care pathways.

Changing care pathways across organisations was seen as particularly complex, but an important component of effective process re-design.

Service development, clinical development and organisational development need to link with each other, to ensure an appropriate focus on service modernisation, change management, leadership development and clinical governance.

Director of Service Development at an NHS Trust

Part of the complexity stemmed from the need to co-ordinate work between organisations, while also giving primacy to the patient experience.

When designing services there is a need to follow care pathways through and think about the patient experience. We need to always emphasise the importance of the patients. We need to have enough understanding between organisations and individuals so that they are prepared to think of the patient before their own organisations.

Director of Modernisation at a Strategic Health Authority
Whole systems approaches recognise that local modernisation projects often have impact outside and across organisations

Many of the organisations that we spoke to were developing local modernisation solutions in the context of the whole local health system (for instance, see ‘care pathways’ above). Key to the development of a whole systems approach was ensuring that modernisation featured within priorities for the whole of the local health community. Interviewees described the process of agreeing local priorities through the development of a local modernisation plan that set out strategic priorities and identified resources for achieving them. Typically, the SHA or a team working across the health community had a role in facilitating the development of the local modernisation plan.

Often local modernisation plans were then closely linked to the work of individual Trust and PCT modernisation groups or boards, part of whose role was to support delivery of the plan.

The local health community is currently in the process of re-establishing the Local Modernisation Board. The structures have been agreed as well as the service vision and principles. These were agreed through workshops and continuous discussion. The key success factor has been the establishment of good, trusting relationships between key leaders and individuals from different organisations in the health community. The resulting open and discursive culture (for example around financial issues) has been vital to good co-work.

Director of Service Development at an NHS Trust

The Chief Executive Forums (acute and PCT) meet together every two months to develop the overall approach in the local health community.

Head of Modernisation at a Strategic Health Authority

Each of four areas in the SHA meet up regularly and they have modernisation leads. Modernisation programmes have been incorporated in the Local Delivery Plans.

Head of Modernisation at a Strategic Health Authority

‘Quick wins’ are important for maintaining momentum and convincing sceptics

Whether the change being sought is incremental or transformational, quick wins were seen as important for maintaining momentum and convincing sceptics of the value of change. Quick wins might take the form of immediate performance improvements, production of a newsletter or the establishment of a new partnership.
A lot of communication and planning was required. Certain groups of staff were anxious about the implications of the change and reassurance was required … The key success factors for the project included early success stories and encouraging feedback from GPs using the system.

Head of Modernising Healthcare in an NHS Trust

It is important to promote and value small incremental changes within departments as well as larger, step-changes.

Individual at the Modernisation Agency

**Peer networks and ‘buddying’ schemes are a way to support local change agents**

The importance of peer support was widely recognised as a way of supporting local change agents. Mentoring schemes range from systems that ‘buddy-up’ people and problems through to forums that allow support networks to develop more ‘organically’.

The MA Associate scheme was recognised as good for personal development and allowing individuals to develop their experience while also supporting local mentoring. Agency Associates are local level champions of change who will act as a resource for local and national health communities and to the Agency. Associates are to identify sites for testing MA programmes and to support the spread and sustainability of local programmes.

**Communication is important in making the case for change, sustaining momentum and changing organisational cultures**

Communication was seen as key to encouraging the organisational and individual learning crucial to sustaining the modernisation agenda within local organisations. Examples of communication initiatives included:

- staff newsletters;
- regular talks to staff;
- frequent multidisciplinary team meetings; and
- celebrating success events.

It was seen to be important that communication methods were not merely ‘tokenistic’ but that time was spent ensuring that newsletters, for example, were made relevant to the target audience – including recognition of the work of front-line staff in order to engage those with a key role in embedding modernisation. Similarly, thought should be given to the timing of communications – ensuring that successes are publicised at an appropriate point. This is further discussed, later in this report.
4.4 Review and spread

The issue of reviewing performance and feeding back to local support systems is discussed in the same section as spreading good practice, because there are links between the two processes. Evidence of effective practice generated by the review process for use by those implementing change can usefully be shared with a wider audience to encourage the spread of effective practice to other parts of the organisation or the wider local health community. The three themes identified by respondents as helping review and spread were:

- setting clear targets;
- providing effective monitoring; and
- developing systems for local support and development.

| Change needs to be measured from the beginning if review and consolidation is to be possible |
| The importance of measurement was stressed by interviewees. In the past, there has sometimes been a lack of robust monitoring arrangements and performance monitoring in the modernisation process. However, the culture is shifting so that, more frequently, ways of measuring the success of a project are established at the outset. It was seen as important to include both quantitative and qualitative measures. |

**Outcome measures are identified usually in the beginning of a project, followed by a baseline analysis. Qualitative studies are also done to form a baseline – for example, walking through the patient journey and documenting different steps. Monitoring mechanisms are then implemented to monitor effectiveness. Usually these measures are already collected by the trust and the need to avoid burdening staff with additional data collection has been recognised.**

Head of Modernisation at an NHS Trust

**On all programmes monitoring systems have been set up and a baseline has been established. It has then been possible to capture the impact of the changes made.**

Director of Planning and Services at a PCT

**Individuals are encouraged to measure issues that are important to them. Sometimes this requires the usage of proxy measures rather than the established performance indicators.**

Director of the Modernisation Team in a Health Community
The use of local targets is a powerful mechanism for sustaining a programme of change

The power of locally generated targets and measures in sustaining modernisation was also seen as important.

*The trust’s key performance targets are from the National Service Framework but the trust is keen to develop local targets. The trust has just developed its own performance assessment framework, which has been developed at directorate level. This is also linked with personal development planning, financial planning and local delivery plans. This allows the usage of measurable targets to monitor effectiveness of the change.*

Director of Human Resources at a Care Trust

Local forums meeting regularly can exchange effective practice within the local health community

Most of the trusts included in this review were part of a formal modernisation network or forum designed to enable learning from each other via the spread of good practice. These networks usually met every month or every two months and the activity was often centrally co-ordinated by the SHA. The most common forums and networks included:

- network of Directors of Modernisation in Trusts and PCTs coming together to share good practice and also being used as a sounding board for ideas developed within the SHA;
- networks to engage ‘frontline’ modernisation project managers within Trusts and PCTs, seeking to identify good practice, but also to identify the blockages that prevent local modernisation occurring;
- monthly meetings of all Chief Executives and Directors of Social Services covering a range of issues, but also being used to discuss strategic modernisation issues;
- local modernisation forums of boards based around health sub-economies; and
- service specific groups.

*The Modernisation Network involves modernisation leads from healthcare organisations and also champions of modernisation. Champions of modernisation don’t have modernisation ‘as a part of their job title’ but are delivering modernisation work … The network agreed to meet quarterly for a half day. Also, once a year the network meets for a whole day to celebrate what has worked well and to disseminate that information more widely.*

Head of Modernisation at a Strategic Health Authority

Local collaborative programmes are a way of spreading effective practice and encouraging closer partnership working within local health communities
In some of the trusts the ‘need to go beyond the national programmes’ was recognised and where there were no obvious national programmes the trusts had set up their own local collaboratives.

The trust has set up nine local mini-collaboratives. These are not part of national collaboratives but projects that trust wants to undertake locally. Examples include maternity, diabetes, and stroke. Mini-collaboratives use the same elements and techniques as the national collaboratives, for example: using PDSA cycles; process mapping; away days; and workshops etc. The trust is trying to spread this more widely within the organisation – not just have pockets of excellence.

Director of Corporate Development at an NHS Trust
5.0 Mainstreaming modernisation

A number of respondents highlighted the limitations of a project and programme-based approach to modernisation and stressed the need to ensure that the modernisation agenda was ‘mainstreamed’ across local organisations. This can be identified as the second phase in the local modernisation process and in this section we look at the roles and structures that local organisations have put in place to embed and sustain local modernisation within the mainstream of service delivery.

5.1 Workforce and skills development

Developing ‘in-house’ capacity to deliver modernisation can help an organisation move away from a project-based approach to modernisation, to one focused more on changing mainstream practice.

One approach to mainstreaming modernisation focused on the individuals within organisations and the use of training to ensure that modernisation skills and thinking were spread throughout the organisation, rather than being concentrated in a project-based modernisation team. One way to do this was to use specific modernisation projects as high-level modernisation training programmes to equip team members with modernisation skills and thinking to take back to their department at the end of the project.

Where the Modernisation Agency has developed ‘project individuals’ they have often seen them improve and progress. Sometimes the rest of the organisation and staff gets left behind and they don’t feel included. There is a need to develop local capability by doing a lot more training and involving more core staff across the care processes. If everyone involved develops a greater level of skills this will have a major impact.

Individual at the Modernisation Agency

Rather than bringing people continuously into the trust e.g. from the service improvement management teams, the trust is working with [a local learning alliance] to develop in-house capacity around process redesign and reengineering. We need to ensure a wide number of staff at different levels have the required knowledge.

Director of Service Development at an NHS Trust

Some of the interviewees emphasised the importance of individuals at the organisational level knowing what is expected from them and knowing their responsibilities. It was felt that increasingly a link was being established between individual responsibilities on modernisation and personal development plans.
A range of training is required to develop appropriate skills across organisations

In addition to local innovation, the role of existing national and local training programmes was seen as important in disseminating and increasing the improvement skills and techniques at all levels across organisations. Skills development of people across local communities was often supported by the SHA in the form of funding, expertise or facilitation. However, some of the interviewees felt that where organisations themselves were contributing to funding they tended to take initiatives more seriously. The need to use existing skills more effectively was also recognised.

The SHA also hold ‘Big Tent Events’ where they identify a particular service area, and invite anyone within the area doing particularly good work to present their work to other individuals from the area (around 100 people invited). This serves not only as skills development but also a form of network.

Director of Service Improvement and Modernisation in a SHA

The main focus in terms of skills development has been a capacity planning exercise to look at opportunities for using current skills more effectively. The SHA has a strategy for getting all middle/senior managers trained in capacity and demand management – 100 middle/senior managers have been trained in the last three months and this is continuing and will be provided to clinicians.

Director of Modernisation in a SHA

The SHA has asked organisations to identify the support, in terms of skills development, that will be needed in implementing the local delivery plans … This is partly about ‘training the trainers’ so that skills development can take place internally without a reliance on external support.

Director of Modernisation in a SHA

Creating specific mainstream roles can be a way of embedding modernisation within mainstream practice.

Several PCTs, acute trusts, local health communities and SHAs we spoke to throughout the study had created specific mainstream jobs to embed modernisation. Examples of mainstream posts, often mainly funded by the organisations that we spoke, included:

- leads for service development;
- project managers;
- posts relating to modernisation/service improvement at director level in trusts and SHAs;
- clinical champions;
- clinical staff seconded to undertake improvement work and develop their skills and who return to their normal practice area with increased skills base;
- training and development posts; and
additional service improvement post to the ones funded by the MA.

*One of the GP champions is now seconded full time to work on developing electronic GP booking. It is hoped that this individual will be able to sell the programme to his GP colleagues more effectively.*

Head of Modernising Healthcare in an NHS Trust

Not all posts were funded by organisations themselves, which is reflective of the range of national organisations and initiatives playing a part in the local modernisation agenda. Examples of mainstream posts often funded partly from external sources include:

- Pursuing Perfection Programme Support Manager (some funding from the MA)
- Booked Admissions Project Manager (through Booked Admissions funding)
- Collaborative Manager (through Collaborative funding)
- Service Improvement post (SHA post, funded by the MA)
- Specific posts such as half-time secondment to SHA to lead work on Emergency Care Improvement
- Emergency Care Collaborative Facilitator (SHA post, funded for two years by the MA)

There were also good examples of when local health organisations had merged their resources and funded a person to take specific issues forward in the local health community.

*It was agreed through the Steering Group that the two PCTs and the acute trust would pool their resources and the little extra money that was given to each organisation for emergency care led to the appointment of a very senior lead person to work patch-wide on emergency care. The emergency leads role was to review and modernise the emergency care part of the system. The job description and key responsibilities for the emergency care lead were agreed with all the Chief Executives from the local organisations. The steering group also appointed two modernisation facilitators to support the work.*

Director of Modernisation and Performance at an NHS Trust

However, reservations about the creation of specific modernisation posts were noted. Some of the interviewees highlighted that the large number of temporary posts created has been an issue. In several posts time limited contracts for modernisation work had been created. Some trusts/local health communities expressed reservations in creating posts directly linked with modernisation (for example Director of Modernisation) as they felt that modernisation should be seen as ‘everyone’s job’. However, in these organisations there were often roles that had service improvement at their heart, for example, commissioning jobs at PCTs driven by service improvement and middle managers with aspects of service improvement as part of their job.

*The SHA didn’t want to create separate modernisation posts, but wanted to embed modernisation and service improvement within performance management to encourage mainstreaming from the outset. There are therefore six performance improvement*
managers, responsible for routine performance management and modernisation, with supporting modernisation including as part of their job description.

Director of Modernisation at a SHA

The role of middle management is key in turning the vision of an executive team into reality and ensuring that frontline views are fed up through the organisation

The role of middle managers was seen important in making modernisation mainstream as they were seen as being at the centre of service provision. Their role as advocates feeding information from 'bottom to top and then back to bottom' was vital in 'keeping the show on the road'. It was felt that middle managers were not always getting the required support and that their skills development needed attention.

The role of middle management is to keep close to clinicians and clinical work so that they can speak with authority about potential changes in service. They should also keep up to speed with the work of other trusts – currently this varies according to the individual.

Director of Modernisation in a health community

The health community tend to talk of service improvement rather than modernisation, and there are roles within the PCT and acute trust that are centred on improvement. All the middle managers see their objective as being to achieve the objectives within the Local Health Economy Access Work Programme – which is an agreement that the whole health community has signed up to and which provides the work programme for the next five years.

Modernisation Lead in a health community

Making modernisation part of all staff's job descriptions can be a factor in developing a sustainable approach to modernisation

Focusing on the individuals within organisations, the process of embedding modernisation thinking and skills in mainstream service delivery through the use of job descriptions was seen as one way to embed and sustain modernisation thinking.

‘To make things mainstream, they have to start in the mainstream’. This exemplifies the importance of embedding the structures and processes of change within the existing organisational structure. They must be an integral part of the organisational structure and not an external, disconnected element.

Assistant Divisional Director of Finance and Performance at a NHS Trust

We need to ensure achieved change is put in all mainstream activities and documentation and we need to ensure that improvement is embedded in all job descriptions and in all organisational business planning. If it is left in individual projects
there is a risk that when the project ends people forget it and slip into old ways of working. When looking at successful organisations (their job descriptions, their strategies etc.) they have all done it. Improvement and change is a part of their everyday vocabulary.

Individual at the Modernisation Agency

There is a need to embed change within roles of people at all levels and make ‘change’ part of their role so that they feel empowered to use improvement thinking and address the change agenda.

Individual at the Modernisation Agency

Including modernisation within the responsibilities of clinical divisions and directorates can encourage sustainability.

At an organisational level, one approach to mainstreaming the modernisation agenda has been to devolve responsibility for it to clinical divisions.

The trust has purposely included modernisation as a part of the clinical divisions’ responsibilities so that modernisation can be seen as everyone’s responsibility. Therefore there is no specific corporate department responsible for taking the agenda forward, though it is Service Development Teams’ responsibility to oversee the service modernisation strategy at a strategic level.

Director of Service Development at an NHS Trust

Many of the interviewees felt that their organisations were increasingly building responsibility for improvement and modernisation into the everyday jobs. This was most visible at director and project management level where modernisation was often embedded into the job descriptions.

5.2 Strategy and policy

Clear links with organisational strategy can help turn modernisation from a short-term to a long-term goal

Another approach to mainstreaming modernisation at the organisational level has been to ensure that modernisation is embedded within the organisation’s strategy and business planning processes. It was recognised that there is a need to move from an opportunistic approach to a more systematic approach and to ensure modernisation work links with long term strategic planning. This was seen as particularly important in terms of making modernisation mainstream. Some of the organisations had also made progress in connecting modernisation with Improving Working Lives, and with clinical governance and risk management.
There is a need to examine the relationship between the modernisation agenda and day-to-day work programmes and practices of local organisations in more detail. Sometimes the modernisation agenda is not well aligned with local organisational priorities.

Individual at the Office of Public Services Reform, part of the Cabinet Office

To get the project to mainstream it needs to be more primary care driven and part of GP objectives. It therefore needs to be incorporated into primary care policies and strategies and maybe incentivised through a reward system. It is important to get to a stage where a deadline is set to fully replace paper referrals with electronic booking.

Head of Modernising Healthcare in an NHS Trust

The trust is currently working on a values document with the local organisations. When the organisations came together to identify the values they noted that values and aspirations were very similar across the organisations. The people setting up the values included senior managers and directors (the modernisation leads from the healthcare organisations and the leads from the social services department). The process was facilitated by the Service Improvement Manager from the MA. The aims link closely with The NHS Plan targets.

Director of Corporate Development in a NHS Trust

Some of the interviewees pointed out the importance of having a balance between clinical needs and modernisation. In some situations the role of redesigning services is vital for achieving set objectives and targets.

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**Placing modernisation and service improvement as a regular agenda item in the trust board meetings can help sustain change and make modernisation mainstream**

One effective way of developing senior leadership commitment and sustained change was to regularly discuss modernisation and service improvement at trust board meetings. Ensuring that members of the trust board had a good understanding of the modernisation agenda and initiatives taken forward within the organisation, locally and nationally, was seen as a key in developing future services. Emphasis was also given to promoting a solution-based approach rather than a problem-based approach by some of the interviewees.

Focusing on waiting times doesn’t encourage boards to ask further questions about what could be improved. Looking at underlying processes, for example whether patients are booked chronologically and treated chronologically encourages examination of areas for improvement in underlying processes – which would add up to an improvement in waiting times, in addition to other improvements.

Modernisation Lead in the local health community
5.3 Communications and partnership

Approaching modernisation and service improvement issues by constantly placing the patient at the centre of care helps organisations to see the significance of other organisations in a process

Through the study almost all of the interviewees highlighted the need to involve more patients, service users and carers in modernisation activities and to always think about the patient perspective when delivering change.

It has been recognised that there is a need to have integrated services that meet the needs of the patient. It doesn’t matter to a member of the public whether a particular service is managed by the social services, PCT or the acute trust – it doesn’t matter – it is health and social care services that the individual needs and that is what is driving us forward. Organisations working individually cannot deliver integrated services.

Director of Corporate Development in a NHS Trust

The recognition of achievements and celebrating success can act as a way of making modernisation relevant to the mainstream work

Encouraging a systematic and coordinated approach to publicising work undertaken and communicating key messages was seen as a vital element in making modernisation mainstream. The examples ranged from internal newsletters and intranet sites to articles in local newspapers. The local networks also had a strong role in changing ideas and celebrating success.

It was seen as important to publicise information at an early stage, not just finished results, to build individuals knowledge on modernisation activities. The importance of making modernisation relevant to each level within an organisation was emphasised in the context of making modernisation mainstream. It could also provide a vehicle for asking for help or sometimes of ‘shaming’ the department that’s slowing progress.

There are 2 monthly, community-wide modernisation bulletins, leaflets. The diagnostics department are holding a drop-in day for staff and patients to find out about what they are doing in terms of modernisation. Exhibitions have been held in the foyers of the hospital and there have been articles in the local newspapers. The newsletters have charts and graphs but also photos and names of staff. The recognition is encouraging for staff and it acts as a way of making modernisation relevant to the mainstream work of hospitals.

Director of Modernisation in a health community

Key to communicating achievements was attention to the way that messages are presented. The importance of presentation ranged from using language appropriate to all members of the
organisation, through to considering the impact of particular messages on organisational processes and performance.

For example, if waiting times are reduced, there’s a need to make sure that processes are in place to manage demand, otherwise publicizing the reduction will lead to increased demand and so to increased waiting times. We struggle with how and when to publicise improvement activity.

Modernisation Lead in a health community

Using appropriate language was also seen to be important in communicating with staff about modernisation in general.

The majority of monitoring is undertaken by the Local Health Economy Access Group, which measures performance against ‘impact measures’. We are trying to move away from the term ‘targets’ as this simply causes distress.

Modernisation Lead in a health community

We are trying to get middle management to talk about ‘service redesign’ or ‘best practice’ rather than ‘modernisation’ as this term can have negative associations i.e. it implies that current practice is old fashioned or traditional. We encourage middle management to find ways of talking about modernisation with clinicians without using ‘the M-word’.

Director of Modernisation in a local health community

### Investment in IT and knowledge management is important to ensure dissemination of knowledge

The use of IT and knowledge management systems was seen by many of the interviewees as a current weakness. Organisations were lacking the required IT systems and training to use knowledge management systems effectively. In some organisations the use of intranet was seen as a powerful tool to develop practice.

There is an excellent knowledge management system in operation across all the trusts, there is a shared library and an e-list/e-resource which are thought to have been the result of local implementation of Information for Health. These include information on ‘what’s good evidence’ and they are quite practitioner focused. The modernisation team are looking into linking their website into this.

Modernisation Lead in a health community
6.0 Conclusions: Taking modernisation forward

In this concluding section, we identify some of the factors likely to be key in taking the modernisation agenda forward in the coming months and years. In particular, we have focused on the implications of leadership of the modernisation agenda by local organisations and the challenges local organisations face in moving away from a project-based approach to modernisation to an approach where modernisation is part of mainstream activity.

6.1 Making ‘space’ for transformational change

The NHS Plan promises radical change in healthcare over the next ten years and this will almost certainly entail a move from transactional to transformational change. ‘Transactional’ change focuses on ‘doing things better’. It builds upon what has already been accomplished in an incremental way. Transformational change focuses on achieving a ‘step change’. It aims to achieve dramatic improvements in key areas of performance\(^{15}\).

The vision for the modernisation agenda that has been developed by the MA in partnership with local organisations is for the achievement of transformational change in healthcare. However, in our discussions with interviewees, it was often apparent that while members of the MA and SHA modernisation leads tended to focus on achieving transformational change, the extent to which transformational change was espoused at trust and PCT level varied. One of the key challenges to devolving the modernisation agenda will therefore be to encourage transformational change within and across local organisations. For this to occur a number of issues need to be considered.

Drivers for change

The degree of central management control that is exercised in implementing change varies. At two ends of a spectrum, the implementation of change may be ‘directive’ or ‘organic’\(^{16}\).

- directive change is centrally driven, with the change being planned in detail and implemented by the centre; and
- organic change relies more on bottom-up learning and live feedback to shape the change process, with the centre having less influence over the speed of change and the precise direction of change.

Issues such as the stability of the organisation and the certainty of the environment in which it operates will have an impact upon whether the strategy for implementing change is directive or organic\(^{17}\).

While transformational change can potentially be achieved using either a directive or an organic implementation strategy, it is more likely to be sustained if it is achieved organically.

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\(^{16}\) See, for example, Audit Commission (2001) *Change Here!: Managing Change to Improve Local Services*, London: Audit Commission p. 13

\(^{17}\) See, for example, Audit Commission (2001) *Change Here!: Managing Change to Improve Local Services*, London: Audit Commission p. 13 16 for a discussion of these issues and their impact upon change.
This will entail successfully changing an organisation's culture so that acceptance of the need for change, together with the knowledge and skills required for improvement are 'mainstreamed' within the organisation. For instance, many interviewees saw it as crucial that clinical teams need to be asked what support they would need in order to make a change rather than being simply told to make a change.

Modernisation is more about 'tickling' an organisation than leading or commanding it.
Director of Modernisation in a heath community

A supportive culture
Most of the interviewees emphasised the importance of developing an organisational culture supportive of change. Building a level of trust between managers and front line staff was seen as an important factor in developing a culture where staff feel comfortable and safe and where it is acceptable for people to think and act in innovative ways.

Continuous and honest dialogue between all parties has been a key success factor. If 'frontline' people involved in the discussions go back to their fields of work and inform others about new developments this works better than having some more distant manager 'selling' the ideas.
Director of Service Development at an NHS Trust

People need to feel safe. People reject change if they feel personally rejected. This can be helped by ensuring that individuals’ employment contracts are not at risk if they come up with suggestion of doing things differently that may affect their job.
Individual at the Modernisation Agency

6.2 Stakeholder involvement
As suggested above, transformational change often works best when it is an organic process that involves a wide range of stakeholders. There was a strong agreement amongst interviewees that without staff, patient and carer involvement and commitment a lot of healthcare change struggles, both in terms of implementation and sustainability.

A key group to involve are clinicians. One of the main difficulties in involving clinicians was to ensure that clinicians would be able to attend activities around the modernisation agenda as it was recognised that they have high clinical workloads, particularly as they seek to help their organisation to deliver today’s targets at the same time.

Staff involvement is crucial as they stay and deliver services when the project manager has moved on to next job. Staff are usually the ones who notice the problems and know the answers to these problems.
Director of Corporate Development at an NHS Trust

Modernisation efforts over the past few years have recognised the importance of patient involvement. Several organisations that we spoke to always thought about the patient's
perspective when driving healthcare improvements by designing services around the needs of the patient rather than the needs of the organisation.

A very powerful tool to drive change is if patients/users have identified the need for change or have expressed dissatisfaction with existing services.

Head of Modernisation at a Strategic Health Authority

There is a need to help people to challenge current service provision together and to look into new ways of service provision and engage all of the relevant patients in strategic planning.

Director of Human Resources at a Care Trust

However, several of the interviewees pointed out that involving patients and carers is often complicated and difficult, one obstacle being clinical language, which can easily overwhelm patients.

6.3 A whole systems approach

Most interviewees recognised that the development of local change support systems required a degree of inter-agency working. However, the degree to which developing local change support systems was seen as an intra or an inter-organisational issue varied among people we spoke to. This not only has implications for the types of local change support system that local change agents favour, but also the types of support that they look for from other local and national organisations. Inter-agency working around local modernisation can be discussed in terms of two dimensions: vertical and horizontal inter-agency links.

Vertical inter-agency working

The vertical links that can be made during inter-agency working on local modernisation are complex, with a wide range of health organisations having a stake in the modernisation agenda. At a national level the MA is obviously key, but other parts of the Department of Health (DoH) are involved. Strategic Health Authorities, Trusts and PCTs all have modernisation leads. One cannot delineate the roles of these organisations, based simply upon the level (e.g. national, regional, local) at which they are based. For instance, in many ways the MA and other DoH teams take a more ‘hands on’ approach to modernisation than the SHAs. Several interviewees have noted that the MA, or another part of the DoH may well be found performing a ‘hands on’, local ‘consultancy’ role within a particular organisation in the local health community, while the SHA, with its limited resources, is likely to be operating at a more ‘hands off’ strategic level. It was clear from our review, that the relationship between local change agents and the MA and SHAs is important in the development of local change support structures, however its complexity did not always seem to encourage a focused approach to local modernisation. A challenge as the modernisation agenda is devolved will be to simplify current roles and relationships.

18 Although this is likely to change over time
Horizontal inter-agency working

Horizontal inter-agency links within local health communities were generally seen as important to local modernisation, with most organisations we talked to participating in local knowledge sharing and mentoring networks, often facilitated by SHAs. However, the lack of links with local organisations outside the health sector was marked. Generally speaking, local support systems in the health sector do not make effective links with similar support systems from other parts of the public sector, despite the similarities between systems, and the opportunities for synergy. To take an example, the Improvement and Development Agency (IdeA) runs leadership programmes for strategic staff within local authorities, that are similar in content to those run by organisations such as the MA within health, and there is little evidence of participants and resources on these courses being combined.

Performance management

The relationship between performance management and modernisation was the subject of significant comment. For a number of respondents the concern was expressed that the change agenda with its focus on service delivery targets was beginning to overwhelm organisations, consequently making modernisation less rather than more likely:

So far some organisations have met interim targets by making people work harder – for example reducing waiting times by making consultants work harder – but there are limits to how hard people can work and as the target deadlines draw near service improvement will be necessary.

Modernisation Lead in a local Health community

However, we also came across organisations that have been able to bring together performance management with service improvement to establish a ‘performance improvement’ approach. Within such an environment a creative tension was seen to emerge which made breakthrough results possible.

The SHA didn’t want to create separate modernisation posts, but wanted to embed modernisation and service improvement within performance management to encourage mainstreaming from the outset. There are therefore six performance improvement managers, responsible for routine performance management and modernisation, with supporting modernisation including as part of their job description.

Director of Modernisation from a SHA

Comment was also made that traditionally performance management has been more institutionally based whereas modernisation often spans across a health economy. Some of the interviewees had countered this by developing health community/economy wide plans. Where plans are drawn up across a community or economy, performance against the plan can be measured on this basis, therefore encouraging individual organisations to take a whole systems approach.

Modernisation has the ability to provide a common framework within which the broader change agenda for the NHS can be situated. Service development supported by policies such as the National Service Frameworks, quality and standards through clinical governance and the new
Commission for Healthcare Audit and Inspection as well as the service delivery targets set out in Local Delivery Plans can be delivered more effectively within such a structure. Such an approach lies at the heart of those local organisations that are successfully embedding modernisation into the mainstream.

6.4 Leadership

Key to all of the success factors set out above will be the presence of strong local leadership. To date, the MA has taken a major leadership role in taking forward the modernisation agenda, through national teams, programmes and collaboratives. In the future, the main leadership role for mainstreaming modernisation will come from SHAs, Trusts and PCTs with support from the MA. Mainstreaming modernisation will only be possible if local leadership is effective.

A range of leadership roles

Most of the interviewees emphasised the importance of senior leadership commitment in the change process and the fact that without it, local project teams tend to struggle. The commitment of the Chief Executive was seen as key to delivering local level improvements.

Senior leaders need to understand the importance of change in order to provide appropriate leadership and support.
Individual at the Modernisation Agency

One of the important factors in the achievement of performance targets was the control and commitment from the Chief Executive. Enabling managers to manage the process was made a top priority.
Director of a Modernisation Team at a local Health Community

While leadership from a Chief Executive is crucial, clinical leadership is also important.

Individuals with vision are important. They can come from the top of an organisation, for example a Chief Executive or Director, or be a clinical lead. To support this, a good understanding of leadership qualities and the change agenda should be part of all NHS managers’ competency frameworks.
Head of Modernisation at a Strategic Health Authority

Different understandings of change management

Our interviews suggested that a change leader’s understanding of organisational structures and processes will also have an impact upon their approach to implementing change. Some people we spoke to conceptualised their organisation predominantly in terms of formal structures and processes. They tended to take a similar approach to the change agenda, emphasising the importance of changing formal structures and specific systems to achieve change. The change support systems they favoured in achieving change included:

- process re-design;
- improving information and management technology; and
- implementing better project management systems;
Others tended to see their organisations more in terms of informal structures, or organisational cultures. Their approach to implementing change tended to focus more on organisational and individual learning such as:

- leadership training programmes;
- knowledge management systems; and
- peer networks and ‘buddying’ schemes.

Those who saw their organisations as open systems (a view of organisational development that emphasises the interdependence between different elements of the organisation and its dynamic relationship with its external environment) tended to focus on local change support systems such as:

- whole systems approaches;
- local collaboratives; and
- partnership working.

Reflection by change leaders upon their understanding of organisational structures and processes and their ability to take a broad view of organisational change and change management will be important in helping them to select appropriate local support systems.
Appendix One: Case studies

Case study 1: Whole systems approach – Central Local Modernisation Team, Brighton and Hove Health Community

STAGE IN THE CHANGE MANAGEMENT MODEL

“**The aim of the team was originally to enhance the leadership and managerial capabilities of the whole system to meet the access targets and to prevent the acute trust achieving zero star status.**”

**Key challenges:**
- achievement of rapid improvements across all organisations in the health and social care system, with a particular focus on the performance of one organisation; and
- enhancing the leadership and managerial capabilities of the whole system.

**Key learning:**
- without the significant freedom and autonomy that was achieved, the seniority of the team and full commitment from the Chief Executives, the achieved change may not have been possible;
- encourage different types of thinking – to focus the emphasis on solutions, not problems; and
- achievement of ‘early wins’ - a key factor in achieving a receptive culture for change.

**Key methodology:**
- use of four levels of change to guide all work - environmental, organisational, infrastructure and micro-systems;
- whole systems approach; and
- adult learning processes – learning to improve is the key to performance enhancement.

**Key Tools**
- PDSA cycles;
- process mapping;
- support, coaching, leadership development;
- demand and capacity modelling; and
- turning elements of the Pursuing Perfection programme into an approach that can be used locally.

1. Recognition of the need for change

In Brighton and Hove health community, the Chief Executives of the local health organisations and the Director of Social Services met before the Star performance ratings were published in 2001 and acknowledged that unless something radical happened to enhance the leadership and managerial capabilities to meet access targets the performance of the entire health and social care system would be poor.

**Key success factors:** the key to the approach was that the three Chief Executives and the Director of Social Services recognised that the trust getting no stars would not just be a measure of the performance of the acute trust but a measure of how the whole system was performing - they recognised the interrelated nature of the system.

**Key hindering factors:** the lack of availability of staff to start the team, releasing them from other duties.

2. Start of the change process

As a result they decided to establish external change agents by setting up a Local Modernisation Team. The Local Modernisation Team was established 18 months ago to centrally plan, co-ordinate and manage the work. The aim of the team was to enhance the leadership and managerial capabilities of the whole system to meet the access targets set for primary and secondary care. The team reports to the Chief Executives of the three healthcare organisations and the Director of Social Services.

**Key success factors:** the team was created to include a mixture of people who had a) senior level managerial/clinical experience and b) good knowledge of the local health community. There was full commitment to the change process at a senior level.

**Key hindering factors:** the team was set up in the winter of 2001. However it took until April 2002 before a full team of five members was established. It is possible that hindrance around the process of appointing a team, reinforced perceptions of fear amongst some staff.

3. Diagnosis

The work undertaken by the team was needed to help the staff and managers meet their targets and to help the acute trust improve their performance in a radical way. The aim was to improve performance and avoid the acute trust achieving a zero star status.

**Key success factors:** there was recognition that the team would need significant freedom and autonomy to implement the required changes. The approach was very focussed on supporting staff and teams struggling to meet the targets. Clear direction by the CEOs and clear performance management structures.

**Key hindering factors:** there were minor levels of mistrust from some senior and middle managers about the team’s role and purpose, reflecting the high pressure and scrutiny staff were experiencing.
**4. Planning and preparing for implementation**

In the beginning of the process, the team developed a work programme, which was agreed with the chief executives, and which was largely focussed on care settings. There were specific clinical teams who were experiencing difficulties in meeting the targets. The team has since developed a support framework which has included planning the support and development needs likely to arise for the whole health system during the following 2-3 years. This has included considering external help that would be required outside the modernisation team, such as MA initiatives, and disseminating examples of good practice developed outside the local health community. In brief the team works in three different ways:

- they provide strategic level support to the whole system on how to meet the access targets;
- they provide practical help for the clinical teams; and
- they create a learning environment and support network.

The team aims to achieve dramatic improvements beyond the achievement of the performance targets.

**Key success factors:** the team was given the full performance fund to manage, clear direction, good access to CEOs, and was encouraged to take risks.

**Key hindering factors:** the team was challenged by low managerial capacity in the organisations at a time of significant stress and threat to individuals’ careers and livelihoods, due to star ratings and massive organisational change.

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**5. Implement change**

During the first 6 months, the team provided very practical help to the clinical teams experiencing difficulties. The team also co-ordinated the MA programmes to ensure people in these specific areas were getting the best available information and help. The team provided hands on support and coaching to general managers experiencing difficulties in meeting the targets, doing their jobs and sustaining the change. The approaches used included, for example, the use of the PDSA cycle approach and demand and capacity modelling.

**Key success factors:** the team work to find out from people what their needs and problems are instead of just offering what the team feels is needed. They have become intelligent interpreters of national targets rather than simply instructing staff to meet targets. The achievement of a receptive culture needed patience, commitment from the CE, early success stories and an approach that operated as close to the frontline staff as possible. An understanding of adult learning processes and its use in work place settings also helped.

**Key hindering factors:** achievement of a receptive culture for change was difficult with some managers. The team experienced some resistance from managers who felt they had failed if they were asked to work with the team. The culture of coping is felt to be very common in the NHS.

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**6. Review**

The work undertaken contributed towards the acute trust achieving two stars. At individual service level, for example, the work undertaken in digestive diseases led to a reduction in waiting times for outpatients appointments from two years to four months. Following the first six months and achievement of the milestones set for the star ratings the team set a more long-term strategy and work programme. Part of the review of the first six months led to real understanding of what a four level approach meant - the team realised that they then needed to invest energy in strategic support and supporting managerial leaders more than supporting clinical teams.

**Key success factors:** the team is keen to encourage whole system wide measures, which will encourage further questions such as ‘why is X process done in Y way?’. The key is that the measure needs to relate to the desired improvement.

**Key hindering factors:** the lack of time, energy and resources to continue to develop the thinking, and to develop the evidence base of the team’s work.

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**Mainstreaming**

The development of the LHE (Local Health Economy) Access Programme was the first step in the mainstreaming process, the team co-ordinate and support 8 areas of improvement work in key areas that the whole system believes will be necessary to achieve long lasting improvements in performance. The team decided to continue to work in clinical areas by using the Pursuing Perfection approach, using the issues that clinical teams wanted to improve as a window into whole systems issues. In doing so ideas are tested from the 8 strategic areas in very practical ways. The third element of the teams work (creating a learning environment and support network) has become more important and time is spent equally on all of the three areas.

**Key success factors:** it is too early to say if the mainstreaming aspects are working.

**Key hindering factors:** The team has encountered weak performance measurement systems in some areas of the system, due to recruitment issues. There has been a lack of evaluation time and resources to assess the success of the approach. It was felt that support from the MA and other bodies could have been better coordinated.
### Case study 2: Whole systems approach – Peterborough Transformation Team

STAGE IN THE CHANGE MANAGEMENT MODEL

"To change the process of patient care – to improve it and make it more efficient. A whole systems approach involving both the primary and acute sector."

- **Key challenges:**
  - introducing something new; trying to introduce a change across the different departments; and convincing people of new ways of working; and
  - success could be dependent on type of project, the aims of the project, and the characteristics of people involved.

- **Key learning:**
  - need to pick the right people and support them; people need to have the right personal characteristics; they need to be resilient, have stamina and a sense of humour – they can come from any professional background;
  - the message needs to be that the change process is not forced or dictated;
  - someone who is well known in the organisation and experienced enough should lead the whole project;
  - there needs to be top level commitment;
  - there needs to be a dedicated team to take forward the issues, as clinicians and other staff are too busy; and
  - there is a need to keep working at it and keep going back and doing regular reviews to ensure that the things that are meant to be done have been done properly. There needs to be an acceptance that changes take time.

- **Key methodology:**
  - whole systems approach.

- **Key tools:**
  - process mapping;
  - facilitated workshops;
  - best practice research; and
  - coaching and support.

1. **Recognition of the need for change**

   Peterborough Transformation Team was established 7½ years ago and pre-dates the publication of the NHS Plan or establishment of the Modernisation Agency. It operates as a mini agency for the Peterborough health and social services community and is a development of the initial reengineering projects at King’s Healthcare in London and Leicester Royal Infirmary. The imperative for the project was the need to change healthcare processes and reduce workloads in the face of a continual increase in demand for treatment within the then financial constraints.

   - **Key success factors:** gaining buy-in from the Trust's staff, particularly clinicians and local general practitioners.

   - **Key hindering factors:** the time required in the early stages to enlist participation of key personnel and develop examples which encourage further involvement.

2. **Start of the change process**

   A project plan was agreed by the Trust Board and presented to the regional and local health authorities for support. Running parallel with this were a series of visits to every GP practice in the catchment area explaining the purpose behind it, the realities faced by everyone in the NHS and a request for active participation and support. A similar series of presentations was given to all departments, specialties and professions within the Trust. A key element of the plan was the recognition that for patients their care started and finished with the GP and that any review of the processes involved must be total and not simply the acute element.

   Details of the project were advertised locally, and volunteers invited on secondment basis from any of the local health and public service organisations. 70 applicants were interviewed and 22 were accepted to the training, from a range of professional backgrounds. Three GPs were also recruited as active participants and advisors. Formal training in the tools and techniques of change projects was provided by an external consultancy but that was the limit of any management consultant involvement – a deliberate decision as it was felt that a locally owned and managed project would have a better chance of success. All the other aspects of the project have been managed and directed by the Director of Organisational Development.

   - **Key success factors:** commitment from all organisations involved and active participation of primary and secondary clinicians.

   - **Key hindering factors:** no major hindering factors. The main challenges related to the fact that the project was something new, different and difficult, as it aimed to change the way services had been provided for many years. It took some time to convince people that this was something they should aim for.

3. **Diagnosis**

   Out of the 22 trained, 12 were then selected to form the first Transformation Team for a 6-12 month period of time to start the work in reviewing how health services were organised. A broad remit for the group was set. The high level review of healthcare provision in Peterborough included: referral system, emergency admissions, elective admissions and public consultation. Out of the four initial pieces of work, areas of work were prioritised for developing better services to the patients.

   - **Key success factors:** asking people their opinions instead of telling them the priority issues. Broad involvement of different staff groups.

   - **Key hindering factors:** the sheer scale of the task and the need to determine priority areas for review.
4. Planning and preparing for implementation

The principle behind the Transformation Team is to provide an example to others. In practice this means that individual teams have a maximum amount of delegated responsibility and freedom without very hands on management input. For example the team does not have a secretary or administrative support – individuals are responsible for their own work and lead by example. There is no manager between the team members and the director.

Out of the four initial workstreams, topics (‘building blocks’) were identified to take work forward. The aim was that when each of these ‘building blocks’ were put together and in place, it would result in a better service. Each of the ‘building blocks’ formed an individual project. For example, in emergency admissions, they broke the types of admissions down into individual components. All individual ‘building blocks’ contribute to a different and better emergency care system for patients and staff.

5. Implement change

The 12 members of the Transformation team were split into three groups (emergency admissions, outpatients and GPs, and elective admissions). The three teams were responsible for facilitating discussions between all participants and doing the research to find out about best practice in healthcare in the particular area. The small team would then be responsible for making it work.

For example the early work in emergency admissions (1996), introduced the principle of ‘assessment rather than admission’, which was quite a radical change. It was recommended that an assessment area in which patients could be diagnosed by a consultant be established, and that the decision to admit or discharge back to the care of a GP be made. Admission pathways were followed through in other ‘building blocks’ as well. Examples of other changes include:

- allowing GPs to refer individuals with DVT directly for tests, and deciding whether to admit the individual or refer them back to the GP based on the test result;
- changing the working patterns of physicians (physician of the week – one physician responsible for all the emergency admissions during the period); and
- agreements between consultants and GPs regarding who should be admitted (for example consultants to always have mobile phones so they could speak to GPs and provide required support and advice).

These resulted in an approach where only those who needed to be admitted were admitted.

Key success factors: the whole process took time. Involving staff in the process, to give directorates examples and opportunities for change. This is an ongoing process. Staff have realised that the Transformation Team is serious and credible and involves people rather than telling them what to do.

Key hindering factors: professional roles; the number of discussions required; and the need to continually audit outcomes prior to wider rollout.

6. Review

There are two levels of review:

- the initial review following the change, which leads to further adjustment; and
- ongoing monitoring and review.

There is no set approach to the issue - it varies according to the topic and specialty. For example in ophthalmology the Transformation Team supports the audit of patients' experience and they look at the audit results to ensure that any changes made have led to an improvement. Weekly meetings are penned in to allow for regular feedback and dissemination. In addition, monthly and quarterly reports are produced. Generally the Team supports the departments undertaking the work to review results.

Key success factors: the need for comprehensive and accurate data, regular monitoring and analysis.

Key hindering factors: information is not always available and systems need to be designed to collect it.

Mainstreaming

There is a need to have examples that work and a need to spend time with staff talking and explaining what has been done. There is no magic answer. People need support, including financial support. However, most of the time it is about changing the culture and persuading people to do things differently without feeling that it is wrong or feeling isolated.

The Director of Organisational Development is now in his fourth team of Transformers. The project is essentially a high level training programme in change management. People who have joined rarely wish to go back to their previous roles and instead have taken up many of the opportunities which now exist in the NHS at a more senior level.

For the Transformation Team there is a commitment to continuity and sustainability. They are working closely with other stakeholders such as the PCTs, social services, and the council since many of the projects involve joint-working. Such close working relationships must continue in order to ensure that the projects benefit the entire health economy.

Key success factors: The need to maintain credibility and be seen as a source of help and support. Successful partnership working with other stakeholders.

Key hindering factors: The time it takes particularly when there is primary care involvement. There are 50 referring practices and 250 GPs in the area. Any change needs to be implemented across all to achieve a new, improved and standardised system. In addition there is a need to achieve and demonstrate progress in implementing the NHS Plan.

For more information please contact Sarah Butler, the project lead for the Peterborough Transformation Team sarah.butler@pbh-tr.nhs.uk
Case study 3: Setting up a local mini collaborative - Blackburn, Hyndburn and Ribble Valley NHS Trust

<table>
<thead>
<tr>
<th>STAGE IN THE CHANGE MANAGEMENT MODEL</th>
<th>“Where there are no obvious national programmes the trust has set up their own mini collaboratives. The trust is trying to spread this more widely within the organisation – not just have pockets of excellence.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key challenges:</td>
<td>▪ ensure good practice is spread across the organisation.</td>
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<td>Key learning:</td>
<td>▪ improvement work is undertaken more widely than in just a few areas;</td>
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<td></td>
<td>▪ multidisciplinary work can bring major benefits to the patient without any significant investments;</td>
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<td></td>
<td>▪ there needs to be a link between senior managers and project teams to ensure adequate support and resources;</td>
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<td></td>
<td>▪ staff involvement is crucial as they stay and deliver services when the project manager has moved on to the next job. Staff are usually the ones who notice the problems and provide the answers to these problems;</td>
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<td></td>
<td>▪ project managers need to be able to access senior level support to solve any possible blockages;</td>
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<td></td>
<td>▪ there needs to be a clear understanding of what it is that is being changed and there needs to be clear measures to benchmark the improvements; and</td>
</tr>
<tr>
<td></td>
<td>▪ collaborative work usually works well in the areas where people have given much thought to an issue and are keen to take the opportunity when it is offered. Collaborative work is usually less successful in areas where people haven’t given as much thought to the issues.</td>
</tr>
<tr>
<td>Key methodology:</td>
<td>▪ whole systems approach.</td>
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<tr>
<td>Key tools:</td>
<td>▪ PDSA cycle;</td>
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<td></td>
<td>▪ process mapping;</td>
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<td></td>
<td>▪ away days; and</td>
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<td></td>
<td>▪ workshops.</td>
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</table>

1. Recognition of the need for change

   Approximately 2 years ago, it was felt that national collaborative work needed to be launched across the organisation.  
   **Key success factors:** examples of successful change through the national collaborative programme.  
   **Key hindering factors:** some areas were prepared to accept status quo or recognised the need to change but felt overwhelmed by the agenda.

2. Start of the change process

   The trust held an off-site meeting for an afternoon with 85 members of staff. The staff were drawn from across the organisation from different levels and professions. The meeting was led by the Chief Executive with the aim of developing local improvement projects. There was a series of speakers from the local community who had been involved in the national programmes. For example someone who had been working on the Action on ENT programme for 6-12 months gave a presentation on the changes they had made or were about to make.  
   **Key success factors:** experience gained from the national collaborative work.  
   **Key hindering factors:** inability to free all required staff from their normal duties.

3. Diagnosis

   This was followed by a series of group workshops and the 9 local mini-collaboratives emerged from these groups (for example maternity, diabetes, and stroke).  
   **Key success factors:** the trust felt that the afternoon sent out an important signal, as the trust had made the commitment to take those 80-90 people off site, the CEO had emphasised the importance of the improvement work, and then the individuals were allowed to work in groups to work through what they thought the key issues were.  
   **Key hindering factors:** no natural leader emerged in some areas, or there was inertia or a perceived lack of time, skills and knowledge.

4. Planning and preparing for implementation

   Currently the trust has several structures and sub-structures within individual project teams based on the needs of the project. Considerable investments to individual project teams have been made within the trust.  
   **Key success factors:** projects were “owned” by the teams; resources were made available for time out; and some corporate and MA facilitation resources were available.  
   **Key hindering factors:** the lack of a dedicated resource.
| 5. Implement change | These 9 mini collaborative groups are now up and running and delivering service improvements. One of the key elements is that improvement work is undertaken more widely than in just a few areas. The projects have had a huge local ownership and the trust have given project teams the freedom to run the projects. Support for the process has also been provided throughout. Some funding has been put aside to be able to undertake away days and workshops. The projects are very much run by their own teams and the trust brings in external facilitation for example from the MA when it is required. Mini-collaboratives use the same elements and techniques as the national collaboratives, e.g. PDSA cycles, process mapping, away days and workshops.  
**Key success factors:** people delivering the services need to be involved and the project managers need to be there to facilitate. Involvement and support from key clinicians is particularly crucial. Project managers need to be able to access senior level support to solve any possible blockages. It helps if strong leaders emerge to drive the project team. Previous experience of working across departmental and organisational boundaries is also important, as is commitment to improvement and redesign.  
**Key hindering factors:** some areas made less progress than others due to some of the issues already mentioned such as: lack of dedicated resource; and lack of a driving force in the team. Some areas were entirely new to the modernisation agenda and needed to spend a lot of time establishing trust and understanding across the multidisciplinary team, beginning to use new tools, techniques and ways of working. Day to day pressures hindered progress, as they needed to be addressed at the same time as running the change programme. |
|---|---|
| **Mainstreaming** | The trust is trying to spread this more widely within the organisation – not just have pockets of excellence. The next step in the process is to integrate, as a community, all the project teams to one large modernisation resource. These resources can then be targeted to priority areas. For example experts in PDSA cycles can go and give training in clinical areas outside their direct responsibility.  
**Key success factors:** Staff involvement is crucial as they stay and deliver services when the project manager has moved on to the next job. Staff are usually the ones who notice the problems and provide the answers to these problems. |
Case study 4: Patient-Practice Partnership – Elliott Hall Medical Centre

<table>
<thead>
<tr>
<th>STAGE IN THE CHANGE MANAGEMENT MODEL</th>
<th>“The initiation of a Patients’ Association in 1993 has lead to a successful patient-practice partnership and improvement in services.”</th>
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</thead>
</table>
| **1. Recognition of the need for change** | The Elliott Hall Medical Centre has a large elderly catchment population. Many of the elderly population have recently retired and therefore have more time available. The need for a Patients’ Association was first recognised by the practice staff, who approached patients to find out if they would be interested in developing the Association. However, the need was also recognised by the patients.  
**Key success factors:** the sheer number of volunteers.  
**Key hindering factors:** red tape re insurances, consent, confidentiality etc. |
| **2. Start of the change process** | Initially a notice was put in the patients waiting area and every patient received a letter from the practice asking if they would like to be involved in the Patients’ Association. This was in 1993 when the Medical Centre moved to new premises. Over 5,000 patients over the age of 18 were approached. The Medical Centre had around 400-500 positive responses.  
**Key success factors:** not telling patients what to do but instead empowering them.  
**Key hindering factors:** there were no major hindering factors. However, there were time requirements for, for example, posting the questionnaire, or holding meetings to ensure volunteers and coordinators were appropriate. |
| **3. Diagnosis** | The Centre held an open meeting with 120 patients who were interested in participating in the work and able to attend the meeting.  
**Key success factors:** the patients did the diagnosis and planning work. Medical Centre staff offered their support where it was needed which was mainly facilitative. Financial support was also provided (for example, to send out the questionnaires).  
**Key hindering factors:** the time required to organise and ‘pump prime’. |
| **4. Planning and preparing for implementation** | A range of services were set up following the meeting based on what people felt they could do and what they were keen to help out with. The centre tried to get external help with the process but this was not available due to a lack of resources.  
The patients association appointed a chair and developed a database of all individuals who expressed an interest in the work. Each work stream had a volunteer co-ordinator and the co-ordinator contacted each person interested in their work stream.  
**Key success factors:** establishing mutual trusting relationships. Early production of a magazine to inform patients.  
**Key hindering factors:** a lack of external resources to help with the process and troubleshoot the problems. |
| **5. Implement change** | The Elliott Hall Medical Centre developed a Patients’ Association (EHMCPA) in April 1993 when the practice moved into new premises. The Patients’ Association is now an autonomous charity organisation and provides support for patients in the local area. For example they provide a visiting service, a transport service, a shopping service, a bereavement service, a carers group, a group for children with special needs and mother and baby group. They also run a number of social activities. A newsletter is produced twice a year by the patients involved, which is distributed to all households in the practice catchment area.  
For the transport service there are approximately 20 volunteer drivers with whom the Patients’ Association have regular contact. The co-ordinators organise the transport services based on the needs of both patients and the drivers and try to ensure that no driver is requested to make a journey more often than once or twice a month. This service has now been developed so that there is a volunteer in the Medical Centre three times a week between certain hours to answer requests and to try to match the person who needs the journey, with a driver.  
There are also two volunteers developing a website and the Medical Centre is soon to launch the website with the Patients’ Association.  
The work carried out by the carers group has provided an excellent mechanism to support carers.  
**Key success factors:** the need to ensure that the volunteers are not overloaded by the activity. There is a need to look after the volunteers by regularly speaking with them and checking that they are coping well with the work.  
**Key hindering factors:** the need to ensure that the volunteers are not overloaded by the activity. There is a need to look after the volunteers by regularly speaking with them and checking that they are coping well with the work. |
Key hindering factors: there are difficulties in maintaining the level of volunteers. All larger jobs are broken down to smaller components so that no one feels irreplaceable. Hospitals can be unfriendly to volunteers i.e. no protected parking or passes.

6. Review
The Executive of the Association meets regularly, approximately three times a year, with the representatives from the Elliott Hall Medical Centre to look at how the Association and the Medical Centre are developing as organisations. There is also an AGM. These meetings are usually well attended by both patients and Medical Centre staff. The meeting is Chaired and run by the Patients’ Association and usually the attendees include all of the co-ordinators and partners, and the Manager of the Medical Centre.
There is also constant review by the lead Partner of the Medical Centre and Chair of the Patients’ Association, identifying success and areas for improvement. This is usually carried out via telephone conversations. Nevertheless all partners are involved as are representatives of the nursing and administrative team.
The trust has received NHS Beacon status for Patient Involvement. The lead Partner of the Medical Centre is the lead involved in the Beacon set up. The additional funding has helped to fund the time required by the Medical Centre to support other practices in similar work.

Key success factors: many practices have visited the Medical Centre and volunteers of the PA have willingly given of their time and indeed provided ongoing support with visits to other practices.

Key hindering factors: finding protected time for interested practices.

Mainstreaming
The Medical Centre invites the Patients Association members to a ‘garden party’ on an annual basis. This has been held in the Medical Centre or in a patient’s home. Information about the activity is distributed to every household through the Newsletter. Representatives from the Patients’ Association have been invited to the Medical Centre’s team-building events. This has allowed the practice development plans to reflect the needs of patients and the Patients’ Association.
The work has helped, for example, to reduce the number of patient journeys to and from the surgery or local hospital. It has also increased and strengthened the trust between patients and the Medical Centre. This has resulted in a minimal number of complaints.
Elliott Hall has been very keen to share their experience. As a part of the Beacon Programme they have been doing ‘road shows’ and have invited people to the practice to talk through their experience. As part of this the Medical Centre ran a PCT-wide patient participation seminar date in 2002. The importance of networking in facilitating the exchange of ideas was found to be great.

Key success factors: there is a need to understand that every practice is different. There is a need to examine an organisation and identify successful areas, where things could be done differently and how patients can potentially play a role in that. Getting over the barrier of feeling frightened to involve patients was identified as being important as patients can help an organisation as much as the organisation can help them. There is an overall need to empower patients and learn from their experience.

Key hindering factors: in some practices there can be an unhealthy suspicion of closer links with patients.

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Case study 5: Pursuing Perfection pilot site - National and International Collaboration, North and East Devon health and social care community

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STAGE IN THE CHANGE MANAGEMENT MODEL
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"The aim of the projects is to engage in partnership working with national and international partners in healthcare to bring about rapid changes in the local delivery of healthcare services, integrating professional and patient perspectives."
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Key challenges:
- the need to convince people that change is something desirable and is something they can all participate in cannot be underestimated;
- the range of targets in the NHS can stifle creative approaches to problem-solving and improving health and social care delivery;
- bringing onboard a wide variety of individuals and agencies, both national and international, is a challenging task that requires good coordination, participation, and feedback; and
- working collaboratively means that the diversity of expectation has to be carefully managed.

Key learning:
- the success of the projects is dependent on good leadership from Chief Executives and other senior level personnel;
- high-level management must be balanced by the capacity to allow individuals the freedom and authority to be involved and to make decisions about what changes need to be made and how they should be rolled out. The empowerment and personalisation of the modernisation and change agenda by individuals is necessary in order for change to be implemented in a responsible and committed manner;
- early evidence of outcome from change may be necessary to keep people on board and to convince them of the need for further change;
- national and international collaboration has enormous potential for effective learning. This facilitates any change process;
- planning, implementing, and monitoring change must be done realistically and pragmatically; and
- modernisation must not be thought of as an ‘add-on’. Instead it has to be integral to the wider organisational framework in order for it to be relevant and sustainable.

Key methodology:
- an organic approach to the identification and resolution of issues;
- working towards a whole systems approach; and
- continuous investment in people and attention to the cultural aspects surrounding and accompanying change.

Key Tools:
- PDSA cycles;
- process mapping;
- support and leadership development; and
- patient and staff involvement.

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1. Recognition of the need for change
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In May 2002, the Modernisation Agency called on Chief Executives of three-star organisations, and their communities, to attend a meeting with a representative from the U.S. to consider taking part in an initiative called “Pursuing Perfection”, which aims to create patient services that are significantly better, more accessible, and more patient centred than anything that exists in the NHS today. This reflects the acknowledgement, particularly at high levels, of the need for greater national and international collaborative efforts, particularly in the exchange of views and experience in managing and implementing change amongst partners from the U.K., U.S. and Europe. There is a desire to investigate how such national and international learning can be transferred onto the local context.

Key success factors: there was a willingness at Chief Executive level to participate in such collaboration and recognition that this is a real opportunity to bring about positive changes. There was also awareness that such efforts can be linked to the meeting of key national targets by translating these targets in a way that made them salient to the local context. Representatives from the spectrum of health and social care were keen on this learning experience.

Key hindering factors: there was no major obstacle to the recognition for the need to change. The Director of Operations was clear, moreover, that it should not be conceived in terms of a recognition of ‘problems’. Instead, it should be thought of as a process of identifying what needs to be changed. There is a tendency to focus on ‘problems’ or ‘failures’ and not enough attention is paid to what is working well.
2. Start of the change process

Four pilot sites were set up in the U.K. as part of the ‘Pursuing Perfection’ programme. There was frequent liaison with the individuals and agencies involved to work closely in developing their programmes and to learn from their experiences. North and East Devon health and social care community was one of the Pursuing Perfection pilot sites. There was a recognition of the need for partnership working as well as its potential benefits. It was felt to be essential for any modernisation agenda to be fully integrated within organisational structures, permeating all aspects of the work conducted. A matrix was developed to illustrate the key issues facing the community and to help focus attention on how steps could be taken to address these issues using some of the existing high-level measures at their disposal. Once the matrix had been populated, they worked with the Chief Executives to identify the types of projects to be put in place in the first instance.

The Modernisation Agency provided support in terms of the range of skills and training they are able to provide. This was supplemented by the Institute for Healthcare Improvement (IHI) in Boston, which supported the projects directly by sending people over to advise the Trust particularly in terms of developing leadership. The components of the change process were thus identified and put in place rather speedily.

**Key success factors:** the individuals involved in the projects were very committed and invested a huge amount of energy into putting things in place to enable changes to be rolled out. There was good high-level leadership that gave others the authority to make a difference. There was an appreciation of the wealth of knowledge and experience at the ‘shop-floor’ level.

**Key hindering factors:** the planning process took considerably longer than anticipated due to the difficulties of working across organisations. There is a long history of individuals being able to spot the obvious but not moving beyond an awareness of the issues. There is also a large degree of caution inherent in the staff as a consequence of modernisation initiatives in the past. This inhibits their willingness to appreciate their ability to make a real difference to patient welfare and to their own individual welfare.

3. Diagnosis

There was a very real appreciation that the views of staff and patients must be actively courted. The Director of Operations at the Royal Devon and Exeter Healthcare NHS trust, as part of the local health community, felt that professional perspectives needed to be balanced by other points of view to ensure that diagnosis and interpretation of issues is conducted properly. Regular process mapping sessions are conducted to bring together different players and exchange views and experiences. This takes on board a multi-disciplinary approach. The team is striving towards achieving a 50/50 balance between professional and lay input.

A review of the status quo was done in a realistic manner, taking into consideration the types of data already available and making full use of these. The emphasis is on what is measurable, and also what is routinely collected. Appropriate targets are then set to enable the team to demonstrate transformational changes while being set within the wider context of high-level national targets.

**Key success factors:** a realistic and pragmatic approach to diagnosis is essential. In addition there is an awareness that diagnosis should not be left entirely to professionals since this can lead to a very biased viewpoint. Staff involvement at all levels is encouraged. This necessitated a more organic approach to the use of staff time by allowing them to take time out from their other responsibilities to participate in the process mapping sessions.

**Key hindering factors:** it was very difficult to balance the need for staff involvement with the pressures of the formal workload. Within the NHS, the pressures of meeting targets coupled with general problems of staff recruitment and retention has meant that there is little flexibility in adopting more creative ways of managing the workforce in the short term.

4. Planning and preparing for implementation

In addition to the diagnosis, a project leader heads each project and a steering group supports them. A Programme Support Manager has been appointed recently to take responsibility for overseeing the two projects. The project leaders work through a project plan. This is a dynamic document that takes into account the complexity of change. The project leaders revisit their project plans constantly. As stated previously, the planning process has taken considerably longer than initially anticipated as a result of the realities of working in partnership with a diverse array of partners. However, there is a tremendous amount of goodwill. The team is also well supported both from within and without (particularly by the Modernisation Agency and overseas partners).

**Key success factors:** those involved in the projects were given the authority and freedom to plan an agenda for change that they felt was appropriate. This enabled individuals to feel empowered and to be able to personalise the change process. Individuals from the spectrum of health and social care organisations were very committed to making it work. There was also an appreciation that in order for change to work, it cannot be a ‘bolt-on’ effort. The change agenda has to be integral to the way things are being done in general.

**Key hindering factors:** time constraint was felt to be the most important factor inhibiting planning and preparation for implementation. The process mapping sessions, for instance, required coordinated effort from various players. These make demands on individuals who are already under pressure to deliver other goals in their routine workload.

5. Implement change

The projects are still in the early stages of rolling out change. The thinking and methodological aspects have already been put in place while the whole system approach will only materialise later. The process of implementing change is complex and throws up a series of unforeseen issues that need addressing. The approach to contingency planning adopted across the projects recognises that things will go wrong. These glitches are not regarded as failures. Instead, they are treated as episodes requiring reflection on why things have not worked as intended. Therefore, the process of implementing change is regarded as a constant learning experience. An example was given regarding an effort to expedite the transfer of patient information to GPs. This was originally intended to be done via fax. However, the team had to contend with issues regarding confidentiality. After more brainstorming, the team decided that instead of using fax to transfer patient information, the use of e-mails is a reasonable alternative. The team has a positive attitude regarding the resolution of problems arising from the change process. Positive thinking was felt to be vital.

**Key success factors:** the staff were very eager to do things that bring about real changes. They were also sensible about the way the change can be brought about. Expectations were realistic and approaches pragmatic. Individuals were aware that they were working with complexity.

**Key hindering factors:** it was difficult to roll out changes in projects that by nature require a multi-agency approach. It took...
### 6. Review

Monthly reports are submitted to the Chief Executive Group who are in charge of monitoring progress. The projects also perform monitoring and progress report exercises for the Modernisation Agency and the IHI in Boston. Formal monthly reviews are supplemented by a constant review process that is highly dynamic. This is to make the process of change workable on a day-to-day basis.

In addition to the above, there is a formal forum for reviewing and disseminating the findings from reviews. This takes the form of monthly meetings where representatives from the various agencies within health and social care attend. The projects also have a website that disseminates findings and this site is linked to the U.S.-based website of the IHI ([http://www.ihi.org](http://www.ihi.org)).

At the monthly steering group meetings, steps are taken to review progress and to identify next steps. A second group has been set up to complement this. This latter group is intended to be a ‘blue skies’ group, coming up with big ideas and bold approaches.

**Key success factors**: the review process enables different partners to be brought together in a constructive team forum. Different ideas are exchanged and such reviews help to focus efforts and thinking. There is integration of more formal reviews with the day-to-day practicalities of implementing change.

**Key hindering factors**: reviewing was felt to be a difficult exercise due to the fact that the diversity of partners meant a wide array of expectations. Some had wished to see more rapid change and were thus disappointed by the protracted planning phase. Managing expectations is therefore important.

### Mainstreaming

The aim of the projects is to demonstrate how change can happen and to create transformational change that is visible to, and felt by the patients. The Director of Operations feels that the projects have every chance of being sustainable in the longer term. In fact, new projects are currently being planned and developed. The modernisation agenda has been built into the entire organisational structure and is integral to the way things are being done throughout the organisation. It is not a detached project.

There is an awareness of the fact that in order for modernisation efforts to be sustainable, the emphasis on tools and techniques has to be balanced by attention to the cultural aspects surrounding the use of such tools and techniques. After all, the types of human relationships in existence within the organisation must be able to complement the types of tools and techniques being put in place to enable change to work.

**Key success factors**: modernisation efforts were ‘mainstreamed’ right from the beginning. They were made an integral component to the organisational structure and workforce management. The leadership of the Chief Executive and senior level personnel facilitated this process by lending their unremitting commitment to making things sustainable.

The appreciation of the human aspects of transformation is vital in ensuring that adequate attention is being paid to work cultures. Modernisation and change are therefore not thought of solely in terms of technical or methodological issues.

**Key hindering factors**: In order for the change agenda to be sustainable, there is a dependence on the energy of various individuals to bring onboard other players as quickly as possible. The commitment of these individuals and other agencies cannot be taken for granted. A developmental approach has to be in place to ensure that adequate support is given to those involved in the projects.
Appendix Two: Rapid review methodology

Interviews
The basis of this rapid review has been a series of interviews\(^\text{19}\), undertaken predominantly by telephone between 16th December and 28\(^\text{th}\) February. Table [1] details the interviews undertaken.

<table>
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<tr>
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<td>• Youth Justice Board</td>
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<td>• Social Care Institute for Excellence</td>
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<td>• Cabinet Office, Office for Public Services Reform</td>
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<tr>
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<td>• Institute of Directors</td>
<td>1</td>
</tr>
<tr>
<td>• Change management academics</td>
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</table>

Table [1]: Interviews undertaken

Interviews were conducted using a topic guide covering issues that included:

- the interviewee’s view of the local modernisation agenda;
- examples of local change support systems;
- success factors in developing and implementing local change support systems; and
- further contacts for the research team to contact.

With the interviewees’ permission, interviews were taped to facilitate note taking. Interviewees were sent a short write-up of their interview to allow them to check information for accuracy and provide additional information were appropriate.

\(^{19}\) A small number of interviews were face-to-face interviews
\(^{20}\) Including one Care Trust
\(^{21}\) For example: teams working across local health communities; a healthy living centre; a community NHS trust; and a medical centre.
A purposive sampling strategy was used, with the intention of gathering a range of good practice examples and views on the local modernisation agenda. An initial list of contacts was agreed between the research team and the MA. Interviewees were then asked to nominate further contacts for the research team to contact. In small number of cases interviewees were interviewed twice in order to gain more in-depth information.

Literature
A range of literature was examined during the course of the rapid review. This included a range of national literature, predominantly originating from the MA, which was then supplemented by literature provided by interviewees. National literature consisted predominantly of guidance notes and findings from research and evaluation on local modernisation. Local literature consisted primarily of project plans, strategies and output from local events produced by local change agents to support specific local modernisation projects.

Limitations of methodology
Four main limitations to the methodology used have been identified. These limitations are primarily a product of the timescales set for the rapid review.

Sampling of interviewees: The challenging timescale for the completion of this project, and the scale of the project, meant that only a relatively small number of interviews could be undertaken and sampling was necessarily purposive. The sample is therefore not representative; rather it has been designed to capture the range of diversity of local practice.

Availability of interviewees: Interviews were undertaken before and after Christmas and New Year and interviewees were given relatively short advanced notice of the interview programme. Inevitably, the time of year and the short notice period led to the unavailability of some people that were approached. In total 67 individuals were approached and asked to participate in the interview programme. A total of 46 interviews were undertaken.

Telephone interviews: The limitations of telephone interviewing are well documented in the research methods literature. Telephone interviewing allowed the research team to speak with a larger number of interviewees than would otherwise have been possible within the time constraints and scale of the project. Furthermore, interviewees were professionals used to conducting business via a telephone. However, telephone interviews make the process of building rapport between interviewer and interviewee more difficult and this can affect the quality of data gathered.

Identifying effective local support systems: Within the time frame and scale of this rapid review, the ability of the research team to verify the effectiveness of local change support systems has been limited. Information on specific local change support systems has generally been gathered via a single interview with a local change agent. The research team has attempted to verify the effectiveness of local support systems by reviewing relevant local literature and seeking the views of SHAs and the MA, however, it should be recognised that the findings presented in this report are the product of a review, not an evaluation.

Although the supply of local literature has been at the discretion of local interviewees.