

# Getting the Basics Right

## Final Report on the *Care Closer to Home: Making the Shift* Programme

Chris Ham  
Helen Parker  
Debbie Singh  
Elizabeth Wade



Bringing  
care closer  
to you



UNIVERSITY OF  
BIRMINGHAM

Health Services Management Centre

May 2007

**DH INFORMATION READER BOX**

Policy	For Information
HR/Workforce	Performance
<b>Management</b>	IM&T
Planning	Finance
Clinical	Partnership Working

**Document Purpose** For Information**ROCR Ref:** **Gateway Ref: 8283****Title** Final Report on the Care Closer to Home: Making the Shift Programme**Author** Chris Ham, Helen Parker, Debbie Singh, Elizabeth Wade, Health Services Management Centre, University of Birmingham**Publication Date** 31 May 2007**Target Audience** PCT CEs, SHA CEs, Care Trust CEs, Medical Directors, PCT PEC Chairs, NHS Trust Board Chairs, Directors of HR, Directors of Finance, GPs**Circulation List****Description** This document evaluates the NHS Institute's Care Closer to Home Programme, which ran from November 2005 to March 2007. It identifies the factors that helped or hindered progress in shifting care outside hospital, and the lessons for the NHS from the experience of field test sites**Cross Ref** Making the Shift: Key Success Factors**Superseded Docs****Action Required** N/A**Timing** N/A**Contact Details** Emma O'Donohue  
NHS Institute for Innovation and Improvement  
Coventry House  
University of Warwick Campus  
Coventry  
CV4 7AL  
02476 475813  
[www.institute.nhs.uk](http://www.institute.nhs.uk)**For Recipient's Use**

# Contents

Foreword	3
Executive Summary	4
Introduction	6
Findings	15
• The evidence base	15
• Creating the right context	16
• Managing projects well	18
• Engaging stakeholders and clinicians	23
• Overcoming barriers to change	27
• Measuring and monitoring progress	33
• Setting stretching but realistic timescales and ensuring sustainability and spread	36
Conclusions	38
References	42
Appendix	43



Bringing care closer to you

## Foreword

The White Paper, *Our Health, Our Care, Our Say* focuses on the importance of patients receiving care closer to home. Implementing this policy will now be increasingly at the heart of commissioning decisions, and clinical leaders will be concentrating on how to deliver effective care outside the acute setting in or near patients' homes.

This is a challenge faced by health systems around the globe. *"Health care systems have evolved around the concept of infectious disease, and they perform best when addressing patients' episodic and urgent concerns. However, the acute care paradigm is no longer adequate for the changing health problems in today's world. Both high and low-income countries spend billions of dollars on unnecessary hospital admissions, expensive technologies, and the collection of useless clinical information. As long as the acute care model dominates health care systems, health care expenditures will continue to escalate, but improvements in populations' health status will not."* (World Health Organization, *Innovative care for chronic conditions: building blocks for action: global report*. Geneva: WHO; 2002.)

This shift of care will be a significant challenge for local health communities. Clinicians and managers have seen the potential benefits of redesigned, community-based services for many years. In some cases these service developments were implemented; in many other cases, they were not. Over the last year the NHS Institute for Innovation and Improvement has worked with five field test sites across the country testing solutions for shifting care across a wide range of conditions, to answer the question how can care be shifted in practice, quickly and successfully? Tools and approaches to help the NHS deliver care outside hospital are now becoming available.

As the NHS Institute releases this evaluation report, commissioned from the Health Services Management Centre at the University of Birmingham, the message is clear, "get the basics right". By following the advice set out in this report to put in place the conditions that have to be met to enable these shifts in care and by using the tools and approaches we shall be offering, I believe NHS and social care organisations together can realise the "shifting care dividend" - the quality and financial benefits at the core of *Our Health, Our Care, Our Say*.



Bernard Crump  
Chief Executive, NHS Institute for Innovation and Improvement

# Executive Summary

The NHS Institute's Care Closer to Home Programme was established in 2005 to explore the scope for bringing about shifts in care within the NHS. Following an observation phase that ran from November 2005 to February 2006, the NHS Institute selected five healthcare communities to act as field test sites. In these five sites, 14 projects were identified to provide the focus for the programme. These projects received intensive support from management consultants, AT Kearney, and from staff of the NHS Institute during the test and learn phase that started in June 2006.

The Health Services Management Centre (HSMC) was chosen by the NHS Institute to evaluate the programme. The aim of the evaluation was to identify the factors that helped or hindered progress in making shifts in care, and the lessons for the NHS from the experience of the field test sites. A comparative design was used in the evaluation involving interviews with key stakeholders in each site, participation in and observation of meetings, and documentary analysis. HSMC was not asked to assess the extent to which shifts in care occurred, although its role did include helping the sites to develop quantitative indicators to enable them to monitor and report on changes that occurred as a result of the programme.

This report summarises the main findings of the evaluation and the lessons for the NHS. It notes that almost all the 14 projects have started to test the scope for making shifts in care, with some getting underway more quickly than others. To make the projects feasible within the timescale of the programme, their focus has been narrowed in most cases and consequently small numbers of patients have experienced the new services to date. Partly because of this, and also because it took some projects longer than expected to get going, we have not sought to quantify the extent to which shifts in care have occurred.

The factors affecting the ability to bring about shifts in care identified in this report are:

- receptive organisational and policy contexts in which shifts are attempted
- a clearly defined focus for projects with specified outcomes and success criteria
- organisational leadership and sponsorship of service improvement
- dedicated and competent project management capacity as part of a team with relevant skills
- analysis of appropriate stakeholders to involve in change initiatives
- engagement of and where appropriate leadership by clinicians
- action to overcome cultural barriers to change and improvement
- aligned incentives that demonstrate to clinicians and other stakeholders the benefits of participation
- training and support to develop skills and competencies among project staff and clinicians
- expertise in developing measures of progress towards objectives and analysing data
- sufficient time to make shifts, particularly during a period of organisational change
- arrangements for sustaining shifts and scaling them up, including developing business cases

Based on these findings, the report sets out the conditions that have to be met to enable shifts in care in programmes of this kind to occur. In line with previous research into service and quality improvement programmes, the report emphasises the need for the NHS to give priority to **'getting the basics right'**. Actions designed to achieve improvements need to be linked and implemented simultaneously if change programmes are to succeed. It is the interaction of the factors listed above over time that explains the extent to which improvement occurs, and we explore these interactions in more detail in our sister report on five of the projects that took part in the programme. In addition, a requirement that projects should demonstrate that they are 'acting on the evidence' of service and quality improvement should be built into future programmes.

In parallel with the work reported here, HSMC has reviewed the progress made in the programme in developing measures of progress and putting in place arrangements to collect information to assess the impact of the changes being made (Singh, 2007).

# Introduction

The White Paper, 'Our Health, Our Care, Our Say: a new direction for community services', sets out a vision for the future of primary care and community services. A key component of this vision is to provide care closer to home, shifting from a model of hospital-based services towards more proactive community-based approaches. The proposals set out in the White paper include:

- shifting care within particular specialties into community settings,
- allocating a larger share of the available resources to preventative, primary, community, and social care services,
- developing a new generation of community hospitals,
- reviewing service configuration to accelerate the development of services closer to home,
- refining tariffs to provide stronger incentives for practices and PCTs to develop more primary and community services, and
- offering information to the public about specialist services available in the community.

While these proposals may be widely supported, there are challenges in 'making the shift' on the ground.

Recognising these challenges, the NHS Institute for Innovation and Improvement established a programme of work in five healthcare communities (also known as field test sites) to explore the scope for bringing about shifts in care over a six month period. The NHS Institute's 'Making the Shift' programme aimed to identify learning to inform national as well as local developments by examining how shifts could be accelerated and the factors that helped and hindered change.

A major focal point in working with the field test sites is the management of long term conditions. This includes reviewing and fundamentally redesigning the process of support and care for those with long term conditions so that the system fits around the person, rather than the person fitting in with the system. At the outset, the NHS Institute identified a number of underpinning themes of the programme and these are summarised in Box 1.

The stated aims of the field test phase were to:

- make a sustainable shift from acute settings to community settings
- provide better outcomes for patients
- get best value from resources
- create system change faster and more effectively
- build positive and productive relationships between all the players in the health and social care system
- design the future system (commissioning arrangements, financial flows, etc) on the basis of what works and how to go about it.

## **Box 1: Underpinning themes**

### **a) Integration**

Creating effective, trusting relationships between the contributions to the health and social care system which result in seamless, integrated care; ensuring that choice and contestability are built on a platform of multi-disciplinary, multi-organisational working.

### **b) Substitution**

Providing more convenient and accessible care for patients by:

- Location Substitution: substituting high tech clinical environments for community based settings
- Skills Substitution: enhancing the skills of staff to undertake roles previously undertaken by those higher in the NHS skills escalator
- Technological Substitution: maximising the use of new technologies in maintaining the individuals independence
- Clinical Substitution: moving from a medical care model to self care being supported by a broader range of care providers.
- Organisational Substitution: looking at a wider range of providers to those who have traditionally delivered NHS care. In this area, we would be seeking substitution with both the commercial and voluntary sectors.

### **c) Segmentation**

Grouping patients and designing services around them in ways that enable everyone to get the service they need and choose and everyone to flow through the system at the rate they need to go

### **d) Simplification**

Counterbalancing the risk of creating extra structures and extra complexity between primary and secondary care; keeping the number of patient "handoffs" to a minimum and ensuring that every step in the care process adds value for patients.

Ensuring that new structures have been put in place where old ones have been removed.

The NHS Institute commissioned support from the management consultants, AT Kearney. A consultant from AT Kearney was assigned to each site and spent two to three days per week advising on the development of the projects, how progress would be reviewed, and project management arrangements.

One of the specific contributions of the consultants was to apply the 'gateway' process to assess whether projects were appropriately designed and resourced, and whether stakeholders were on board. Projects were expected to meet criteria used at different stages of the gateway process in order to proceed to the next stage. In the early phase of the Making the Shift programme, considerable effort was put into this process in order to ensure that the projects were in a position to deliver shifts in care in the timescale of the programme.

### **Success criteria**

The NHS Institute identified the following success criteria for the 'Making the Shift' programme at the outset:

**Completion** - all the major milestones and timescales are met and the programme is synchronised with the timescales of the specialty taskforces and the whole community pilots.

**Adoption** - there is evidence of widespread formal adoption of our approaches by health and social care communities and by commissioners.

**Spread** - commissioners and local communities have not just adopted our frameworks, but they have been implemented and institutionalised across a range of patient and disease groups and specialties. Metrics might include the proportion of patients who are receiving a redesigned service based on our high-impact solutions, and the proportion of specialty redesign projects that are based on our principles. Success will also be measured by the extent to which our principles have been adopted into 'mainstream' arrangements such as commissioning plans, service specifications and Foundation Trust Improvement plans.

**Impact** - the services that people receive following redesign are of better quality, more responsive and make better use of resources than either a) previous arrangements or b) services that were 'shifted' but without our evidence-based approaches.

**Learning** - we are able to distil high impact solutions from our field tests and reviews that go beyond 'success factors' to powerful practical steps that really make a difference.

## Selecting the sites

The NHS Institute wanted to include a range of areas in the programme, to encompass examples of organisations working across a whole health community, an approach based on health and social care integration, a practice based commissioning initiative, and an area in which there was involvement from third sector organisations.

The selection of sites took place during an 'observation phase' that ran from December 2005 to February 2006. In this phase, a scoping seminar was held, and the NHS Institute visited a number of areas that had come to its attention. There was also close liaison with policy leads in the Department of Health, especially in relation to the implications of the White Paper which was published towards the end of the observation phase.

Site selection was informed by the experience gained by the NHS Modernisation Agency in its work on service improvement and redesign. Of particular importance was the need to work with sites likely to be receptive to change because of a history of partnership working and a focus on service improvement.

The knowledge of the NHS Institute's team of the work that had been done in different areas played a part in the selection of sites, and helped in the decision to work with the following areas:

**Birmingham** – an example of working across a whole health community.

**Derbyshire** – an example of working with the third sector in an area with a track record of work on service improvement.

**Manchester** – an example of working between primary and secondary care with strong interest in practice based commissioning.

**Stour** – an example of an innovative GP practice that was interested in making the shift.

**Torbay** – an example of health and social care integration.

The NHS Institute acknowledged that the selection of sites had not been 'scientific' but in the context of the timescale of the programme it felt that an appropriate spread of areas and health care communities with a history of relevant work and experience had been identified for inclusion in the programme.

In each site, three projects were chosen for inclusion in the programme (two in the case of Stour). The key characteristics of the 14 projects are described in Table 1.

**Table 1: Projects participating in the 'Making the Shift' programme**

<b>Project</b>	<b>Planned outcomes</b>
<b>BIRMINGHAM</b>	
<b>Segmentation and substitution of skills:</b> promoting heart failure self management education for South Asians.	Increased number of people interested in participating in courses and attending and completing a course; increased confidence and satisfaction among participants.
<b>Integration, substitution of location and simplification:</b> providing a back pain clinic run by team including acute sector specialist in a primary care setting.	Reduced number of visits, referrals, and inter-referrals; decreased waiting times; increased service user satisfaction; more cost effective service.
<b>Integration, substitution of location and simplification:</b> raising awareness of primary care incontinence clinic for women.	Reduced inappropriate outpatient referrals; reduced time from symptoms to diagnosis; more cost effective service.
<b>DERBYSHIRE</b>	
<b>Substitution of location:</b> admissions avoidance education programme for people with COPD based on home visits.	Increased confidence and satisfaction; increased people receiving self management plans; reduced A&E admissions; cost effective.
<b>Substitution of skills and organisations:</b> using community paramedics on 999 calls to reduce admissions to hospital by referring to other services.	Reduction in A&E admissions; increased proportion of eligible people seen by community paramedic, referred to a community doctor, or using Red Cross services; more cost effective service.
<b>Substitution of location and simplification:</b> improving end of life care to reduce inappropriate admissions.	Increase people identified and dying in their place of choice; description of current management; cost effective service.

Project	Planned outcomes
<b>MANCHESTER</b>	
<b>Substitution of location and skills, and segmentation:</b> providing diabetes services in primary care rather than secondary care.	Reduced outpatient appointments for people with Type 2 diabetes; improved level of services offered by practices; increased service user satisfaction; more cost effective service.
<b>Simplification and substitution of location and skills:</b> improving referral pathways for infertility treatment.	Reduced waiting time; improved service user satisfaction.
<b>Simplification:</b> improving pathways for unscheduled care	Reduced admissions and waiting time; improved staff perceptions.
<b>STOUR</b>	
<b>Substitution and simplification:</b> self-monitoring of hypertension instead of appointments with a practice nurse.	Proportion of eligible people participating in self-monitoring project; reduced appointment waiting times; reduced number of clinic appointments; improved satisfaction with services.
<b>Integration:</b> supporting people at 'high risk' of admission, by working across agencies to 'flag' unplanned contacts to a practice-based liaison nurse	Reduced unplanned admissions, analysis of costs.
<b>TORBAY</b>	
<b>Substitution of location and skills:</b> initiating insulin in primary care rather than in secondary care.	Increased % practices initiating insulin; reduced referrals to initiate insulin; reduced hours spent by specialist nurses on insulin initiation; increased satisfaction among service users; costs.
<b>Substitution of location:</b> developing a decision making tool about feasibility of projects to shift diagnostics.	Model development and implementation.
<b>Segmentation and simplification:</b> communication plan aimed at practitioners to improve care for people at the end of life with any diagnosis	Number of practices implementing GSF; % dying in place of choice; proportion of unplanned admission dying within 48 hours of admission; increased satisfaction with services; cost effective service.

## The evaluation

The University of Birmingham's Health Services Management Centre (HSMC) was chosen by the NHS Institute to evaluate the programme. The evaluation was designed to identify the factors that helped or hindered progress in making the shift, and the lessons for the NHS from the experience of the field test sites. HSMC was not asked to assess the extent to which shifts in care occurred during the programme, but rather to draw on the perceptions and experiences of staff in the five health care communities to develop greater understanding of the challenges facing the NHS in implementing the vision set out in the White Paper and how these might be overcome.

Given the scope and timeframe of the Making the Shift programme, the HSMC team used a comparative design including:

- qualitative baseline and follow up interviews with key stakeholders in each health community,
- documentary analysis of project documents and other background materials
- helping the sites developing quantitative indicators of any changes in resource use, service use, and quality of life, to enable staff in each of the 14 projects to monitor and report on progress early in 2007.

To gather baseline information, the HSMC team participated in face to face interviews, telephone interviews, and discussion groups with representatives from the five health and social care communities.

A key aim of the interviews and discussion groups was to understand what roles, relationships, and contextual factors might explain whether shifts in care do or do not occur. Those involved in leading the projects in the programme were interviewed at the outset and, as far as possible and appropriate, at the mid point of the programme and again towards the end of the test phase to establish the extent of progress, perceived helpful and hindering factors, and examples of good practice.

Box 2 lists some of the key topics used in the initial interviews. Additional prompts and questions were also used as required. These topics were developed drawing on previous work on Making the Shift carried out by HSMC for the NHS Institute (Singh, 2006; Parker, 2006) and research on the factors that facilitate or hinder the implementation of quality improvement initiatives.

## Box 2: Key questions for initial interviews

- 1 The projects: what projects are being undertaken and what are their aims? How will they know if they have succeeded? What is the timescale for demonstrating success (e.g. how realistic is it to do so by the end of the year?)
- 2 The history and context of the making the shift work: is it new? Does it build on previous work? How 'receptive' is the context?
- 3 Project management arrangements: what are these arrangements and who is doing what for (1) the site as a whole, and (2) each of the three projects?
- 4 Clinical engagement and leadership: what is the extent of clinical engagement and leadership? Specifically, who are the named clinicians involved in the programme, and what is their role?
- 5 Resourcing: how is the programme funded and resourced (with staff and other resources as appropriate)? Has extra money been earmarked (if so how much and where has it come from?) Distinguish funds for project management and funds for the projects themselves.
- 6 Financial context: are the organisations involved in balance/deficit, and if the latter what is the extent of this?
- 7 Critical success factors: what do interviewees perceive to be the CSFs e.g. workforce development and training, 'trust' or lack of between primary and secondary care, timescales, resources, IT, etc?
- 8 Policy context: are current DH policies like PbR and PBC facilitating or hindering shifts of care?
- 9 The role of the NHS Institute: what has been the involvement of the NHS Institute? What has been positive/negative about the NHS Institute's involvement?
- 10 The role of AT Kearney: what has its involvement been? What has been positive/negative?
- 11 Other issues seen by interviewees as relevant to the evaluation.

Subsequent interviews focused particularly on the progress made by the projects and the factors that interviewees perceived had helped and hindered progress.

Over 60 people were interviewed as part of the evaluation, many on more than one occasion. The people who provided feedback included:

- Managers from NHS Trusts (including Foundation Trusts and Care Trusts)
- Project champions
- Clinical leads
- Project leads
- Project managers
- Frontline staff, including consultants, nurses, and GPs
- SHA staff
- NHS Institute staff
- Other stakeholders with a special interest in the projects, including the voluntary sector

Participants provided feedback on the understanding that comments would not be attributable to individuals, but would instead be used to help understand themes within and between local healthcare communities.

Service users were not interviewed, because the focus was on system or organisational factors that may help accelerate change. However, a number of the projects conducted surveys or discussion groups with users to help assess the performance of their projects and the impact on quality of life or service user's experiences.

HSMC prepared an interim report on the evaluation in September setting out descriptive information about the field test sites and the 14 projects. The interim report also identified emerging lessons from the first phase of the programme. These lessons were discussed with the NHS Institute and some of the staff in the sites, with a view to assisting those involved in the programme to benefit in real time from the work of the evaluation team.

This report builds on these emerging lessons to summarise the learning that has been gained during the period June-December 2006. Where possible the report not only identifies the factors that helped or hindered progress but also describes how the projects included in the programme overcame barriers and the practical strategies they used to bring about shifts.

In a separate report, HSMC has reviewed the status of each of the projects in relation to measurement of progress towards objectives and this aspect of the programme is therefore not covered in detail in this report (Singh, 2007).

# Findings

## The evidence base

As we noted in the introduction, the evaluation was informed by reviews of NHS experience (Parker, 2006) and of the research evidence (Singh, 2006). These reviews drew on a wide range of research on service and quality improvement programmes in health care organisations, as well as previous summaries of the evidence on the factors that help or hinder progress. For example, Shortell and colleagues (1998) reviewed 55 studies, mainly in the United States, and identified the importance of a receptive context for change, sustained leadership, training and support, measurement and data systems, and protection from over burdensome regulation.

Walston and Kimberley (1997) reviewed the literature on re-engineering in United States hospitals and summarised facilitators of change as:

- establishing and maintaining a consistent vision
- preparing and training for change
- planning smooth transitions in re-engineering efforts
- establishing multiple communication channels
- ensuring strong support and involvement
- creating mechanisms to measure progress
- establishing new authority relationships, and
- involving physicians.

These authors emphasised that ‘in an overall strategy for change these factors have to be linked and to be managed simultaneously’ (p.16).

Many of these facilitators have been found to be applicable to quality improvement programmes in the NHS (Ham et al, 2003). Research into these programmes has particularly emphasised the importance of project management and the time needed to bring about and sustain change:

*‘quality improvement often takes longer than expected to take hold and longer still to become widely and firmly established within an organisation’ (p.436).*

The same study highlighted the challenge of sustaining improvements, and emphasised:

*‘the need for the momentum that accompanies quality improvement initiatives to be maintained over time and for the pilot period to be long enough to overcome challenges and obstacles. Establishing long-term responsibility for quality programmes at the outset is therefore essential’ (p.436).*

Evidence from these studies and reviews underline the generic challenges in leading and managing change identified by Kotter (1996) in his seminal work in this area.

In our evaluation, we drew on the evidence base to gather data from the field test sites and the 14 projects, beginning with the context for change.

## Creating the right context

### *Receptiveness to change in the sites*

The sites in which there was a history of NHS organisations working together to bring about changes in line with the aims of the Making the Shift programme initially appeared to have an advantage in comparison with other sites. This is illustrated by the experience of Birmingham and Torbay.

In these two sites, the organisations involved had been collaborating for three years prior to the inception of the programme in adapting principles from Kaiser Permanente's integrated care approach. This included working with each other and with a third site (Northumbria) as part of a programme supported by the former Modernisation Agency. In both Birmingham and Torbay, the PCTs and Care Trust (in Torbay) had experience of working on projects linking primary and secondary care, and they were therefore able to build on this experience in seeking to bring about shifts in care.

The remaining three sites were also receptive to change (indeed, they were selected for the programme in part because of this), but other factors discussed below had an impact on the progress they achieved. This suggests that receptiveness to change at the site level is a necessary but not sufficient condition for service improvement. This assessment is reinforced by the observation that, as the programme evolved, Birmingham appeared to implement change more quickly than Torbay, underlining the fact that many factors apart from receptiveness to change help or hinder the implementation of programmes of this kind.

### *Receptiveness to change at the project level*

Our work suggests that projects have proceeded at different speeds even within sites that have been receptive to change. This observation draws attention to the importance of 'clinical microsystems' (Nelson et al, 2002) as the focus of change (or lack of it). In health care organisations, these microsystems (such as GP practices and clinical directorates) vary in their willingness and ability to implement new ways of working, and this underlines the importance of understanding the factors that help or hinder change at the project level.

Projects where there was a history of organisations and staff working together appeared much better placed than projects where these preconditions did not exist. Where there was a history of joint working, staff had developed relationships that enabled them to use the programme to take further and sometimes faster work that was already underway. Elsewhere, time had to be invested in establishing and negotiating these relationships, especially among clinical staff, before the work could proceed.

## Project Examples

The importance of receptiveness to change at the project level is illustrated by the contrasting experience of two of the Derbyshire projects. The first of these, on COPD, built on previous work that had explored the scope for reducing emergency admissions to hospital through developing specialist nursing services in the community. Established relationships between the staff involved facilitated the implementation of this project and enabled it to proceed in line with plans.

The second project, on unscheduled care, required different agencies to come together to agree the focus on the work without the benefit of previous joint working. The NHS organisations involved did not always see eye to eye on the project and there were challenges in securing agreement among these organisations on the priorities for improving unscheduled care and the involvement of the third sector. As a consequence, implementation occurred more slowly than in the COPD project.

## *The policy context*

The policy context also had an influence on the programme but varying and sometimes conflicting views were expressed about whether it supported or hindered change. The policy context was taken to include key elements in the health reform programme such as patient choice, care closer to home, and changes to the flow of funds around the NHS.

In broad terms, 'Our Health, Our Care, Our Say' was seen as supportive, as was the priority attached to improving care for people with long term conditions. Other relevant policies identified were practice based commissioning and payment by results. Conflicting views were voiced about practice based commissioning, with a majority of interviewees seeing it as supportive of the programme, while others expressed concerns that it might hinder change.

The concerns centred on the embryonic state of practice based commissioning which was recognised as creating uncertainty, especially in relation to the involvement of GPs. Disagreement between practices and PCTs over the approach taken to practice based commissioning was seen as hindering its potential to drive shifts in care. A related concern was the need to secure the support of practice based commissioners to the continuation and extension of projects which had been initiated by PCTs and hospital staff.

In some projects, relationships between practices was also identified as a risk, particularly where these relationships might not be sufficiently strong to support collaborative involvement in practice based commissioning. At the same time, the potential of practice based commissioning to bring together primary and secondary care clinicians to discuss service redesign was seen by some as an opportunity.

Payment by results was acknowledged as offering opportunities (to move money away from acute hospitals) and threats (if it led to acute hospitals being reluctant to support shifts of patients and resources into the community). The decision to reduce the tariff for emergency admissions was reported to be an obstacle to shifts occurring in so far as it attenuated the incentive to avoid admissions. Projects in which hospital staff led shifts in care may be affected in future if they result in a loss of income for NHS Trusts. A related threat is the likelihood that practices may take on some of the work previously done by hospitals leaving the latter with a more complex and appropriate case mix that is not adequately funded under the tariff.

Sites with a history of partnership working were explicit about these opportunities and threats and recognised the need to avoid policies with potentially adverse effects getting in the way of the work they were doing. Despite this, disputes over contracts and the funding of contracts in some areas put real pressure on the commitment of NHS organisations to work together to bring about shifts in care.

## **Managing projects well**

### *Project focus*

A major priority in the projects in the initial stages of the programme was to agree the focus of their work. The short timescale of the programme and the expectation that some results would be demonstrated by the end of 2006 resulted in most projects narrowing their focus e.g. around specific groups of patients, localities or partner organisations.

The gateway process overseen by AT Kearney contributed to the narrowing of focus, and meant a scaling back on the plans and ambitions envisaged at the outset. The sites valued the discipline of the process even though it was challenging to the staff involved. Staff reported that they would have welcomed more information about the gateway process and its requirements at an earlier stage of the programme. There was also a suggestion that another stage or hurdle should be built into the process at the outset to test thoroughly the readiness of projects before they proceed.

## Project Examples

Work on project focus had a significant impact in some sites. In Torbay, a project focused on diagnostics and unscheduled care went through a number of changes in emphasis. Initially the plan was to provide GPs with direct access to diagnostic tests in a wide range of specialities. Given feasibility issues and the desire to show measurable changes within a short timeframe, this scope was narrowed to focus on three diagnostic areas.

In the event, only one of these areas was scoped fully as part of the gateway process. This led the Torbay team to decide that it would not be feasible to set up and assess direct access to diagnostic services within the project timeframe. The project team finally decided to focus on producing a modelling tool that would help organisations consider all the factors needed to make decisions about whether projects would be feasible in future.

The Manchester gynaecology project went through a similar process. Originally, the focus of this project was to transfer activity from the Early Pregnancy Unit in St Mary's hospital to primary care, providing a GP led service at various community locations. In exploring the model it became apparent that there would be difficulties in recruiting sonographers for a multi-location service and that the actual need for service change had not been fully identified and agreed between GPs and hospital clinicians. Working through suggested areas for change identified a need for a redesign of the infertility care pathway to shift some hospital activity into primary care and this became the focus of the final project.

Projects in which there had been previous work and which were working in a receptive context spent less time discussing their focus and were better able to begin the process of making shifts in care. An example was the clinical team delivering Birmingham's back pain service at Heart of England NHS Foundation Trust which had already spent time developing and agreeing a new community service model. The programme provided them with the support to test that service model and undertake evaluation against agreed outcomes. The same applied to the end of life projects in Derbyshire and Torbay.

### *Project sponsorship and leadership*

In the main, chief executives lent their support and endorsement to the projects at one step removed, for example by chairing meetings associated with the programme, and signalling that work on Making the Shift was a corporate priority. Where there was a history of organisations working together in the sites, this was often the result of chief executive leadership and the creation of a strategic framework conducive to the aims of the Making the Shift programme.

A good example is the Working Together for Health programme in Birmingham that had been established as part of the adaptation of the Kaiser Permanente integrated care model. Working Together for Health served as an umbrella for the work on making the shift, illustrating how chief executives exerted influence by creating a receptive context for change. In Birmingham, one of the PCT chief executives regularly reviewed and commented on progress reports, and intervened as necessary to overcome barriers to change, and her commitment contributed to the progress made in that site.

Some sites and projects took steps to ensure that their work was communicated to NHS boards to share the learning gained.

### Project Example

Birmingham East and North PCT used its projects to capture learning for the whole organisation as well as individual service areas. The Programme Manager submits a monthly report to the PCT Board with a view to developing organisational learning in this area. The report provides feedback on each project and identifies any issues and barriers that hinder project progress, using a red, amber and green light system. It is felt that this process has increased the level of ownership at a senior level for each project but also provided some leadership in delivering timely solutions that can be fed into existing and future projects. This has included challenging the Annual Leave culture to ensure continuing responsibility for patient care and developing Human Resource policies to create greater flexibility within the workforce. Organisational learning is then communicated throughout the PCT via the intranet and staff newsletters.

### *Project management*

The existence of adequate time and resource for project management had a critical bearing on progress. In many cases, the sites experienced difficulties in identifying the necessary time and resource. Project managers were therefore expected to take on the work involved in the programme in addition to existing responsibilities. It also meant that responsibility for project management shifted between individuals in some projects.

Where this happened, there was a risk that progress would be slower compared with projects where dedicated project management capacity was allocated and maintained throughout the programme. Project managers with previous experience of managing change programmes appeared to have an advantage over those without this experience. *While enthusiasm for a project was helpful in enabling progress to be made, even more important was clear competency in project management, and hence the need for project managers to be selected on the basis of competency.*

## Project Example

Birmingham is an example of a site that benefited from effective project management. The Making the Shift projects in Birmingham are part of a broader work programme comprising 10 initiatives overseen by a dedicated project manager. The project management capacity available in this site may be one of the reasons why projects appear to be progressing well.

Birmingham East and North PCT has developed a sustainable model for ensuring strong project management and leadership that has demonstrated success in delivering change. Each project has an identified project lead, clinical or non-clinical. This lead is supported by a project facilitator – a PCT manager with project management skills that adds management capacity to the team and is responsible for co-ordinating the various work streams. The leads and facilitators are supported by a Programme Manager who provides the interface between the organisation and the projects. The role has also been seen as one that 'monitors, mentors and motivates' supporting leads in overcoming project barriers by liaising with senior managers from all organisations. This role has been identified as having a significant impact on the success of the current projects.

Another example is the end of life project in Derbyshire. This project benefited from a history of work on end of life care but in the early stages appeared vulnerable to the absence of dedicated project management. The critical factor in enabling the project to make progress was the ability to identify an experienced manager able to provide leadership of the work and to accelerate the work that had been started on end of life care.

In a number of other projects, the absence of spare management capacity and the expectation that staff would find time for project management alongside their other responsibilities was a hindrance to progress. This was a particular challenge in the Stour site where resources to support the programme were in short supply. In a programme working to a tight timescale (see below), this affected what could be achieved within the framework of the Making the Shift programme.

The intensive support provided by consultants from AT Kearney and staff of the NHS Institute went some way to filling gaps in project management in some sites. This support was generally welcomed and seen as positive by NHS participants in the programme. There were, however, questions about the impact of withdrawing this support at the end of the test and learn phase, even though there was recognition that projects should not become dependent on external input.

Some of those interviewed during the evaluation felt that the resources used to pay for this intensive support might have been better used by the sites themselves directly employing additional project management capacity.

## *Project teams*

Linked to the issue of project management is the composition of project teams and decision making authority within teams. Effective team working was facilitated by the presence of relevant stakeholders and skills and by regular communication between team members. In many cases, communication took the form of email and telephone contact rather than meetings, because of the difficulty of bringing team members together in the timescale of the programme. In Birmingham, it was reported that the contribution made by independent facilitators was helpful in keeping projects on track, and ensuring effective communication.

Progress was sometimes hindered where teams lacked specific skills e.g. in finance when they were engaged in the development of business cases to support their work. Changes to the composition of teams helped in overcoming these barriers.

### **Project Example**

Towards the beginning of the Manchester Urgent Care project the team was experiencing difficulty managing the timescales to gain inter-departmental and inter-agency agreements due to organisational processes and structures. The group membership was reviewed and identified a gap in key decision makers. As a result a PCT Director joined the project team and when required was able to accelerate the decision making process both within the PCT and with stakeholder organisations.

The end of life project in Derbyshire illustrates the value of having project teams with complementary skills. In this project, the leadership provided by a public health consultant allied with an experienced project manager and an analyst able to audit current practice and gather prospective data on the care of patients at the end of life were key factors in enabling progress to be made during the programme.

## Engaging stakeholders and clinicians

### *Stakeholder analysis*

A critical aspect of managing projects well is analysis of the appropriate stakeholders to involve in change initiatives.

One of the factors that impacted on stakeholder analysis was the complexity of relationships in terms of the change being made. This was seen in the Stour site where the hypertension project was established more quickly than the vulnerable patients' project because the former was under the control of the practice whereas the latter required starting from scratch with partner organisations. The vulnerable patients' project illustrates the challenges involved in securing stakeholder engagement:

#### Project Example

The Vulnerable Patients (VP) project highlighted the importance of *getting the right people around the table at the right time*.

This project was designed to extend an existing initiative, in which a 'liaison nurse' was employed by the practice to coordinate community-based care for individuals identified as being 'vulnerable', and thus to reduce their risk of unnecessarily attending, or being admitted to, hospital. The practice wanted to increase the impact of this initiative by involving the other organisations with which such patients may come in contact. Specifically, they wanted to establish patient-held management plans for all individuals on the VP list, and a system whereby the liaison nurse would be alerted if a VP had an unplanned contact with any other agency.

The project team attempted early on to identify the full range of organisations that may be involved, but did not undertake a really detailed analysis of exactly who from each organisation they needed to involve, why, and at what point. The local PCT, Social Services department, NHS Foundation Trust, Mental Health Trust and Ambulance Service were all therefore invited to send a representative to the project launch event. However, while all agencies sent delegates and expressed enthusiasm for the project, their ongoing engagement proved difficult to sustain. Exacerbated by absences during the summer holiday period, this situation meant that little progress was made for several months.

The 'breakthrough' or 'turnaround' came following a meeting in September attended by a new representative from the Ambulance Service. This individual had experience of working on similar projects in other areas, was able to discuss the practical implications of what the group was trying to achieve, and was in a position within the organisation to authorise changes. By the end of this meeting the group had a much clearer sense of the steps that had to be taken to put their plans into action. Thus, *"finding the right people who could change things" was critical: "... it became exciting at that point"*.

Similar learning about stakeholder engagement emerged in one of the Birmingham projects:

### Project Example

The Birmingham Heart Failure project demonstrates the value of a comprehensive stakeholder analysis on commencing a project. The project, targeting the South Asian population, had been established for a few weeks before community workers were engaged in the project. Their involvement challenged a number of assumptions the initial team had made that were hindering the success of the project:

- Identifying that not all South Asians speak Urdu and therefore the literature translated into Urdu would not be appropriate for everyone.
- That many first generation South Asians have a good command of the English language.
- First generation South Asians are not familiar, or comfortable, with a self-help model of care. As such educational programmes focused on self care would not be appealing. That sector of the population engages more readily with a medical model of care. Any marketing activities should include 'tests' such as cholesterol and glucose checks as this helps the population to engage with healthcare workers.
- Whilst Friday prayers at the local mosques are an effective way of reaching the population, the elder generation also attend every afternoon providing more opportunities for engagement.

The inclusion of the community workers in the project group helped to bring a greater degree of focus to the project, distinguishing between the characteristics of the different ethnic communities and added to the learning of the organisation about how to engage effectively with the population.

Undertaking a detailed stakeholder analysis at the beginning of projects may be helpful, but it is equally important to acknowledge that not every individual or organisation needs to be involved in planning discussions (although a good communication strategy to keep all stakeholders informed is beneficial). Targeting change champions or people who can really make a difference within organisations may help to accelerate implementation.

### *Clinical engagement and leadership*

The effective engagement of clinicians and the identification of clinicians to work with project managers in leading the process of shifting care contributed significantly to the programme in a number of areas. Clinical engagement and leadership were seen as important not least because of the need to embed new patterns of service provision and provide continuity in order to counter the potentially adverse effects of organisational change on the positions of project leaders and managers.

The sites took different approaches in this respect, with some identifying clinicians to take on project leadership roles and others seeking to engage clinical staff at different stages of the work. There were challenges for the clinicians concerned in balancing clinical commitments with involvement in the programme, not least in attending meetings called at short notice. GP involvement was particularly challenging, especially in respect of GPs who do not already have leadership roles and in the face of competing demands such as practice based commissioning.

Two projects found that an audit of care was useful as a way of engaging clinicians in service improvement. In Manchester, an audit of gynaecology care within general practice demonstrated a discrepancy between what GPs said they were doing and what was actually done. This raised awareness and interest among GPs in developing new pathways of care. Similarly, in Derbyshire, an audit of deaths in hospital at the end of life was useful in illustrating the scope for care to be provided in alternative settings in line with patient preferences.

Taking time to involve clinicians is essential, as the experience of Torbay shows:

### Project Example

Torbay has a joint health and social care trust, with good relationships with hospital providers. As part of the Making the Shift programme, Torbay developed a project to help primary care practices initiate insulin, rather than referring insulin initiation to hospital-based consultants or specialist nurses. A key challenge was involving practitioners in project development and implementation.

To address clinical engagement, the project team in Torbay:

- invited hospital consultants, specialist nurses, and practice teams to scoping days to plan the project from the outset,
- worked closely with specialist nurses to design and implement every stage of the project,
- communicated regularly with GPs, including at 'clinician to clinician' groups set up to help share information and perspectives between clinicians from different sectors and disciplines,
- visited GPs personally to provide updates and gain feedback at times that fitted around primary care schedules,
- targeted practices for specific support rather than working with everyone,
- provided financial incentives to the acute sector to give specialist nurses time to work with primary care,
- considered how practice-based commissioning and local extended services agreements could be used as levers,
- held an evaluation event about three months after project initiation to which all key stakeholders were invited.

The project aimed to start recruiting primary care practices to insulin initiation education programmes over the summer period, but found this difficult as many GPs are away on holiday or providing holiday cover at this time. A learning point was to time implementation carefully to account for holiday periods.

Clinical engagement in Derbyshire was most developed in the end of life and COPD projects. In both projects, clinical engagement was facilitated by work that had been undertaken before the inception of the programme and the fact that improving care in these areas of service provision was a priority for a number of the practices involved. Nurses played an important part in both projects, especially in the work on COPD which has been led by specialist nurses working with the project lead. In other projects, clinical leadership was provided by allied health professionals such as physiotherapists.

## Overcoming barriers to change

### *Cultural change*

Cultural differences between primary and secondary care may be a significant barrier to service improvement with professional attitudes and behaviours slowing the pace of change. In order to be successful, the Making the Shift projects often had to invest time in developing relationships between primary and secondary care clinicians, through meetings or facilitated redesign events. This included recognising the value of shadowing key roles to overcome cultural barriers and develop better understanding of respective roles and relationships.

#### Project Example

The Birmingham Back Pain project attributes some of its success to the dialogue between the Consultant and GPwSI and general practice. The two project clinicians spent time visiting and discussing the proposed new service, referral process and expected outcomes with GP colleagues to raise levels of awareness, gain clinical engagement with the change process and develop confidence in the new service. The benefits of this are beginning to be seen in the number of referrals from GPs to the new service rather than into secondary care. Instead of moving existing services into the community, the project has resulted in an entirely new service developing with a different use of staff and resources.

The project lead for the Manchester Diabetes project identified a knowledge gap in terms of the existing patient pathway and the role of the Diabetes Centre. To fill this gap he arranged to shadow the Consultant and Specialist Nurse at the Diabetes Centre. This involved sitting in on consultations during clinics and observing the range of activities within the Centre. This enabled him to increase his knowledge of the pathway and of the skills and services provided by the Centre. Outcomes of this exercise included the development of professional relationships between him and the hospital clinicians, a greater understanding of the context within which the project was operating and a challenge to some of the assumptions he had about the diabetes service.

In the Derbyshire project on unscheduled care, cultural change was an issue in relation to ambulance staff. The focus of this project was helping patients to remain at home through the use of emergency care practitioners, community paramedics and the Red Cross. Although the ambulance service itself was supportive of the project, in the early stages there was a perception that ambulance crews were concerned at the risks they were being asked to take in not transferring patients to hospital, and there was therefore limited uptake of the new approach. The wider issue here is the willingness of specialist staff to work with non-specialists (in the case of Derbyshire, the third sector), and the perceived threat to jobs that is associated with new ways of working.

One of the lessons from Stour was the importance of inter-professional communication in the vulnerable patients' project:

### Project Example

Effective communication is critical when roles and responsibilities are shifting between different organisations and professional groups.

Stour's VP project involved the practice team producing patient-held management plans, which were to be flagged to and reviewed by paramedics and A&E clinicians if the patient contacted the ambulance service or attended the hospital in an emergency. The intention was that these plans would help the paramedics and hospital staff to interpret the patients' needs, and identify whether an agreed care plan was already in place to address them. It was hoped that this would reduce the likelihood of individuals being conveyed or admitted to hospital simply due to a lack of information about their condition and existing packages of care.

The system for 'flagging' patients with a management plan was agreed and implemented relatively quickly. However, the project team encountered problems when it came to using the plans themselves. It quickly became clear that the different professional groups had different expectations of what a 'management plan' would include, and different information requirements. As a result, the first time a patient within the project cohort called for an ambulance, the management plan was not used, the patient was taken to hospital and a number of investigations were carried out which, according to the plan, were unnecessary.

In retrospect, project group members recognised that representatives from all of the relevant professionals needed to be involved not just in agreeing a template for the plans, but in actually discussing the type of information to be included under various headings, and how it should be written and presented. It was also observed that communication about the existence and status of the management plans to all staff within the ambulance service and Foundation Trust was necessary, as an individual clinician being presented with a plan with no prior knowledge of who had authorised it would probably not use it.

In Torbay, the end of life project overcame barriers to change by seeking to make 'the right thing the easiest thing to do'. Actions in this project included providing training to practices, ensuring that different staff and agencies could readily identify patients who were on the gold standards framework, providing opportunities for practice managers to share what was working, and sharing successes quickly with case studies and carer stories.

### *Aligning incentives*

Creating the right incentives to encourage shifts in care appears to be a key success factor. The Making the Shift programme found that, particularly in general practice, it is clear that participants need to be able to see ‘what is in it for them’ if they are going to engage in a new initiative. There has to be a business rationale as well as benefits for service users. The potential of practice-based commissioning to provide those incentives is recognised, but this is underdeveloped in many areas.

The following example illustrates how these issues have been addressed in Manchester:

#### **Project Example**

Manchester PCT and its Practice-Based Commissioning Board has used the GMS contract to embed new service changes for diabetes into general practice. The project team adopted a ladder model to determine the level of care provided by general practice and the acute trust. New levels of care provided by general practice were agreed by the Commissioning Board and will be funded through the PBC DES as a one off payment. The outcomes of this work include the ability to immediately discharge approximately 7% of patients from the hospital's Diabetes Centre back to primary care, reducing significant outpatient activity and extending care across the PCT to include insulin initiation. This equates to a shift of PbR resources of approximately £175k per annum.

Non-financial incentives are also important, particularly where clinicians can see that they will benefit from new ways of working.

The following example from Birmingham illustrates this.

### Project Example

The Birmingham Integrated Continence project has developed a new community based service for women between 40 and 70 years of age delivered by an integrated multi-disciplinary team. The new service aims to reduce referrals to gynaecologists and urologists by redirecting them more appropriately to extended nursing and physiotherapy practitioners. It also aims to prevent the need for secondary care services later in life by ensuring earlier intervention through a simpler care pathway and targeting women who have not yet accessed services through mail shots and other advertising such as posters in local pharmacies. The pilot project involved 4 practice populations (14 GPs) and within the first three weeks had 81 referrals with fully booked clinics.

Modelling of the new service and early projections from the pilot service suggest that there will be benefits to the PCT in terms of reduced inappropriate secondary care activity (100-200 per year) but more significantly a reduction in the need for continence products used by this group, a long term saving estimated at £21k per annum just for the pilot practices. The DNA rate at the new clinics were about 3% compared to the national average of 13%. Benefits to the secondary care urology service are seen as a reduction in the inappropriate activity but more significantly an increase in appropriate activity due to identifying and treating current unmet need.

### *Training and support*

Reviews of UK and international literature and overviews of past NHS experience suggest that training to support staff in new roles is a significant enabler for service change.

Increasing competencies rather than assuming proficiency is essential for sustainable change. This applies to project management skills and information management expertise. Past reviews have identified concerns about the extent of these skills in the management workforce, including the need to develop skills within primary care to manage a successful pace of change. Organisations need to see this training as an important element of workforce development plans and further investment in education and training may be a high priority.

Training and support was also an issue in relation to clinical staff and the development of new skills. This is illustrated by the following example from Torbay:

### Project Example

One project in Torbay focused on encouraging initiation of insulin in primary care. Rather than merely issuing guidelines or protocols, the project involved a detailed programme of training for primary care staff.

Specialist nurses spent time with individual practices assessing their needs and examining their records to help select people who might be eligible for insulin initiation. Primary care practitioners completed self assessment audits and took part in training sessions to help them identify appropriate people and upskill themselves for insulin maintenance. An important component was knowing that specialist staff were on hand after the training to provide ongoing support and share the management of service users.

The team in Torbay are now considering insulin initiation training as part of a local extended services agreement.

The Birmingham Back Pain project threw up similar learning:

### Project Example

The Birmingham Back Pain project established an integrated multi-disciplinary team to deliver a new service within a community setting. A process of after action review by all team members after each clinic helped to refine clinic activity to ensure maximum effectiveness and patient satisfaction. This review included monitoring the time patients spent waiting to see clinicians during each visit, the length of time with each clinician and the range of clinical interventions required. As a result of this process, the team were able to identify the range of clinical skills required and the maximum number of patients that could be seen efficiently within each clinic. The review identified that 60% of patients required input from the psychologist, a much higher number than anticipated and that the level of care did not require consultant input as planned. As such the team agreed to increase the psychology input and adjust the skill mix of the team to release Consultant resource back to secondary care.

In one of the Stour projects, the need for training and support for patients emerged as an important lesson.

### Project Example

One of the issues raised by the Stour hypertension project is that, where 'shift' depends on greater service user involvement, education and support for those service users may be required.

This was anticipated by the practice when first planning the project, and the nursing team had therefore spent time early on revising and expanding their patient information leaflets. They also intended to refocus their consultations so that more time would be spent addressing healthy lifestyle issues, and developing the confidence of patients to self-monitor and self-care.

While this approach has obviously worked for some patients, the team found that a higher proportion than expected (c.50%) were either not able to, or did not want to, monitor their own blood pressure. The practice had not been able to undertake a patient survey within the timescales of the project, so did not have any detailed or systematic feedback on why this was. However, from their conversations with these patients, the nurses observed that the 'less receptive' group tended to consist of older people who had become accustomed to attending the practice for check-ups, perhaps over a long period of time, and who did not now want to take on the responsibility of self-monitoring.

The team has concluded that it would therefore be helpful to identify and target more specific groups of patients for self-care initiatives in future, particularly when introducing a new approach for the first time.

All project teams were offered external support from NHS Institute staff, management consultants from AT Kearney, and the University of Birmingham Health Services Management Centre. This took the form of group meetings and one to one support. While no formal 'training' sessions took place, the support offered did aim to share knowledge and increase competencies.

The contributions particularly valued from external sources involved:

- helping to scope projects in terms of clarifying their focus and objectives,
- process mapping to help identify areas where care pathways and administrative protocols could be simplified,
- support to develop realistic targets and ways to measure whether these targets were met,
- structured project management protocols, including 'gateway processes' that projects had to be assessed against at different stages,
- and economic modelling, to help assess the resource impacts of shifts in care.

Other change initiatives may also benefit from training and support in these areas.

This is not to suggest that external support is necessary to implement change. Indeed, a number of stakeholders suggested that it was the extra capacity that external personnel provided that was most helpful because project managers had limited time to spend developing and implementing their initiatives. However it does suggest the need to invest training time in these topics.

In some projects, it was reported that the support provided by AT Kearney would have been more valuable if it had been provided at the time when it was most needed. Given that projects developed at different speeds, depending on their history and readiness to implement change, a more flexible approach to the use of consultancy expertise might have made a bigger impact.

## Measuring and monitoring progress

### *The challenge of measurement and data analysis*

A major challenge for the Making the Shift projects was identifying how they would know whether they had shifted care into the community. Most projects had about three months worth of 'testing time' before they started reporting back to the NHS Institute about outcomes.

The three key issues that emerged were:

- Some areas found it difficult to develop ways to measure their success because they had not fully defined the scope of their projects (examples included the diagnostics project in Torbay, the unscheduled care project in Derbyshire and the vulnerable patients' project in Stour)
- Some project teams said they had insufficient experience to consider the range of measurement strategies possible, including knowledge of existing datasets or expertise to develop questionnaires (examples included the heart failure project in Birmingham, the gynaecology project in Manchester and the diabetes project in Torbay)
- And some projects felt that they had inadequate capacity to process or analyse any data emerging from their projects

Box 3 lists some of the principles that projects found useful when addressing these potential barriers.

Three questions were important in developing an appropriate set of measurements:

- 1 What will the project achieve? (especially any numerical targets)
- 2 What is the situation now? (baseline data, sources, and person responsible for compiling)
- 3 How will we know we've made a difference? (follow up sources, comparators, and person responsible)

Although every project was different, there were three key areas that were important to measure in most of the projects: changes in service use / resource use (such as emergency admission rates); financial changes / cost-benefit analyses; and service users' experience and satisfaction. Future change projects may wish to consider these as core variables and work on identifying appropriate local measures.

### **Box 3: Principles to help with metrics**

- 1 Focus on simple methods that will not take too much time to collect or analyse.
- 2 Focus on 3-5 key indicators per project, rather than long lists of potential metrics.
- 3 Focus on routinely collected data where possible, rather than developing new datasets.
- 4 There must be some comparator in order to demonstrate shift (either before and after or comparison sites).
- 5 Every stated project objective must have an associated measure.
- 6 Involve information analysts and other appropriate staff from the project outset.
- 7 Set realistic timeframes for collating data and assign people to have a specific responsibility for this.
- 8 Finding out what does not work is as important as whether or not there is a measurable change.
- 9 Some measures need to be ongoing to provide scope for examining change over time.
- 10 It is possible to draw in external support to assist with measurement and metrics, or to provide training for managers and frontline staff.

A significant concern for many of the project teams was insufficient capacity to collate and analyse data. Project teams suggested that it is difficult for them to identify a data analyst or safeguard analyst time to collate routinely available data. It is also difficult to gain administrative support for computerising data from questionnaires, and some project teams say they do not have the expertise to analyse or interpret any data made available to them.

While some projects are finding funding for additional administrative support, this does not address concerns about analytical capacity. The projects found that two strategies worked well to alleviate some of these concerns. Firstly, simplifying the number of potential measures and highlighting the relationship between project teams' stated outcomes and indicators seemed to work well. An example was the Manchester diabetes project that narrowed its goals and decided to focus as far as possible on using existing data to monitor progress. Showing a definite link between what staff want to achieve and how to measure it or show that the objectives have been achieved served to demystify the process for some project teams.

Another successful strategy involved inviting those staff responsible for data collection and collation to meetings. When PCT, primary care practice, or secondary care data analysts attended meetings to discuss the project scope and potential data sources, these analysts went away with a greater knowledge of and enthusiasm for projects; project leads tended to feel more confident that their data needs could be met; and the project teams learnt about what data was readily accessible from colleagues. This was the approach taken in the Birmingham projects.

Overall, the key learning points from helping projects develop metrics were:

- Enough time needs to be allocated to consider metrics – and this needs to be planned into all projects.
- It is essential to involve analysts and see people who hold information as key stakeholders in projects.
- External support can be valuable as this is an area where NHS teams have highlighted a lack of experience.
- Where projects have common themes, providing examples of indicators can speed the process.
- It is important to be realistic about what can be achieved within short timeframes.
- Further simple training may help NHS personnel feel more comfortable planning and using data.

## **Setting stretching but realistic timescales and ensuring sustainability and spread**

### *The timescale of the programme*

The six month timescale of the programme posed a significant challenge for all concerned. With the expectation that some shifts in care should be demonstrated by the end of 2006, most sites gave priority to projects that were already underway, as well as to narrowing the focus of projects to make implementation feasible within this timescale. The discipline of the gateway process delayed the start of many of the projects, although it was recognised that there were benefits from going through this process.

In a number of cases, delay resulted from the need to clarify how progress would be measured and the implications for data collection. In some cases, it was reported that stricter adherence to the gateway process (i.e. not allowing projects to proceed unless they had fulfilled the requirements) might have been beneficial in the longer run. The inception of the programme shortly before the commencement of summer holidays affected the momentum of the projects and resulted in some slippage.

Having made these points, participants in the programme recognised that there was value in having a tight timescale to work to and that this had provided a discipline that might otherwise have been lacking. In the case of projects where the context for change was receptive, it was possible in this timescale to introduce new services and to begin to see the effects on patients, albeit for small numbers of patients in the first instance. Other projects used the first six months of the programme to plan and prepare new services with a view to seeing the effects thereafter. Where projects entailed changes in clinical practice e.g. referrals by GPs, it was recognised that these changes took time to plan and implement, and could not be rushed.

Because of this, the NHS Institute asked the projects to gather information on the impact of their interventions during the first quarter of 2007 in order to quantify whether shifts in care were occurring and the extent of these shifts.

### *Scaling up the work and ensuring sustainability*

Across the programme as a whole, most projects are not as far ahead as they expected to be at the outset. This is largely because of the work that has been needed to refine the focus of the projects, determine how progress will be measured and data for this purpose collected, and agree arrangements for project management and clinical engagement and leadership.

One of the consequences of the narrowing of focus is the challenge of 'scaling up' the work in those projects able to demonstrate benefits from the shifts that are taking place. Towards the end of the test phase, the projects turned their attention to developing business cases to support the continuation and extension of their work, with encouragement and support from the NHS Institute and AT Kearney.

The financial pressures facing the NHS created challenges in this regard, as did the small scale of many of the projects and the limited number of patients experiencing the new services being offered. In some cases, too, project staff lacked the expertise to prepare business cases.

In parallel, the projects face the challenge of sustaining change and improvement beyond the test phase. From the end of December, much of the support provided externally (by AT Kearney, HSMC and the NHS Institute) has been withdrawn and the projects are expected to use their own resources to build on progress already made. With uncertainty as to the future of some project staff, the ongoing effects of organisational change in the NHS (see below), and the removal of the 'Hawthorne effect' associated with programmes of this kind, it remains to be seen whether the momentum that has been generated can be sustained.

### *The impact of organisational change*

Organisational change has impacted on some sites more than others. Both Stour and Torbay were relatively unaffected (the former because it was focused on a GP practice and the latter because it was focused on a Care Trust not caught up in PCT restructuring) compared with Birmingham, Derbyshire and Manchester. The latter three sites all experienced major changes in PCT configurations and leadership, with the effect being felt most strongly in Manchester. Birmingham was better placed to handle these uncertainties than Derbyshire and Manchester because senior staff involved in the programme were less distracted by the process of organisational change than staff in other areas.

# Conclusions

## Service delivery context

The NHS Institute selected five healthcare communities as case studies of service delivery models, including integrated health and social care, practice-based commissioning, and the extent of change that can be achieved by a single primary care practice.

Experience in the field sites suggests that much can be achieved using an integrated whole health system approach. There has been a great deal of joint working across primary and secondary care and preliminary indications suggest that it may be possible to reach larger numbers of service users this way compared to more localised or single organisation approaches.

There was no evidence that using a whole system approach slowed down the pace of improvement because of the need to negotiate change among partner organisations. While stakeholder involvement is time consuming and requires sufficient capacity, even the most localised projects need to involve a variety of different stakeholders and so this is not dependent upon the service delivery model used.

One of the field sites involved an integrated health and social care organisation. In practice, the specific projects undertaken in this area did not explore whether different types of shifts in care are possible in this service delivery framework, and therefore it is not possible to comment on the strengths and weaknesses of achieving shifts in this type of organisational context.

Another topic of exploration involved the contribution of services from non-NHS providers. One site was selected because of the opportunity to involve the third sector as a core service provider. The learning from this site included the ability of the third sector organisation concerned to respond quickly to the needs of statutory agencies, but also the need to explain the role of the third sector to different stakeholders and to secure their commitment to working with new providers.

The field sites also explored what can be achieved when change is driven from practice-based commissioning. The developing nature of practice-based commissioning means it is too early to draw conclusions about what works best in this regard. It is uncertain whether specific areas of service provision such as outpatient services may be more amenable to change under practice-based commissioning.

The importance of identifying key levers and incentives and of involving clinicians in management and decision-making roles was highlighted, as well the challenge for GPs and other clinicians of finding the time to play a major part in service improvement programmes. Practice-based commissioning has the potential to bring about shifts in care if this challenge can be addressed.

Other projects examined the role of a single primary care practice in shifting care into the community. The evidence from this study suggests that single practices can help facilitate change and act as a driver for other organisations. Single practices can also shift the level and scope of care they provide. However, alone, single practices may not have the capacity or control to accelerate change. Under practice-based commissioning, conglomerates of practices are likely to have more power to accelerate change, provided that they can agree on local priorities for service improvement.

### *Specific lessons*

Regardless of the service delivery context, there are some specific lessons to be drawn from the programme.

In the introduction to our findings, we referred to the work of Walston and Kimberley and their conclusion, based on a review of the literature, that a number of facilitators of change have to be linked and managed simultaneously. Our own study confirms the importance of this observation and suggests that, in seeking to bring about shifts in care, projects are more likely to succeed if they attend to the following factors:

- working in contexts that are receptive to change because of a history of relevant activity, particularly in relation to the project or projects that are the focus of the change being pursued
- ensuring that these projects have dedicated and competent project managers with sufficient time to give to the project and working in teams that have the appropriate mix of skills e.g. administrative, analytical, financial, and decision making skills
- agreeing the focus of projects to ensure that they can be delivered within the resources and time available
- undertaking a stakeholder analysis to identify the organisations and individuals able to influence implementation, and agreeing how to engage with these stakeholders and overcome potential resistance
- identifying clinicians to be engaged in the work and to provide project leadership where appropriate and agreeing how to involve clinicians whose support is needed to enable progress to be made (including the incentives that may be needed to achieve this)
- deciding how progress towards objectives will be measured and the data and sources of data that will be used to monitor and report progress, including clarifying how gaps in data will be filled e.g. through patient surveys
- putting in place training and support programmes to facilitate change and to develop skills and competencies among project staff and clinical staff, and to address cultural barriers to change

- agreeing a stretching but realistic timescale for implementation, recognising the need to sustain as well as initiate change
- recognising the need to scale up and 'industrialise' change beyond the scope of pilot projects, for example by developing business cases to make the case for change and by identifying the resources needed to move beyond small scale interventions.

Alongside these facilitators, our study has highlighted barriers to change and factors to be avoided, including:

- avoiding the implementation of programmes such as this at times of major organisational change and disruption
- allowing insufficient time for the planning as well as implementation of new models of service provision
- recognising the difficulties in making service improvements in projects with no history of joint working.

In addition, our work strongly supports the argument that it is the interaction of different factors over time that explains the degree of progress made in improvement programmes. In a sister report, we explore this in more detail by focusing on five of the projects that took part in the programme.

In making these points, we would emphasise that a key requirement in programmes of this kind is **'getting the basics right'**. As many of those we interviewed emphasised, bringing about improvement in the NHS requires dogged attention to the essentials of project and change management. These essentials are often well known to NHS staff and yet there is a gap in practice between knowing what to do and actually doing it. A systematic investment in training and development to strengthen skills in project and change management (including skills in the use and analysis of quantitative data) would enable future improvement programmes to move further and faster in improving performance.

#### *How this study relates to existing knowledge*

Our evaluation has reinforced the conclusions of previous studies of the impact of quality improvement programmes and especially the finding that bringing about change in health care organisations is inherently difficult and often takes longer than expected (McNulty and Ferlie, 2002; Ham et al, 2003). In this context, it is important to acknowledge the work of Ferlie and Shortell (2003) and their analysis of the issues involved in quality improvement in the UK and the US. Ferlie and Shortell argue that there are four levels of change for improving quality: the individual, the group or team, the organisation, and the larger system. These authors conclude that:

*'While it is possible to achieve a small, limited impact by focusing on only one of the four levels of change, we believe that the greatest and longest-lasting impact will be achieved by considering all four levels simultaneously' (p.288).*

The Making the Shift programme concentrated on bringing about quality improvement at the level of individuals and teams, and in only one site (Birmingham) was there a systematic effort to link the programme to the organisation as a whole (pp.15-16 above). This suggests that more work needs to be done to connect change and improvement in microsystems to organisations and the larger system in which they function.

In view of this, it may be premature after only six months to attempt to assess the achievements of the programme in relation to the success criteria set out by the NHS Institute (see p.5 above). The test and learn phase of the Making the Shift programme has been completed and considerable learning has been gained in the process. At the time of writing, there is no evidence of adoption or spread, and data on impact are still being gathered and analysed by the projects and sites.

In the light of the above assessment, one final point to emphasise is the need for future programmes of this kind to draw explicitly and systematically on the evidence base on service and quality improvement in health care organisations. The paradox of the Making the Shift programme is that the NHS Institute did make use of the extensive experience of its staff in developing the programme, and also commissioned HSMC to undertake reviews of the evidence and of NHS experience (Parker, 2006; Singh, 2006).

Despite this, in the test and learn phase, there was limited evidence that projects were using the evidence base, with the consequences for implementation summarised in this report. Building in a requirement for projects to demonstrate that they are 'acting on the evidence' should be at the heart of future programmes such as this. The first stage of the gateway process (see p.14 above) should be used to test whether projects have drawn systematically on the research evidence before they are allowed to proceed.

## References

C Ham et al (2003) *Redesigning work processes in health care: lessons from the national health service*, The Milbank Quarterly, 81 (3), 415-39.

H Parker (2006), *Making the Shift: A Review of NHS Experience*, HSMC and the NHS Institute.

D Singh (2006), *Making the Shift: Key Success Factors*, HSMC and NHS Institute.

D Singh (2007) *Making the Shift: Interim Metrics Update*, HSMC.

J Kotter (1996), *Leading Change*, Harvard University Press, Boston.

S Walston and J Kimberley (1997), *Reengineering Hospitals: Experience and Analysis from the Field*, Hospital and Health Services Administration, 42 (2): 143-63.

S Shortell, C Bennett and G Byck (1998) *Assessing the Impact of Continuous Quality Improvement on Clinical Practice: what it will take to accelerate progress*, Milbank Quarterly, 76 (4): 593-624.

E Nelson et al (2002) *Microsystems in Health Care, Part 1: Learning from High-Performing Front-Line Clinical Units*, Journal on Quality Improvement 28 (9): 472-93

E Ferlie and S Shortell (2003) *Improving the Quality of Health Care in the United Kingdom and the United States: a framework for change*, Milbank Quarterly 79 (2): 281-315.

# Appendix

## **Challenges for healthcare commissioners and providers A response from the NHS Institute for Innovation and Improvement**

When we established the NHS Institute programme on the theme of shifting care from hospital to community settings, we commissioned HSMC Birmingham University to undertake rapid reviews. One was a review of the NHS experience of 'Making the Shift' and the other was a review of best practice in shifting care. The findings of both reviews supported the view that whilst national policy to shift care away from a hospital setting was not new, and whilst many projects had been initiated to shift care, there was little evidence of systematic and sustained shifts taking place. The application of this policy was patchy and peripheral to most commissioner and provider activities. We looked to respond to the challenge. How can care be delivered outside hospital? How could this be done in an exemplary fashion at an accelerated pace?

The programme worked with fifteen projects across five sites. Of these, twelve have been implemented as planned, two have been revised and "taken up a level" to deliver larger scale, more strategic objectives and one has failed to proceed. Even the one that failed was stopped following assessment at a formal review, introduced as part of the structured process for delivery of projects, rather than being allowed to proceed without clear direction and with little chance of success.

So, we know it can be done. There are two major implications. The first is that projects need managing. As the main body of the report confirms, both commissioners and providers need to address deficiencies in both capacity and capability to deliver change. If this is addressed and matched with a systematic, robust approach to delivery then the likelihood of success is increased dramatically. Getting the basics right requires focus and investment. Secondly, shifting care closer to home has to be seen as a strategic endeavour. There has to be an alignment between corporate/community goals to shift care, the selection of the specific opportunities that are most likely to deliver the 'shift dividend' and the actual projects.

We should take the opportunity here to draw attention to the whole issue of 'data'. If data is seen as a key component for commissioning more effectively, then commissioners should review their current capacity and capability in this particular area. All field sites encountered difficulties with data, from being clear what data was required, data quality, availability, determining who was responsible for doing what around data, to the ability to analyse and interpret effectively. This was a major inhibition not only to progress in delivering projects but also to the selection of the projects which would give the greater dividend in terms of service improvement and shifting care.

Shifting care cannot be seen as a panacea. The question of what could and should be shifted can be addressed at two levels. The first level is in relation to systemic change. That is where health communities have the greatest potential for shifting care on a large scale. Greater effectiveness in selection of the areas offering the greatest return is fundamental in delivering care outside hospital. Again the work with the field sites suggests that such a systematic approach is typically not consistently nor comprehensively undertaken. Resources and energy are not necessarily being invested in the areas which will give the greatest 'shift dividend'. A case for change should always be undertaken before embarking on a programme of activity to shift care between settings. We need to assess the health benefits, resource implications and the impact of reallocation of activity and funding between organisations.

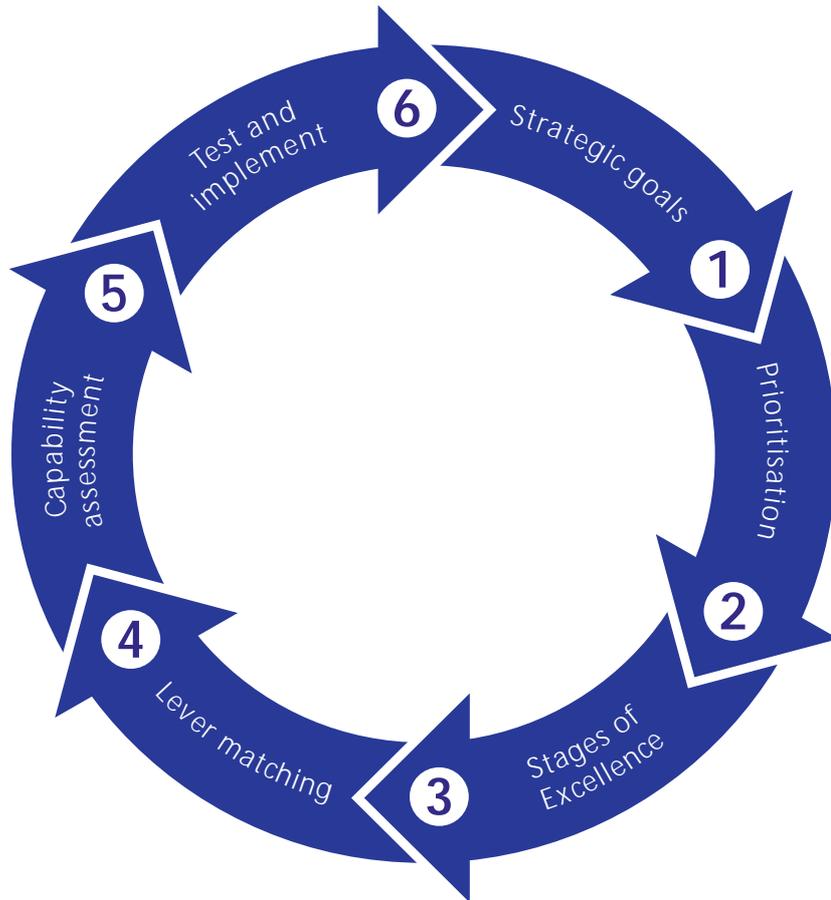
The second level is at project level. We need to identify which areas within the large scale shift programme will contribute to the bigger changes envisaged. The appreciation of clear decision making processes at this stage significantly improves the likelihood of successful implementation. This vision and challenge at the initiation phase of any project is absolutely critical but not universally applied.

Emerging from the theme of selecting the right areas on which to work, is the major challenge presented to both commissioners and providers, of ensuring large scale systemic change is delivered. Tremendous energy, commitment and ability can be expended to deliver projects in an exemplary fashion at pace. But unless they contribute to the larger systemic change identified in the case for change, the evidence is that impact, wider adoption and sustainability will be severely impaired. The challenge is to not only 'scale up' but to 'think big' from the beginning.

Healthcare reform is providing opportunities to manage services in a new way to deliver care closer to home. However, many of these processes are still formative and PCTs will need to consider how to turn this into a coherent process for delivering shift. Strategic management processes are needed, through which a PCT can define the appropriate goals, the right areas to shift, the right levers to use, develop capabilities and implement effectively. A potential approach to delivering this is shown in the figure and described below.

- 1 Strategic goals:** Analysis of existing data will enable the right goals for shift to be set. Data to be analysed should include local prevalence, cross-referenced with the conditions on which most resources are used.
- 2 Prioritisation:** Data analysis should drill down into the processes and patient pathways for each condition with potential for shift. It will then be possible to analyse activities in each condition's pathway, to identify where in the pathway the resources are used, and to what extent part or all of the pathway could be shifted. It is important that PCTs identify the areas for shift which will yield the greatest shift dividend, in terms of positive impact on patient experience and outcomes and finances. This process allows those areas with the greatest importance and potential for shift to be prioritised.
- 3 Stages of excellence in shifting care:** PCTs should compare their current pathways with best practice. This should be carried out in a structured manner, and an effective mechanism to do this is a Stages of Excellence approach, which the NHS Institute aims to develop at the next stage of this programme. Such a model will define levels of competence for those activities that support the shift of care closer to home. Assessing current activities within the PCT using a Stages of Excellence model will allow the identification of specific developments that could achieve shift. This would highlight areas for improvement and models of shift that are relevant.
- 4 Lever matching:** We would encourage PCTs to take a broad view in designing their solutions and consider all levers available to implement change. Levers for change could include training, incentives (including pay for performance), learning networks or formal plans. A lever matching approach is recommended, where a broad range of alternatives for redesign are considered and the relevance of each shift lever determined.
- 5 Capability assessment:** There is a need to consider whether the capabilities for implementing change are available and, if not, how any skills deficits will be addressed.
- 6 Test and implement:** Delivery of the solution should be managed by the PCT using a systematic, programme management approach. Those involved in delivering shift will need support in defining projects adequately, planning them and managing their implementation. The methods developed during the programme of field testing are an effective way of doing this.

## The Improvement Approach



## **1 Strategic goals**

- What are the improvement and change objectives in financial terms, quality of care, patient preferences, market development?
- Are these objectives shared across the PCT?

## **2 Prioritisation**

- What are the comparative performance measures for 'shift-able' treatment areas?
- What are the criteria for shifting care?
- What are the priority opportunities for this shift?
- Where should we target for improvement (Community/GPs/Acutes)?

## **3 Stages of Excellence in shifting care**

- What are the barriers which are stopping this shift?
  - information management
  - clinical practice
  - facilities
  - relationships

## **4 Lever matching**

- What combination of levers and incentive systems should we use to deliver the shift?
  - training
  - pay for performance and other financial incentives
  - learning networks, guidelines etc.
  - LDPs etc.

## **5 Capability assessment**

- What are the capability gaps constraining improvement and change and how do we plan to meet them?
  - relationships
  - governance
  - leadership
  - stakeholders
  - resources
  - change project management

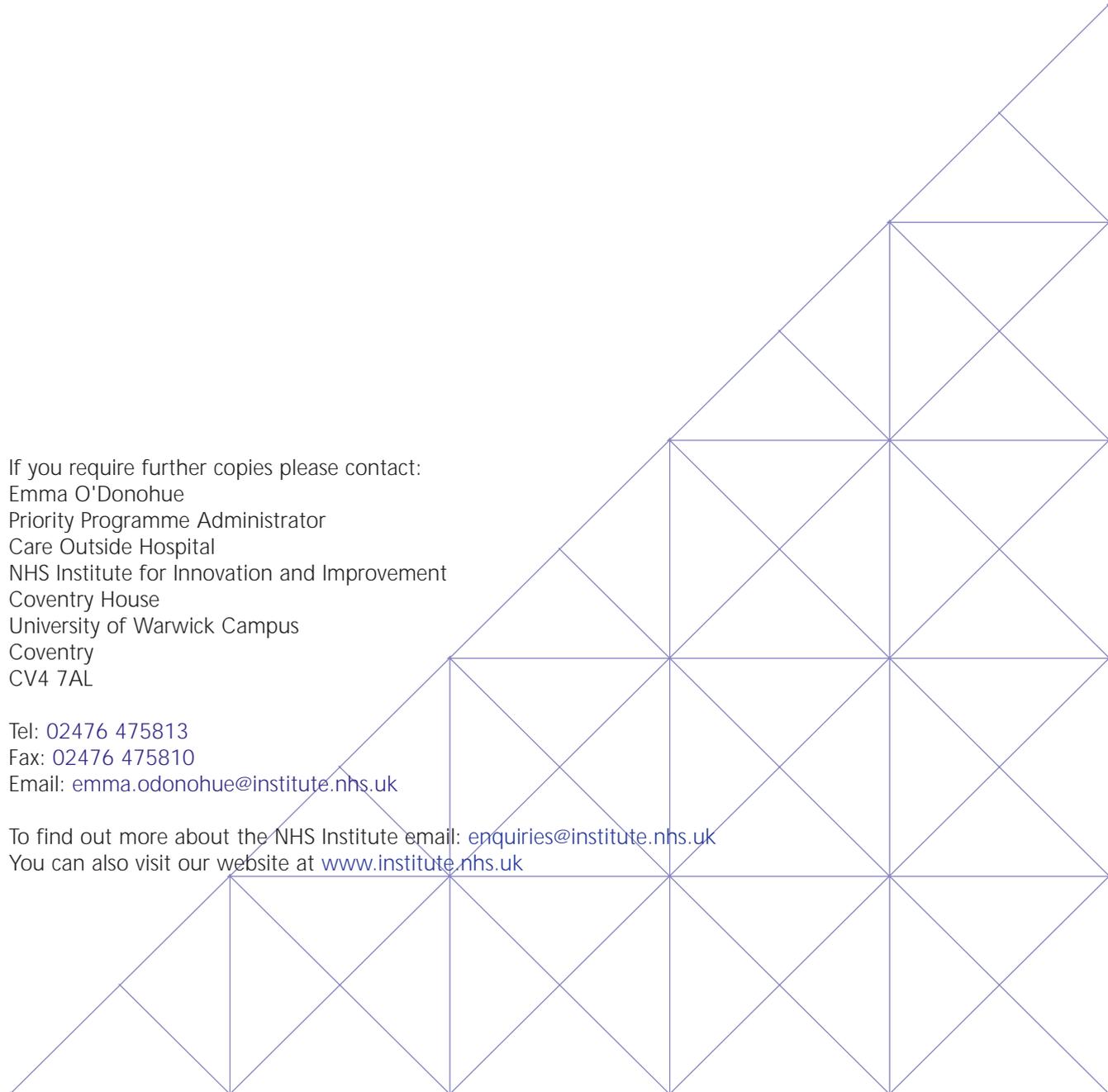
## **6 Test and implement**

- What interventions should the PCT make to drive improvement and realise benefits?
- Are goals achieved?

Following the learning of the field testing phase, the focus of the NHS Institute programme now needs to change. We need to find the best way to support PCTs in developing the strategic management processes that will deliver shifts in care. The analytical processes which will support PCTs with their strategic management of shift need to be developed and tested. We need to take up the challenge laid down by the Health Services Management Centre and 'get the basics' right. We need to embody the significant evidence base for service improvement in our work to create the quality care, closer to home, that our patients deserve.

# Notes





If you require further copies please contact:  
Emma O'Donohue  
Priority Programme Administrator  
Care Outside Hospital  
NHS Institute for Innovation and Improvement  
Coventry House  
University of Warwick Campus  
Coventry  
CV4 7AL

Tel: 02476 475813  
Fax: 02476 475810  
Email: [emma.odonohue@institute.nhs.uk](mailto:emma.odonohue@institute.nhs.uk)

To find out more about the NHS Institute email: [enquiries@institute.nhs.uk](mailto:enquiries@institute.nhs.uk)  
You can also visit our website at [www.institute.nhs.uk](http://www.institute.nhs.uk)