NHS
Modernisation Agency

How do we get a NHS that is continuously improving?

A concept paper for the next phase of NHS improvement

Written responses to the paper required by 21st May 2004 to cathy.green@doh.gsi.gov.uk

Please note that the deadline has been extended to maximise the opportunity for feedback

Main Points

- Ministers have tasked the NHS Modernisation Agency to work with stakeholders on the design of the NHS improvement system
- significant progress has been made in using improvement methods to deliver tangible benefits for patients
- however, the success of improvement work has highlighted a growing gap between what has been accomplished and what is needed in the future
- we need to move the focus to making improvement mainstream in the daily work of clinical teams in the NHS
- our goal must be a NHS improvement system that is fit for purpose at every level
- three major roles for a national support organisation are *innovation, field testing*, and *sharing* and *connecting knowledge and people*
- a steering group of NHS collegues, clinicians and other key stakeholders is being established to oversee the design of the next phase of the improvement system
- we welcome your written response to this concept paper by 21st May 2004 to: cathy.green@doh.gsi.gov.uk. Your ideas and suggestions will be fed into the design process

1. The Agenda

Current discussions between the NHS Modernisation Agency, The Department of Health and Strategic Health Authorities are bringing into sharp focus the need to develop a clear picture of the future. Feedback from the NHS on future needs for support for healthcare improvement has demonstrated a great commitment to modernisation but a desire to move to new ways of working and new patterns of support.

We have learnt a great deal about how to improve NHS services and much has been gained. However, large system change will not come from simply scaling up what we have been doing to date.
We need to put as much, or more, effort into mainstreaming modernisation (the new goal) as it took to demonstrate the ability to modernise (the major focus of our previous efforts).

To realise the potential gains, we need to concentrate on the design of the overall *improvement system* for health and social care. Ministers have commissioned the NHS Modernisation Agency to work with stakeholders over the next three months to develop a detailed action plan for the new improvement system. What processes, relationships and structures need to be developed at (and between) local, SHA and national levels to achieve the goal of a world class improvement support system for a world class NHS?

The aim of this paper is to help start that dialogue. It provides an initial assessment of the current stage of the NHS improvement journey, puts forward future goals and design principles and starts to set out potential roles in the new improvement system. The paper suggests some possible ways forward in designing the new system. Finally, it invites you to contribute in shaping the forward path.

2. The challenge

In recent years, NHS organisations have made significant progress in using improvement methodology to deliver benefits for patients. National programmes, sponsored by the MA, have made an important contribution. They have supplied energy and focus for change and a mechanism for working in more interactive ways.

There are now many thousands of clinical teams across the NHS for whom improvement has become a way of life. Few of these teams were engaged in improvement work even three years ago. We see improvement methods being applied to difficult performance issues at local level, indicating increasing confidence in these methods as a significant way forward for the future. We see the emergence of a cadre of clinical leaders of improvement across a spectrum of specialities.

In many parts of the country, the growth of SHAs, with their role as champions of local improvement, has also been a driving force for modernisation. It has led to improvement strategies and action plans that reflect local needs and local priorities.

With success comes learning. The environment in which the NHS operates continues to change faster than our current ability to respond.

Reflecting on what we have done and what we now know we *could do* with improvement methodology, we believe that we are:

- not progressing quickly enough
- not always integrating improvement methods into every priority effort
- at a national level, not always working in ways that are coherent at local level
- at SHA and local level, not always making best use of improvement methods to improve performance
- good at piloting, but not always as effective as we need to be at spreading improvement across the whole country
- not capturing enough of the impact that improvement work is making
- not always sustaining the improvement gains we have made
- not yet establishing a strong success record at integrating and embedding improvement thinking into day-to-day mainstream work

3. Goals: what we have the potential to do

Over the past few years, we have begun to create the knowledge and skills required to improve healthcare on a massive scale. If we were to put into practice all that we know, and then link that to deliberate leadership for improvement, effective infrastructure, and the required support systems, we could:

- go way beyond NHS Plan targets
- create a system where no-one waits unnecessarily
- create a system where patients make decisions and drive their own care in ways that are comfortable for them
- make care inherently safer than it is today by many degrees of magnitude
- liberate the natural creativity and energy of our staff to make improvement of healthcare services an integral part of everything we do
- provide care that is as good or better than anywhere else in the world

The potential prize is great. We need, therefore, to move on to a new phase of healthcare improvement, without losing the momentum and expertise that we have built up over time.

Many of our current approaches to modernisation were established with the goal of demonstrating the ability to improve systems of care. The fact that the case is now proved is one of the great successes of modernisation over the past period.

The new improvement system has to take on board all that learning. However, it must move the focus to the tougher goal of demonstrating the ability to mainstream improvement work; moving beyond discrete projects to building improvement into everything we do.

Improvement work in the NHS is not yet fully embedded. It has not yet reached the tipping point where it can take on a life of its own. There is a significant geographical variation in the level of 'penetration' of new ways of working. Success still largely applies to specific projects and programmes rather than mainstreaming improvement across the board at a local level. The next phase of improvement requires a collective and deliberate steer to overcome these challenges. It is contingent on clinical and managerial leaders at all levels understanding their role in improvement, having the skills and knowledge to lead it and giving it the attention it requires.

Footnote 1. Definition of a clinical microsystem from Paul Batalden, Dartmouth-Hitchcock Medical School: *Clinical microsystems are the small functional, front-line units that provide most health care to most people. They are the essential building blocks of the health system. They are the place where patients and health care staff meet. The quality and value of care produced by a large health system can be no better than the services generated by the small systems of which it is composed.*

4. Principles for moving forward

Moving forward depends on a renewed and common understanding of the broader improvement system required to take us to the next phase. Key questions that need to be addressed include:

- what needs to happen at every level of the NHS system to help make modernisation mainstream?
- how do we continue to create leverage for improvement and apply what we have learned?
- how do we create the trusting relationships that are required for improvement across organisational boundaries?
- what mechanisms do we need to share and spread improvement knowledge across the country?
- how do we build even greater levels of clinical leadership?
- how do we maintain the confidence of politicians and public?
- how do we help build receptive contexts for change at the local level?
- how do we collectively set priorities?
- how do we maintain momentum and focus as we move to a new system?

The next phase of healthcare improvement needs effective clinical leadership and a focus on improving clinical care processes. At the same time, it must embrace the connectivity between health and social care and the impact that effective social care has on healthcare outcomes and delivery.

Design Principles

The development of the future improvement system needs to be underpinned by a set of design principles for world class improvement outcomes.

These include:

- clinical teams (clinical microsystems[1]), providing care to patients, are at the core of the improvement system; all other levels and parts of the improvement system should have the aim of supporting clinical microsystems to tangibly improve the care they provide
- improvement strategies for service redesign, patient involvement, clinical governance, workforce development, design of the built environment, leadership and organisational development and IT should be integrated at local and national level
- the improvement system should be supported by a deliberate process of innovation; new ideas and approaches should be rigorously field tested
- the system should promote local learning yet avoid reinventing the wheel; there should be a deliberate system for disseminating improvement knowledge across the NHS
- we should create ways of working that are flexible and responsive to all future scenarios including plurality of provision, technology and genetic revolutions
- improvement work should be clinically driven and disseminated through a process of peer to peer spread
- the impact of improvement work should be continuously gauged and evaluated and the resulting learning should be fed into the wider system
- whole systems thinking should become the norm rather than specific projects
- the improvement perspective should be connected at all levels of the system, including the policy environment, incentive structures and payment schemes.

5. How can we help the NHS to continually improve?

We suggest a five-step model to aid our thinking about the improvement system of the future. This model seeks to codify the experience both of NHS organisations that have made the most progress in local modernisation and of Modernisation Agency teams.

Step one:
the first step in the continuous improvement process relates to **recognition of the need** for improvement. This involves (a) seeing a gap between current and potential performance and (b) concluding that alternative approaches (such as changing the data system or tighter performance management) are unlikely to deliver the required results.

Step two:
this recognition and acceptance of the need for improvement creates an active "pull" for knowledge to satisfy the need. The improvement system must provide **ways of knowing and sharing** about what others are doing, how they are doing it and the impact it is having. We require support tools that capture this knowledge from our own efforts across the NHS as well as external sources. We need ways to connect people with knowledge to those who need the knowledge.

Step three:
this stage concerns the process of adoption (as distinct from that of spread). Adoption implies a "pulling" of information and local decision-making about what to do with it. Spread implies a "pushing" of information from some external source of control. This **local decision-making** should of course consider both local and national priorities. But it is fundamentally a question of "what are *we* going to do?" and "how are *we* going to do it?"

Step four:
local decision-making leads to local action to improve. This requires the development 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.

Step five:
successful mainstreaming of improvement requires attention to **sustainability**; building capabilities and systems for holding the gain and creating the climate for continuous improvement.

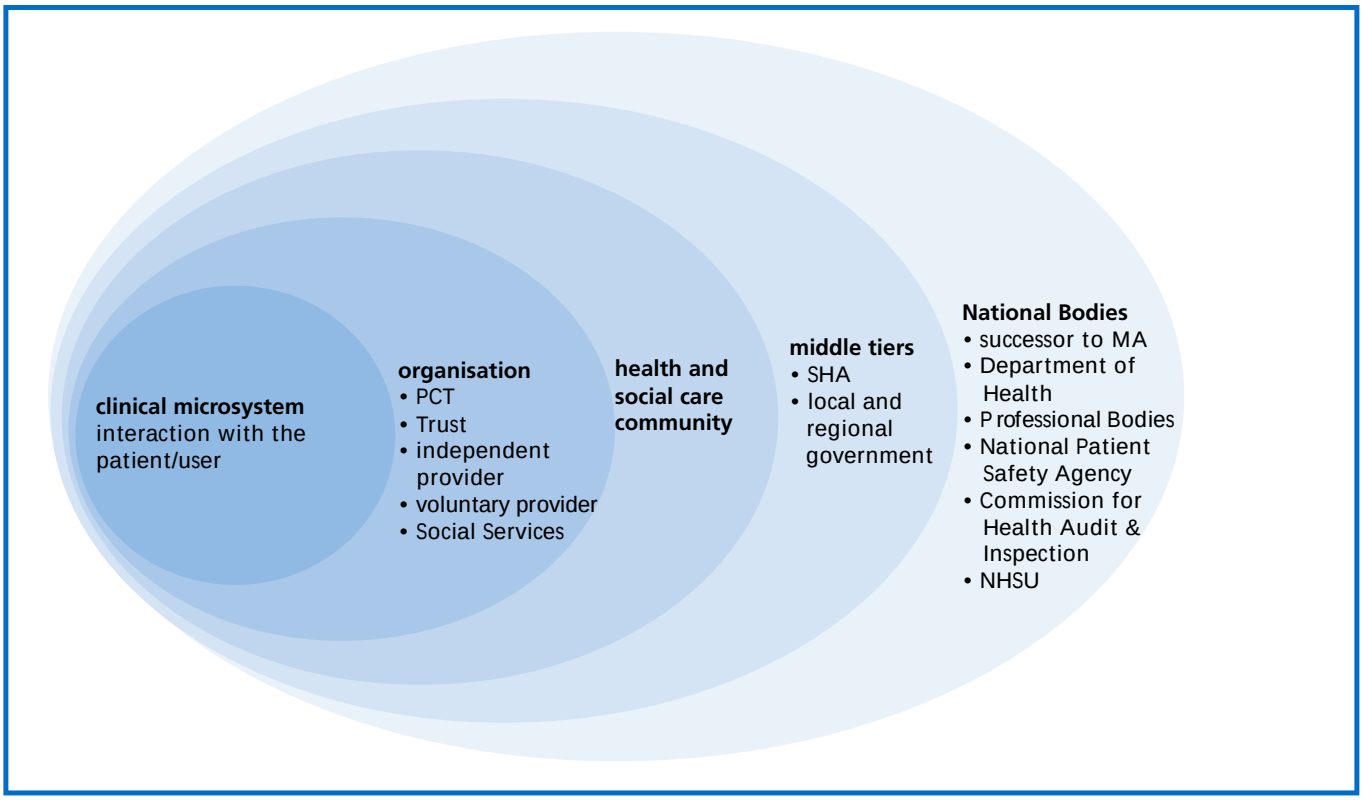
Two additional elements are necessary to create the environment that enables local improvement to flourish - **leadership development and building local conditions for improvement**. To be successful, we will require on-going and innovative efforts directed at constantly creating local leaders at all levels with leadership and improvement skills and local organisations with conditions and cultures where change will flourish.

We present the model here as a series of linear steps. It is more appropriate to describe it as an upward spiral of continuous improvement. If improvement is truly mainstreamed throughout the health and social care system, there will be literally millions of such spirals operating simultaneously as individual leaders and teams apply this process to their daily work and the specific services that they provide.

This approach applies to improvements which are both locally *and* nationally initiated. The recognition of need may be the result of a national policy priority, innovation work sponsored at a national level or local analysis. However, in order for change to be real and lasting, there must be local recognition of the need, local pull of knowledge, local decision making about what to do and how to do it, local support for change and local efforts to sustain the change. Furthermore, local recognition of the need and pull of knowledge might lead to a local decision to collaborate with others on a further improvement initiative. The model is open-ended and encourages innovation.

6. Implications for roles within the improvement system

There are likely to be multiple levels to the improvement system of the future. Success will depend on effective relationships between multiple teams and agencies within the healthcare system and beyond NHS boundaries.



If we are to be successful in embedding modernisation into all that we do, we must address the whole of the complex system that is the NHS and the wider health and social care system. Future design must enable the improvement system to operate effectively as a system:

- all parts of the system need to connect appropriately and contribute collectively to the goal of mainstreaming improvement in health and social care
- system design needs to ensure that the national and intermediate levels of the system support, rather than impede or stifle, the flow of improvement knowledge to clinical microsystems

Much of the change effort in the NHS has focused on *structures*. This has involved changing organisational boundaries, responsibility for resources, introducing new jobs, tools, targets, teams etc. Modified structures will be necessary, but are probably not sufficient to bring about the change we seek in the complex improvement system. We have learned this lesson many times over in past NHS change efforts.

Modernisation efforts over the past four years have been particularly successful in focussing on *processes* to drive healthcare improvement. This means fundamentally redesigning the way that care is delivered, from the perspective of the patient. Process redesign is necessary for the new improvement system but again it is not sufficient.

To truly bring about fundamental change in complex systems, we also need to recognise the importance of *patterns* that drive thinking and behaviour.
By patterns we mean such things as values, trust, mental models, how various groups communicate with one another, relationships, sources of power, beliefs about what is needed, etc. Often, the failure to achieve fundamental change through reorganisations and new initiatives lies in the fact that the underlying patterns in the system remain unchanged and unchallenged.

The large-scale change we require for the future will not come from simply shifting roles and responsibilities from the MA to the local NHS.
We must think and act differently not just at national level, but at all levels of the improvement system. For instance, the Modernisation Agency plays a significant role as a delivery vehicle for healthcare improvement. This role will change fundamentally. If the MA is not majoring on delivery, we need to purposefully design alternative delivery routes. We cannot just assume they will happen. We need to consider the incentives, levers and relationships necessary for improvement at every level of the system and make sure they become embedded. Our goal must be a NHS improvement system that is fit for purpose at every level.

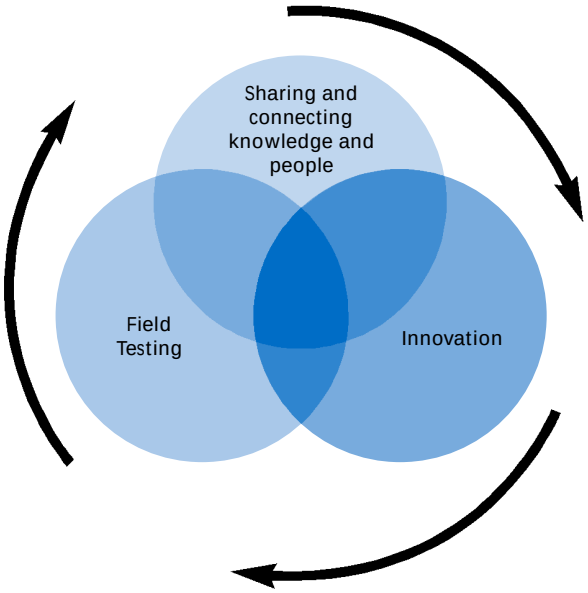
The table demonstrates the kinds of structures, processes and patterns we will need for a world class improvement system for the future.

LOCAL LEVEL	SUPPORT FOR IMPROVEMENT AT SHA LEVEL	SUPPORT FOR IMPROVEMENT AT NATIONAL LEVEL
Recognition of Need		
• creating shared vision and values • listening to the voice of patients, carers and staff • analysing the local situation against required performance • setting local priorities • developing and communicating the local business case for improvement	• understanding local performance against local, national and international benchmarks • agreeing local priorities • ensuring a common understanding of need among local organisations, networks and communities • aligning the improvement agenda with the performance agenda and other key priorities	• providing information on required and comparative performance • providing expertise on measurement for improvement • showing what is possible • providing information about the likelihood of success of alternative approaches
Ways of knowing and sharing		
• building curiosity and innovation into day to day thinking processes • contributing to field tests, networks and communities of practice • sharing skills and experiences within the local health and social care community • providing time and access for local change agents to actively search for and contribute to the shared knowledge • communicating effective improvement practice and gains across the health and social care community • clearly articulating the issues about which knowledge is required	• sharing skills and experiences within the strategic area • communicating effective improvement practice across the strategic area • building effective local networks for improvement • creating and supporting networks and communities of practice	• proactively capturing, cataloguing and synthesising what others are doing and how they are doing it • making information available in an easily accessible format so that local leaders and teams can use it • leading the field testing of new topics and approaches • helping to create and support communities of practice and networks
Local decision making		
• sifting through options • selecting priorities based on the patient perspective • creating local engagement and buy in of key stakeholders • providing resources • linking up to other initiatives and efforts • ensuring coherence between the range of local initiatives supporting improvement • maximising the potential for more radical approaches • thinking in whole systems terms	• setting the framework for local decision making • providing resources • linking up to other initiatives and efforts • ensuring coherence between the range of local initiatives supporting improvement • providing air cover and support for radical approaches • encouraging whole system thinking	• providing advice on national priorities • providing knowledge to support specific options
Local change support systems		
• ensuring that required skills are available and practised at every level of the local system • forming and giving authority to improvement teams and individuals • building change support systems into the mainstream of organisations • rewarding improvement effort • making sure that new ways of working are spread across the local system • removing barriers to change and improvement	• championing capability building for improvement so that skills are available and practiced at every level of local system • ensure change support systems are built into local organisations • implement strategies for spread across the strategic area • providing customised support, specific advice and improvement knowledge	• researching and developing latest approaches in the disciplines of improvement, innovation and spread of good practice • helping to ensure that local change leaders have access to the full breadth of up to date improvement and innovation knowledge • providing customised support, specific advice and knowledge products where appropriate • supporting a 'faculty' of local improvement practitioners who will provide knowledge, skills and learning for the NHS
Sustainability		
• creating local understanding of the factors that lead to sustainability • creating the local conditions from day one that will lead to change being sustained in the longer term • creating and modifying feedback and measurement systems • ensuring that changes take place on a wider level so that practice cannot return to the old ways • seeking to continuously improve the practice, not just sustain it	• supporting the understanding of sustainability factors • ensuring that measurement and monitoring systems are built to encourage sustainability • ensure that incentives and performance systems in the wider system encourage sustainability • providing support and advice	• researching and developing latest approaches to sustainability • helping to develop the regulatory and education frameworks that create a local climate for change and sustainability • helping to ensure that local change leaders have access to the full breadth of up to date knowledge about methods for sustainability • providing customised support and specific advice where appropriate
Leadership development and local conditions for change		
• ensuring that local leaders at every level have got appropriate skills, values and knowledge to lead transformation of health and social care • ensuring that improvement is at the core rather than the periphery of mainstream NHS activities • establishing and maintaining leadership systems to support patient centredness, innovation, risk taking and continuous improvement • creating a cadre of clinical leaders who drive local improvement and demonstrate it in their own practice • setting up systems that continuously evaluate the quality of leadership • making demonstration of improvement a prerequisite for leadership positions • setting up reward and recognition systems that highlight contributions to improving care • creating a team based environment • working with other agencies across the health and social care system	• ensuring that local leaders at every level have got appropriate skills, values and knowledge to lead transformation of health and social care • ensuring that improvement strategy is aligned with core development priorities • demonstrating leadership and receptive context for change through own strategy and practice • setting up reward and recognition systems that highlight contributions to improving care • supporting partnership working across the health and social care system	• developing frameworks that help define the characteristics of effective leadership and conditions for local success • researching and developing latest approaches to leadership and conditions for local success • helping to ensure that local change leaders have access to the full breadth of up to date knowledge about leadership and conditions for local success

7. Implications for the future role of a national support organisation

Ministers have agreed that a new central body will replace the NHS Modernisation Agency from April 2005. Clearly the role of the new organisation will need to be set in the context of the wider improvement system. What does this analysis of the improvement system tell us is required from that body in the future?

The items in the "national level" column of the table that relate to improvement support can be summarised. They suggest three major roles for the new organisation; *innovation, field testing* and *sharing and connecting knowledge and people*. These core roles are intrinsically connected with each other and with the wider improvement system:



Innovation:

- learning from other industries and healthcare systems to ensure that NHS improvement practice is fresh, forward focussed and at the leading edge
- enriching and extending thinking about future NHS improvement by exploring "new" models and theories of organisational improvement and change
- commissioning and undertaking research and development processes to ensure that the NHS gets the improvement knowledge and skills it requires for world class delivery
- championing improvement as seen "through the patient's eyes"
- helping to push boundaries and "raise the bar" in the level of ambition and standard of care delivery by the NHS
- supporting large system design
- accelerating the development of an overall culture of creativity, innovation and change in healthcare
- always keeping ahead on future needs for healthcare improvement

Field Testing:

- continuously evaluating new ideas and approaches
- designing and testing prototypes of new improvement models
- ensuring that the innovative methods and changes championed by the new organisation are practical, suitable and sustainable for the NHS
- rigorously assessing the impact and contribution that improvement work can make
- enabling the learning from the highest performing NHS organisations to be tapped into in a systematic way and spread to the wider NHS community
- making the business case for improvement
- defining the capabilities and skills needed for healthcare improvement at every level of the system
- increasing understanding of the factors which lead to the spread and sustainability of service improvement
- ensuring that improvement strategies, methods and principles meet the needs of the range of "customers" from local clinical teams to organisational leaders to policy leaders in the Department of Health

Sharing and connecting people and knowledge:

- acting as a hub and a central repository of improvement knowledge for the NHS
- providing world-class expertise in specific areas of improvement knowledge
- providing expertise, both to local teams and the Department of Health, about the range of improvement methods and approaches; what is and is not likely to work
- increasing the usage of high quality improvement knowledge by the NHS, thus improving healthcare delivery:
  - building and supporting networks and communities of practice
  - spreading information about effective improvement practice
  - connecting change agents with knowledge
  - compiling comparative performance data
  - creating collaborative links with the research community
- supporting local organisations, communities and leadership teams to develop strategies for healthcare improvement
- linking at a national level with policy and delivery issues to ensure effective connections in both directions

This analysis suggests some fundamental differences for the central support organisation compared to the current approach. For example:

- moving from large scale delivery to pushing the boundaries forward
- increased focus on generation and transfer of skills and knowledge to meet local needs
- initiating but not delivering a small number of national programmes
- more of a role in capturing and synthesising good practices *across* topic areas
- helping to build and facilitate networks and communities of practice
- increased recognition of the role of SHAs and local organisations to ensure coherence and create the conditions for adoption
- providing decision support, rather than making decisions about priorities
- moving from being a large-scale training provider to being a skills development and curriculum designer for delivery by others (for instance, NHSU, SHAs)
- less of a project management role and more of an expert advisor role

We believe that we will be able to work out the needed changes in structures, processes and patterns as we attempt to make modernisation mainstream. At the same time that the role of the central organisation is being shaped, we need a similar process to define the focus and responsibilities of all other levels of the improvement system.

8. An invitation to contribute

We believe that new thinking is required as we undergo the transition to an era where improvement efforts become embedded into the mainstream of all health and social care work. Our past learning and success with national programmes and our over-arching commitment to equity means the NHS has the unique potential to excel at improvement when compared to health care systems around the world.

Ministers have tasked the Modernisation Agency to work with PCTs, NHS Trusts, SHAs and other stakeholders over the next three months to develop a detailed action plan for the new improvement system.

We have established a steering group to oversee the design of the next phase of the improvement system. Members of the group include NHS colleagues, clinicians and other key stakeholders who will provide direction, challenge, and support to the process.

We also want to use established communication mechanisms and events to gain views and perspectives. In addition, we will set up specific opportunities to ensure that as many stakeholders as possible are involved in the debate and can contribute to the next phase of designing the improvement system.

We would welcome your written response to this concept paper. Please send your written comments to Cathy Green at cathy.green@doh.gsi.gov.uk by 21st May 2004. We will feed your ideas and suggestions into the design process.

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