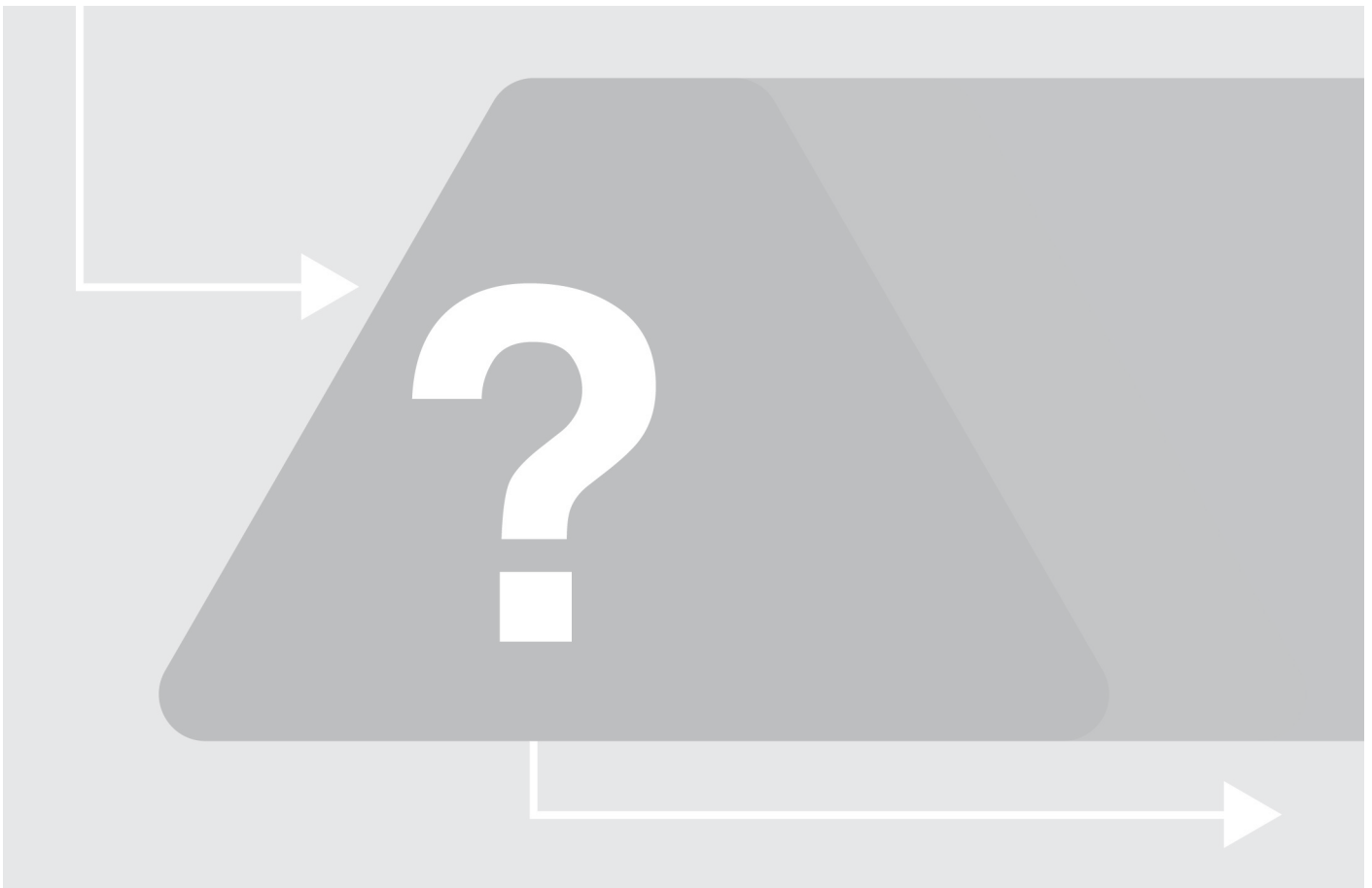# Transformational change in NHS providers

About this report

This report was written by the McKinsey Hospital Institute

www.mckinseyhospitalinstitute.co.uk

MHI

The report was produced as part of the Health Foundation's work on the process of change and, in particular, to support the development of the report *Constructive comfort: accelerating change in the NHS*.

For more details of this work, see www.health.org.uk/acceleratingchange

Acknowledgements

Contents

Summary

The NHS provides some of the best health care in the world. But continuing to do so, and improving care where there are shortcomings, will not be easy in the years ahead. Funding is likely to continue to be constrained, which means NHS providers will have to provide care much more efficiently. Many are already trying to increase quality and productivity through new models of care, different ways of working, use of technology and greater involvement of patients. But the next wave of transformations needs to be different: ambitious on another scale, delivering a step change in productivity while maintaining a focus on improving consistency and quality, as well as 'retooling' leadership.

This report is mainly a 'chief executive view' of how to do that. The content is based on interviews with provider chief executives, chairs, medical directors and other executives leading transformations. Our scope includes acute hospitals, community and mental health care services, but not primary care. Our focus is mainly on the acute sector. This is much less an academic view of transformation than the views of people who lead transformation in practice.

We heard and observed common themes and, from these, drew out **success factors for provider transformation.**[*] A combination of committed and courageous leadership, workforce engagement and motivation, accountability, insights from data, capabilities and resources are all important for an ambitious transformation programme to succeed. In addition, being part of a collaborative and supportive health and social care system is a significant enabling factor for impact.

Doing all of this well is difficult. The NHS workforce is highly educated and 'professionalised' but many members become disillusioned over time, and the incentives which are commonly used in other sectors to drive ambitious change programmes are largely absent. Organisational structures are often unclear and lead to a 'fudging' of accountability. Initiative fatigue, politically-driven demands and day-to-day operational pressures get in the way. There is a wealth of data, but a lack of insightful analysis and relatively few people with strong improvement and change management skills. As the financial pressure increases, protecting the investment in transformation resources becomes ever harder. Incentives – and payment systems – are aligned with individual organisations rather than whole health economies, deterring collaboration to solve shared problems.

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[*] Developed in conjunction with broader Health Foundation work on change – see the report *Constructive comfort: accelerating change in the NHS*, www.health.org.uk/acceleratingchange

Leaders grappling with external pressures and the challenges of running their organisations said that 'the system' – commissioners and regulators, politicians and policy makers, educators and professional bodies – sometimes helps but more often hinders their efforts. Providers want more support from the system to change the background conditions for transformation. And they want greater emphasis on realistic time frames rather than short-term targets and quick fixes. As regional tiers – such as strategic health authorities – have been removed, some leaders of provider organisations have been left feeling that they are fighting too many battles on their own. Many would welcome system infrastructure and support to help solve common problems and learn from one another, including for instance the development of an NHS-wide 'operating model' which would define some common standards of care, rather than focusing on staffing levels. Some of this already happens, through Monitor, the NHS Trust Development Authority (TDA) and central bodies such as NHS Improving Quality, but there is a widely held view that this could be done much more effectively and in a more coordinated way.

Perhaps the simplest request we heard was for more positive and balanced rhetoric; for criticism, where it is due, to be specific and targeted, and for greater appreciation of the many thousands of clinicians and managers working hard in demanding environments. Knocking the NHS has become something of a national sport, and it hardly helps to build people's confidence so that they set high aspirations and take on the difficult challenge of leading transformational change. In future, the narrative will also need to engage us as citizens, in terms of our expectations of the NHS, as well as our own health and wellbeing and how that changes during the course of our lives.

The scale of the challenge implies a need to shift style and emphasis, and to lead differently. Transformational change places huge demands on leaders, particularly chief executives. They must inspire sceptical workforces, be highly visible in their organisations yet also manage external stakeholders. They must be approachable and empathetic, and maintain their own energy and sense of optimism. And through it all, they need to deliver against a demanding set of performance targets which leave very little room for manoeuvre. This requires not only a diverse set of capabilities, but also boldness to take risks.

Does the system nurture and support this kind of leader? We heard several say that their job is a 'thankless task'. Does the system back courageous behaviour? We heard more often that the context is one of fear, which we know is unlikely to be the starting point for people to fulfil their leadership potential. As the challenges increase, in order for capable leaders to be willing to take on the top jobs and then be bold and effective in them, it would help if the system were less directive and short-termist, and more supportive of ambitious change, encouraging creativity in tackling a tough set of problems.

As the stakes rise, this may be the moment to gamble on the next generation of leaders so that they do indeed feel lucky, and therefore willing to invest years of their lives to reshaping the organisations they lead and the way in which care is delivered to patients. This will require the system to share more of the risk, enabling providers to deliver the future outlined in *The NHS five year forward view.* There is no guarantee of success, but if we can help leaders to raise their aspirations in terms of what they are willing to take on, and change the odds of NHS organisations being successful in their transformations, then there is a much greater chance that in years to come, we will have a high quality and affordable health and social care model that we can be proud of.

Introduction

Imagine you are a talented and experienced manager applying for your first position as a hospital chief executive. It's an exciting moment, and daunting. As you weigh up the opportunity, some questions run through your mind:

– **What is the size and nature of the challenge I'm taking on?** The trust is forecasting a £10m deficit this year and the outlook is even worse next year. A&E is struggling, staff turnover and sickness is higher than the national average and the most recent Care Quality Commission (CQC) visit raised significant concerns.

– **Is the organisation viable in the long term?** The trust is a district general hospital serving a population of around 400,000 – smaller than ideal. It could vertically integrate primary and acute care or become part of an emergency care network with other local acute trusts. However, if that leads to 'downgrading' the A&E, there would be an outcry locally.

– **What will it take to transform the hospital? And how long would that take?** Initial priorities will be A&E and the short-term financial position. Being sustainable in the long term will mean more radical changes, which will only be possible if clinicians are on board; in fact, with clinicians visibly leading the plans. Many may already be disillusioned. So it's going to be difficult, and will take time – five years perhaps? Given so few chief executives stay at one place that long, the odds of seeing that through must be low.

– **How is the system-level context likely to affect the trust?** The *NHS five year forward view* (Forward View)[1] suggests changes that would help, like funding for transformation and changes to the tariff for smaller hospitals. But will this really happen and will it be material given the squeeze on public sector spending?

– **Will the system help me succeed personally?** CQC inspections will give me a mandate for change, and Monitor ought to give me the support to see the operational turnaround through. I could also do with a seasoned chief executive as a mentor or perhaps a coach, and I'll need support to reshape the board and my own team.

Your answers may well boil down to a version of Dirty Harry's question: 'Do I feel lucky?'

As we have interviewed the people leading transformations in NHS provider organisations, and weighed their views against our own experiences of supporting transformations in the NHS and internationally, we have found that

the odds of successful transformation are not good. This is not just because most major change programmes still fail, but also because the challenges and pressures facing NHS providers are increasing. At the same time, the average tenure of a chief executive is shorter than the length of time it takes to bring about transformational change in a hospital. Such change takes time because it requires a fundamental shift in mindsets, behaviour and culture as well as changes in processes and structures. Habits are hard to change. So a rational person may well walk away from the opportunity to lead an NHS provider.

This may sound unduly pessimistic, but the top roles in providers – especially acute hospitals – are becoming hard to fill, just when fresh thinking and energy are needed to bring innovative ideas to solve perennial problems.

What will it take to change the odds, to get the talent pipeline flowing and make the transformational changes needed to ensure the NHS adapts to, and thrives in, a new reality?

Our approach

The primary source for this report is an extensive set of interviews with NHS provider chairs, chief executives, medical directors, nursing directors and transformation leads, as well as leaders in national agencies and regulatory bodies, and experts on transformation in health care. It is predominantly a board-level perspective of transformation. We also looked at performance data and a selection of relevant literature.

Our scope included acute trusts, community health care services and mental health services.[*] We focused our research on providers in England, but have also drawn perspectives from beyond the UK. We particularly looked at 'whole-organisation transformations', not just transformations of individual services within providers.

Drawing on this range of sources, we have identified a set of insights on what works in provider transformation, why it's so difficult, and how 'the system' could help providers to succeed. We don't believe we have found all the answers, and there were challenges that we were only able to overcome to a certain extent. For instance:

– Context matters, so the recipe for success in one place might not apply elsewhere.

– Any transformation involves multiple initiatives which are implemented over a long time frame and against a backdrop of changing demand and expectation. This makes it difficult to understand cause and effect.

– 'Provider improvement' is a big topic about which much has already been written. Our aim is not to say everything there is to say, but to draw on the experiences of people at the front line of NHS change in a way that will provide fresh and relevant insights for other providers and for system organisations.

In the following sections of this report we set out why successful provider transformation is so important, discuss seven success factors for transformation, consider what works to establish these factors in practice and conclude with how the system can help providers increase their chances of successfully making transformational change.

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[*] We did not include primary care because it is organised so differently that it would have required a different methodology to investigate.

Why provider transformation matters

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What is transformation?
Transformation describes radical change from which there is no going back

Transformation is becoming an overused term, but the leaders we spoke to found it a useful way to describe change that goes beyond day-to-day service improvements. We have therefore stuck with the terminology of transformation, with the following definition:

– Transformation is a deliberate, planned process that sets out a high aspiration to make dramatic and irreversible changes to how care is delivered, what staff do (and how they behave) and the role of patients, that results in substantial, measurable improvement in outcomes, patient and staff satisfaction and financial sustainability.

Transformation is a dynamic process, with distinct phases

Transforming a large provider with a workforce of thousands takes years. The leaders we interviewed spoke of time frames of between two and 10 years for a whole-organisation transformation. The challenges of transformation evolve as a programme progresses. For instance, at the launch of a transformation the priority is successfully communicating a vision for the future that resonates with staff, building a shared awareness of the need to change and motivating people to invest their own energy in the change process.

After this comes the work of agreeing and designing programmes of work which will often involve coordinating hundreds of staff members to plan change in their areas of work. As initiatives move into implementation, the challenges become more to do with maintaining energy and focus, overcoming barriers and making sure that the benefits envisaged are actually realised. Each stage requires different skills and management emphasis.

The role of 'the system' in transformation

Providers operate within the context of a 'system', not just their local health and social care system but also nationally. By 'the system' we mean, for example, the Department of Health; regulators such as the CQC, Monitor, the TDA and NICE; commissioners such as NHS England and clinical commissioning groups (CCGs); social care commissioners and providers; patient representatives; and, of course, patients themselves, their families and the wider public.

These organisations influence providers through multiple levers. For example, by mandating standards and assessing performance; through financial incentives such as tariffs, and non-financial incentives such as awards; by supplying a professionally-educated workforce; through conversations between regulators and leaders; and the tone and content of speeches and press briefings. These levers can be used to apply pressure to organisations or to encourage and help them.

Chief executives and other board members recognise the effects of the system on their transformation efforts. They generally described feeling as if they are battling to keep the system at bay, rather than being supported and enabled by it. As the system has tried to drive improvement, clinically and financially, over recent years, the emphasis has tended to be on assessing performance and directing change through mandated standards and practices. Incentives have often been in the form of threats for failure, such as a loss of autonomy or a change of leadership. As we set out in section 5, there is a case for the emphasis to be different.

Why is transformation important?

To the public, providers – acute and otherwise – **are** the NHS. They spend more than 80% of the NHS budget and they employ the million or so doctors, nurses and other health care professionals who have the 400m contacts with patients every year and which constitute the nation's NHS-provided health care.

The Forward View emphasised how much the NHS is going to need to change over the coming years to meet the demands of a growing, ageing, sicker population whose expectations continue to rise through a period of continued financial austerity. While quality and access have improved, some indicators show the NHS lagging behind on clinical outcomes[2] and quality is inconsistent both between and within providers.[3] Rising demand and public funding constraints mean that the health service is facing a funding gap of £30bn in 2020/21.[1]

This means that in the coming years, providers across the country need to undergo transformational change. In other words, they need to find fundamentally different ways of delivering care to be much more effective and this, in turn, will require new capabilities as well as new processes. As the Forward View outlined, this is likely to involve new models of care as well as material productivity improvements. And though system attention is often focused on the trusts that are in the greatest trouble, the current predicament means that all providers will need to play a part.

With transformation as the means to such an ambitious end, it's critical that these programmes are successful – yet across industries, transformation is notoriously difficult. A great advantage that the NHS has is the opportunity to learn from within the system, as well as from other health systems. With many hospitals already several years into transformation programmes, there are plenty of examples to study to build up an evidence base of what works. When do transformations succeed, and why? What are the factors both within organisations and external to them, the conditions and incentives which enable success? These are the questions we set out to answer in this report.

Seven success factors for provider transformation

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To understand what makes transformations successful we primarily investigated providers themselves, but we also considered their context and particularly invited reflections from interviewees on what, at a system level, helped or hindered transformation efforts.

Success factors for provider transformation

Overwhelmingly, we heard that transformation is difficult. In our interviews we also identified a consistent set of characteristics that transformation leaders saw as critical to success. These crystallised into the seven 'success factors' set out below, provider-specific instances of success factors identified in broader Health Foundation work (see Constructive comfort: accelerating change in the NHS, www.health.org.uk/acceleratingchange).

This is not a simple recipe for success, and the relationships between the factors are not well understood. Their relative importance varies depending on context, as does the way each is achieved. What we can say is that strong performance against these factors is important to both the extent and the pace of improvement that can be achieved. This is the case whether transformations are focused on finance, quality or culture. The factors are:

1. **committed and courageous leaders** who set out a clear vision and inspire staff to work towards it

2. a **motivated workforce** that responds to the vision and 'opts in' by committing to improvement activities

3. clear **accountability** for performance and **effective management structures** to implement change

4. **insights from data analysis** that enable a fact-based understanding of problems, inform decision making and track performance

5. **capabilities** to identify the root causes of problems, plan and prioritise how to solve them and manage implementation in a structured way

6. **funding** for staff to 'do the work' of transformation and for improvements necessary to the transformation itself

7. being part of a **collaborative and supportive local health and social care system**, increasing the impact that a transformation will have.

Factors 1 and 2 provide the initial energy and impetus for transformation, as well as maintaining momentum over time.

Factors 3 to 6 become particularly important for developing solutions, driving and sustaining improvement over time.

Factor 7 – only partly within the control of the trust – influences what can be achieved through transformation and the return on investment.

What good looks like – the seven success factors in practice

4

In this section we explore in more detail the seven success factors for provider transformation. We discuss what doing them well involves and consider what makes this difficult. We also include some short 'transformation stories' that show how different trusts have approached the challenges involved in transformation.

Factor 1. Committed and courageous leaders who set out a clear vision and inspire staff to work towards it

Engaging and inspiring staff is critical, but for leaders this can be incredibly challenging. Much work has explored good leadership, and how to develop great leaders in the NHS.[*] Here we have focused specifically on transformation leadership.

What works?

– Leaders who are strong and brave enough to make real changes and to take the initiative rather than waiting for permission.

– Leaders who visibly commit to the transformation and act as role models, exemplifying desired behaviours.

– Leaders with a clear understanding of where the organisation is going over a three- to five-year period (better still, over a five- to 10-year horizon) and how it is going to get there, and who communicate an inspiring and personal change story, with goals and an approach that chimes with the values of staff.

– Early, genuine engagement of frontline staff that is more 'listening' than 'telling' and that solicits their expertise to solve problems.

– Leaders who understand how to manage stakeholders, create headroom and have the courage to stand their ground on what they believe is right for their organisation.

Key to this type of leadership, and also a consequence of it, is meaningful clinical engagement. This is not paying lip service to a requirement to consult, but genuine collaborative engagement in which staff are listened to and influence decisions, because leaders believe it will lead to a better answer which is truly supported.

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[*] For example, the work by the King's Fund on leadership in the NHS, including the May 2012 report *Leadership and engagement for improvement in the NHS*, www.kingsfund.org.uk/publications/leadership-engagement-for-improvement-nhs

Shifting a critical mass of staff into the mindset that transformation is needed **and** possible is a necessary part of the launch of a transformation process and takes substantial leadership effort in the early stages. This includes setting out an aspirational vision, creating an evidence-based case for change, detailing a credible improvement plan and 'quick wins' to demonstrate change.

In addition, a capable chair and non-executive directors play a critical role in supporting the executive to take on a difficult transformation and providing constructive challenge. They can also be more mindful of the wider context for a trust than executives coping with the day-to-day pressures of running it.

What makes it difficult?

Being this kind of leader and motivating a large clinical workforce is difficult. Staff often have longer tenure in the organisation than the executive team, and have loyalties to other organisations such as their professional bodies. Behaviours are well established through training as well as habit. Clinicians – especially doctors – lack strong incentives to assume leadership roles and engage in improvement efforts, and are often sceptical of the chief executive's agenda.

To transform, rather than respond tactically to the pressures that they face, chief executives have to be bold. But they feel more incentivised to meet targets day-to-day than to deliver sustained improvement. Changes to system structure and vision have made it difficult to plan for the long term. Many leaders feel unsupported by the system in which they work, and beaten down by the negativity of rhetoric about the NHS. Several questioned why anyone would want to take on the top job, while non-executives told us that there is a shortage of candidates.

Questions for the system

– What can the system do to help leaders of provider organisations be the most courageous and inspiring leaders that they can be, in the face of so many pressures?

– How can the NHS attract, develop and retain great leaders? And how can effective leaders be encouraged or enabled to stay in post for longer in order to see through ambitious, long-term change plans?

– If great leaders are as scarce as they seem, how can the NHS make the most of those who are in the system?

Factor 2. A motivated workforce that responds to the vision and 'opts in' by committing to improvement activities

Successful transformations demonstrate a prevailing culture that strives for improvement. Particularly in quality turnarounds, the development of this kind of culture is a necessary part of the transformation itself – something particularly recognised since the publication of the Francis report into failings at Mid Staffordshire NHS Foundation Trust.[4] A culture that is open about problems, receptive to change and committed to doing what is best for patients is a vital foundation for a successful and sustainable long-term transformation.

'We need a different message from the system; the real message at the moment is not transformation.'

Chief executive, acute trust

From special measures to a role model for other hospitals: lessons learned from transformation at Basildon and Thurrock University Hospitals NHS Foundation Trust

Basildon and Thurrock University Hospitals NHS FT (BTUH) is an acute teaching trust serving a population of 400,000, with 667 beds and 4,500 members of staff.

Basildon's transformation story

Within five years of becoming a foundation trust (FT), concerns began to be raised about clinical quality at BTUH. In 2009, the CQC issued a warning notice. A few months later, Monitor deemed the trust to be in significant breach of its 'terms of authorisation', with concerns about compliance with standards and governance.

The start of the transformation can be tracked back to 2011, when Monitor brought in an interim chair. In 2012, a new chair was appointed, followed by a new chief executive and several other board-level appointments. The leadership team set out to turn the trust around, starting with a diagnostic to identify underlying problems and extensive staff engagement to understand their concerns. The governance structure was redesigned together with personnel changes in leadership roles. New risk escalation processes were rolled out. Mortality was tackled through pathway improvements, mortality reviews and data transparency. Developing a culture in which staff would support and challenge each other was a priority.

While this was in progress, the trust was investigated as part of the 2013 Keogh review.[5] Keogh's report acknowledged the work going on, but the trust was put in special measures, mainly due to its high mortality rate (SHMI).

By June 2014, performance had improved materially. With SHMI 'within expected range'[6] and a 'good' rating from the CQC, the trust was taken out of special measures. Staff and patient experience ratings also improved. However, in parallel, the financial situation deteriorated with the trust projecting a £14m deficit for 2014/15.

What made a difference?

- **Committed leaders who engaged and motivated staff.** The transformation was led by a top team, members of which were mostly new to the trust, giving them a fresh start. The leadership was visibly committed to turning the trust around and the chief executive told a compelling change story. CQC warnings and special measures provided a clear mandate to change.

- **Clear accountability for performance**. A new divisional structure made clinical directors clearly accountable. A firm approach was taken to address underperformance, and there was sustained management focus on understanding and resolving problems. Improving project management and putting clinical accountability fully into practice were ongoing priorities.

- **Developing the culture.** A patient- and quality-focused culture has been developed through the leadership's genuine engagement with staff, role modelling and consistent messaging. Learning from incidents is taken very seriously. However, anecdotally, some parts of the medical workforce remain sceptical of recent changes.

- **Using data to understand performance.** Investment in analytics, for example an in-house SHMI calculator, and learning from incidents helped the trust understand its problems. However, there is more to do to increase transparency into clinical outcomes.

- **Capabilities to identify and solve problems.** The trust invested in developing capabilities, for example root-cause analysis training for more than 50 staff members.

- **Financial headroom to fund improvements and resources to do the work of transformation.** Financial surplus enabled spending on extra beds, nurses and consultants. There was no in-house transformation team, so most of 'the work of transformation' was done by front-line clinical and management staff. The performance improvement team is now being boosted to drive ongoing improvement. With the current projected deficit, improving financial performance, as well as continuing to improve quality, has now become a priority.

- **Regulators were slow to intervene but were then supportive of the new team.** Following the warning notices, regulators took little action until Monitor's appointment of the interim chair. Once in place, the new leadership team was given time to make improvements. The relationship with regulators and CCGs was broadly supportive and inspections provided helpful insights into problems.

What works?

– A workforce with high aspirations, willingness to change and an absolute commitment to improvement and doing the best for patients.

– An organisation that rewards initiative and problem-solving, recognises and celebrates team and individual efforts, and is intolerant of poor performance.

– An organisation that values curiosity as well as expecting continuous improvement, including encouraging staff to 'go and see' other organisations in order to learn and 'steal with pride'.

– An organisation that makes a concerted and prolonged effort to develop this kind of culture, challenging 'it won't work here' attitudes, silo-thinking and unwillingness to take risks and try things.

– A critical mass of clinicians as active supporters, advocating change. When a significant proportion of consultants, for instance, oppose a change programme or when the majority are passive supporters ('I agree in principle, but I'll wait to see what happens'), then it flounders. Likewise, committed senior nurses were described as instrumental to making transformation happen in practice.

What makes it difficult?

Winning over the workforce can be difficult. Staff can be unaware of performance shortcomings. Some don't know how their team performs compared to others, or they have not gone beyond challenging the integrity of performance data. Managers have to think about scarce resources, but clinicians don't necessarily share this perspective – even though inefficiency can lead to avoidable harm. Everyone has seen hospitals bailed out and proposals to change or downgrade services quashed, so NHS staff are unsurprisingly sceptical about 'it's now or never' change messages. Busy clinicians lack strong incentives to find the time to get involved in anything beyond their clinical work, or to step into leadership roles which may set them apart from, or against, their peers. Trusts want to recruit clinicians who will play a role beyond their clinical duties, but in practice they sometimes struggle to find staff with the clinical skills needed, let alone clinicians with the desire to lead major change.

Trusts which felt that they were succeeding in consultant engagement attributed this to active recruitment of consultants who have a mindset of 'going the extra mile' in the first place, strong relationships between the management team and the consultant body (helped by stability in the trust executive team), building a robust evidence base for change and giving doctors true accountability for performance.

Questions for the system

– What can be done to make it more attractive for doctors to participate in service improvement efforts and take on leadership roles? Can universities and royal colleges do more to develop understanding of clinicians' roles in service improvement and incentivising participation, for instance, through professional recognition?

– How can the system help raise awareness among provider workforces of their performance relative to peers, linking quality and other outcomes to how well run the organisation is?

'We don't "go and see" nearly as much as we should – it's not part of the NHS culture'

Chief executive, acute trust

'Quite frankly, I would earn more and have a lot less hassle if I just did clinical work'

Medical director, acute trust

Transformation as a work in progress: Nottingham University Hospitals Trust

Nottingham University Hospitals Trust (NUH) is an acute trust serving a population of 2.5m, as well as providing specialist services to 3-4m people. It has three main sites, 1,700 beds and 14,000 staff. NUH was created in 2006 through the merger of two acute trusts; Queen's Medical Centre and Nottingham City Hospital.

Nottingham's Transformation Story

A whole hospital transformation was launched in 2009 following a 'tough' post-merger financial turnaround. The Trust aimed to raise quality, inspire staff and improve morale and value for money.

The transformation has involved two main programmes: *'We are here for you'*, which focuses on values and behaviours, and *'Better For You'*, which coordinates and supports operational improvement initiatives. To date the transformation has involved more than 5,000 staff in over 300 projects.

During this period the trust's CQC rating was amended to be 'good', NUH has been one of the top 20 improvers for RTT (referral to treatment time) and has also improved its Friends and Family score from 54 to 79 (out of 100). Staff satisfaction has moved from bottom to top quintile. However, the trust is still struggling to meet A&E and cancer targets, and has put in place a financial recovery programme during 2014/15 to avoid a projected deficit of £19m.

What has made a difference in NUH?

– **Committed leaders who engage staff:** The top team are frequently on wards/in A&E speaking to staff, helping with escalations and showing appreciation. In a recent initiative to improve performance against the 4 hour A& target, the chief executive's visible involvement has created focus and signalled the commitment of the Board, contributing to improvements in performance. There is a dedicated senior-level director who leads the transformation programme. The focus on quality helped enthuse staff, but there's now a recognition that financial impact needs to be a more explicit objective.

– **A culture of improvement:** Medical leaders are visible role models (e.g., lead/participate in working groups). Grass roots change initiatives make clear that it's everyone's job to help the trust improve. The transformation focuses on values as well as operational changes and has involved thousands of staff members.

– **Capabilities to identify and solve problems, and the use of standard methods and tools:** The internal transformation team has significant knowledge of improvement tools and change methodologies. The trust has a standard range of tools and improvement techniques that are taught in development programmes and these have become the 'way we do things', also providing a common language for improvement efforts. There's widespread participation in skills development programmes with an expectation that clinical staff, including senior doctors, attend workshops to strengthen their skills and confidence in leading improvement activities.

– **Resources to do the work of transformation:** NUH has an internal transformation team of ~20 FTEs and some secondees. The trust has also made use of external consultants for performance analysis, and to boost skills and capacity for specific projects.

– **Being part of an aligned health and social care system:** Recently, there has been collaboration with local CCGs to develop "One Version of the Truth", on the system level issues which contribute towards challenges in the emergency pathway, especially in meeting the 4 hour target.

Factor 3. Clear accountability for performance and effective management structures to implement change

NHS organisations struggle to fully implement change plans. There is no shortage of ideas, but staff complain about a never-ending succession of initiatives which fail to be completed. For transformation to succeed, the leadership team needs to be committed to following transformation initiatives through. The management system – by which we mean the governance structures, formal incentives, performance metrics and dialogues – helps leaders track progress, particularly beyond the start-up phase.

What works?

– **Clear accountability for transformation initiatives, from the board down to the front line.** We have seen projects driven by general managers making good progress when supported by clinicians, but the most compelling hospital-level improvements involved clinicians in meaningful positions of accountability.

– **Management commitment to see the plan through, at board level as well as further down the organisation.** A board-level sponsor who reports back to the board is one way to achieve this. We heard criticism from system organisations that many boards are not very effective in how they hold provider executives accountable.

– **Effective management structures to monitor performance, manage and track progress and hold people to account.** Some organisations set up a separate governance structure for their transformation programme to increase the level of top management attention and encourage more strategic or transformational approaches; others use existing governance structures. The governance structure needs to maintain momentum, escalate setbacks and monitor performance.

– **A structured approach to implementation,** including measurable goals, milestones and performance scorecards. These give the board transparency and help keep projects on track. Although these tools are well established, many NHS providers are not good at using them consistently and systematically, which means that many initiatives start well but fade over time.

– **Clearly defined, evidence-based standards of care** that are supported by clinicians (for instance, because they lead to a reduction in unwarranted variation) and help create a focus for improvement through a clear, common goal.

What makes it difficult?

Existing organisation structures frequently fudge accountability with parallel reporting lines for managers, doctors and nurses, and changing them is disruptive. Maintaining management attention on execution is difficult when system-level priorities shift and regulators demand to see, receive frequent updates on and action plans for, very specific performance problems. When clinicians take on leadership roles they generally lack the experience and skills to lead performance improvement in a structured way, so they are learning on the job.

Questions for the system
– How can provider boards be helped to put in place programme governance that maintains continuity and sustains focus through to completion for transformation programmes?

– How can knowledge of good management practices be disseminated more effectively, including among clinicians?

Factor 4. Insights from data analysis that enable a fact-based understanding of problems, inform decision making and track performance

Many transformation programmes are initiated in response to performance data, especially nationally-set targets such as RTT, cancer waits and A&E waits. Within an organisation, data are often used to prioritise effort and measure improvement, but pulling disparate data sources together to draw out the insights and tell a coherent story is seldom done effectively.

What works?
– IT systems that enable easy collection of data and ready access to reports, with people at different levels able to access the appropriate level of data.

– Outputs from reporting systems, such as patient-level information and costing systems (PLICS), that enable clinical and management staff to understand easily what is going on, and to drill down into problems.

– High quality data that are trusted as a basis for analysis and decision making. Inevitably, datasets rarely start out being entirely reliable. However, once they are used they give the people recording and entering data impetus to ensure that they are accurate, and the data can improve rapidly as a result.

– Use of insights from data to build a compelling case for change, understand the root causes of problems, prioritise actions, set goals and track progress.

– Transparency of performance data including access to trends as well as comparisons between teams, enabling frontline clinicians and managers to understand the performance of teams and, where relevant, individuals.

– Comparison against relevant peers (for example, benchmarking with similar hospitals), to understand improvement potential, and 'hold up the mirror' so that staff know how the hospital and their area are doing relative to others.

What makes it difficult?
Providers often struggle to create timely and insightful data analyses to inform performance dialogues. Many trusts lack staff to analyse data and manage performance, or struggle to attract or retain people with the necessary skills. Data acquisition and data entry are often a time-consuming burden on clinical staff, and when analysis is not shared with those recording the data, they see no value in doing so. Outcomes are difficult to measure and track; proving causality is difficult. Clinicians often lack confidence in data quality, so discussions focus on challenging the data, rather than on what it shows.

Questions for the system

– If the importance of good non-clinical NHS staff were recognised and talked about, would this help attract and retain these people, including analysts?

– Are there ways in which the NHS could build analytical capabilities across providers, for example through commissioning support units rather than each provider trying to do it themselves?

– Can the system help providers identify the best IT solutions, or enable them to be developed at scale?

– What would it take to put in place a national benchmarking service to give providers access to timely, relevant comparative data of their performance against peers?

Factor 5. Capabilities to identify the root causes of problems, plan and prioritise how to solve them and manage implementation in a structured way

The leaders we interviewed spoke about the importance of having people with the right expertise leading and supporting transformation. There are many established approaches to transformation, quality and productivity improvement methodologies as well as tools for specific types of initiative.* A few leaders had particular approaches they favoured, but in general the specific choice of improvement model was not described as a critical factor. What mattered more was having people with the ability and a methodology which enabled them to get to the root cause of seemingly intractable problems, identify solutions and manage implementation.

Transformation directors were more focused on the choice of improvement model, and a common strategy was the development of an in-house improvement approach, drawing on established methods like Lean, which is focused around maximising customer value while minimising waste. Experts counselled against using multiple methods within a single trust to avoid confusion and wasted effort in training.

Most NHS leaders we spoke to acknowledged skill gaps within the NHS in improvement methodologies and change management.

What works?

– Capability to identify problems rapidly, understand root causes and prioritise focus. This involves making effective use of data, drawing on the knowledge of staff and often bringing to bear experience from elsewhere.

– Gaining practical experience in improvement methodologies and tools, to develop the capability to adapt and apply these to the specific circumstances.

– Ability to design effective solutions, drawing on good practice elsewhere as well as using imagination and initiative to develop novel approaches.

'Methodology matters – Lean, Theory of change, 6 sigma etc. You need to be able to draw on the right method for the situation.'

Health care improvement expert and Health Foundation Fellow, previously acute trust transformation director

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* For example, John Kotter's 8 Step Process for Leading Change, Kurt Lewin's 3 Phases Change Management Model, Rosabeth Moss Kanter's Change Wheel, the NHS Change Model, the IHI Model for Improvement (Plan-do-study-act), McKinsey's '5 As' approach

- Project managers and clinical leaders who can guide robust implementation planning, including resource requirements, timelines, milestones and so on.

- Understanding how to manage and lead improvement projects, including their long-term implementation.

What makes it difficult?

Attracting and retaining change experts is difficult and capable analysts are few and far between, often moving on every couple of years. This often leads providers to use external consultants, but their skills do not necessarily become embedded in the organisation. Clinicians often lack experience of leading major change, and some place little value on this skill set.

Questions for the system

- What is the right way to develop change management and improvement knowledge and capability on the scale required? Some hospital executives referred back to the Modernisation Agency as a positive example, but in general, they were ambivalent about current support organisations like NHS Improving Quality and the Intensive Support Teams.

Factor 6. Funding for staff to 'do the work' of transformation and for improvements necessary to the transformation itself

Ambitious transformation programmes cost money – to set up a team to manage and drive the process, to take staff away from clinical duties, for external support, for 'quick wins' and sometimes for infrastructure, equipment or staff.

A trust with strong finances but with quality problems, like Basildon when it went into special measures, can spend money on quality improvement. A trust in a weak financial position has to tackle quality issues while also finding savings. Some financial situations are so unworkable – for example, some trusts with costly private finance initiative (PFI)-funded buildings – that wider, system-wide transformation will be required to solve the problem of the viability of individual organisations.

What works?

- Funding visible improvements builds momentum, demonstrates commitment and boosts morale, for example, fixing new equipment, repainting tired parts of the hospital.

- Funding staff or facilities without which the hospital cannot achieve mandatory service standards (for example, one-to-one midwife care for established labour).

- Underlying financial viability, which often has to do with local funding allocations and the competitive landscape.

- Dedicated transformation teams staffed with individuals who have change management skills and credibility with clinicians. In the trusts we spoke to, these ranged in size between eight and around 20 employees, and provided expertise and impetus for the most important improvement initiatives. In other industries, these teams can be much larger (up to 1% of the workforce). The teams built capabilities among divisional staff, rather than 'doing the work'.

- Short-term, external support to inject energy, pace and expertise.

'Our central improvement team is critical – a catalyst for change, bringing energy and fresh ideas. They help develop capabilities across the hospital'

Transformation lead, acute trust

On the road to financial turnaround: lessons learned from Poole Hospital NHS Foundation Trust

Poole Hospital NHS Foundation Trust is an acute general hospital with 621 beds and 4,200 staff, serving a population of 270,000 people in Poole, East Dorset and Purbeck.

Poole's transformation story

In 2009/10, Poole Hospital reported a £4.5m deficit, instead of a planned £2.1m surplus, and in July 2010, the trust was placed in significant breach of its FT authorisation by Monitor. The financial problems triggered high turnover in the trust leadership team. A new chief executive joined the trust shortly before the Monitor notice, and the day after the departure of the financial director. In the following months, the chair, chief operating officer and two non-executive directors also left. Several were replaced by interim staff and, over time, a new permanent team was established.

The turnaround began with a diagnostic and a big effort to engage clinical staff to raise awareness of the problems. Immediate actions included establishing strong financial controls and developing the capability of the board. Once stablility was achieved, the leadership developed a two-year turnaround programme. Initiatives included the creation of a Medical Investigation Unit to reduce length of stay and a Rapid Assessment Care of the Elderly Unit. Matrons were the driving force for these initiatives, supported by consultants.

In 2010/11 savings of £8m were achieved (against operating costs of £191m), and the underlying deficit was reduced from £6m to £1m. In January 2012, Monitor released the trust from 'significant breach'. In 2011/12 the trust achieved an operating surplus of £1m, which was maintained in subsequent years (excluding the impact of estates revaluation).

Throughout this period the hospital continued to achieve good clinical performance. The CQC judged it to be meeting all standards in February 2014, and assigned the trust to band 6 (lowest risk) in its intelligent monitoring.

The trust sought to secure a sustainable future for the long term through a merger with its neighbouring trust, but this was rejected by the Competition Commission in 2013. Like many trusts in the NHS, Poole is again facing significant financial challenges.

What made a difference?

–   **A new leadership team which was frank about the scale of the challenge**. During the early stages of the turnaround there were eight board-level appointments, including the chief executive and chair. Developing the board capability to lead the turnaround was an early priority. The chief executive led communication with staff, including 'town hall' events and one-to-one meetings with clinicians who would be highly influential for the turnaround. He took the approach that, 'you have to be brutally honest' and used the fact base from the diagnostic to build understanding of the extent of the problem.

–   **Clinical leadership and engagement.** Operational changes were driven by capable matrons. After initial scepticism, consultants generally accepted the need for change. Significantly, some vocal opponents became advocates for the turnaround when they saw the positive impact of some of the changes.

–   **Robust financial management practices.** Strong financial controls were introduced early on, centralising information and decision making. Changes to increase clinical accountability were made later, once the financial situation had stabilised.

–   **Using data to understand performance.** The diagnostic was critical for building understanding of the trust's financial problems. The leadership accepted that data quality would be challenged, but this led to improvements in the data and subsequent recognition of the problems.

–   **Expertise and robust processes to drive the turnaround.** A turnaround director brought expertise and focus to drive the process. External support was valuable for the diagnostic, establishing the programme structure and programme management office, as well as for board development.

–   **Support from the regulator but challenge from others.** Monitor's notice of breach provided the leadership with a mandate for change, and monthly performance meetings were broadly supportive. However, the trust's merger plans were blocked by the Competition Commission. For more details about the proposed merger between Bournemouth and Poole hospitals, see the Health Foundation report *Mergers in the NHS*, www.health.org.uk/nhsmergers

What makes it difficult?

Interviewees identified a lack of funding continuity and strategy. Improvement teams and initiatives are often seen as luxuries and are among the first things to be cut when finances are tight. Some trusts cannot see how they can fund some service standards, for example levels of consultant cover, without going into deficit. In this report we cannot do justice to the challenge of underlying financial viability.

Factor 7. Being part of a collaborative and supportive local health and social care system

No provider operates in isolation. Patient journeys commonly involve multiple providers and big decisions need the support of commissioners and other stakeholders. How the local health system functions, and the collaboration between organisations, affects what a provider can achieve in a transformation programme.

What works?

– Collaborating with other organisations in the system to solve problems, for example, working with primary care and social services to improve flow along the emergency pathway.

– Having support for your strategy and transformation efforts from CCGs, regulators and other organisations in the system, and being willing to work with rather than against them. Chief executives told us that the conversations with CCGs and regulators do make a difference; for instance, the sort of questions they ask, the dynamic of interactions, and whether the focus is on the short term or the longer term.

– Other local providers (for example, GPs, social services) performing well, so you are not expending large amounts of time and resources on coping with, or solving, problems beyond your organisation's scope.

What makes it difficult?

Some problems cannot be solved without primary, community, acute, mental health and social care providers working together – for instance, keeping patients out of hospital and enabling discharges. While providers can build relationships and work together, incentives are poorly aligned and often conflict. Some providers felt their CCGs were holding them back, for example lacking the same sense of urgency or willingness to innovate, while others found them supportive.

Transformation to maintain and improve good performance: Frimley Park Hospital NHS Foundation Trust

Frimley Park Hospital NHS FT (now Frimley Health NHS Foundation Trust since the merger with Heatherwood and Wexham Park Hospitals NHS FT) is an acute trust with 720 beds, serving a population of more than 400,000 across Hampshire, Surrey and Berkshire. It also hosts a Ministry of Defence hospital unit. The trust acquired Heatherwood and Wexham Park NHS Foundation Trust in October 2014.

Frimley Park's transformation story

The trust has been a strong performer for many years; it was one of the first to achieve FT status in 2005, it was Dr Foster's *Hospital Trust of the Year* runner-up in 2012 and was rated 'outstanding' by the CQC in September 2014. Strong financial performance has given the trust surpluses to invest in its services, including a new emergency department in 2012.

The chief executive has been in post since 1991, and at Frimley Park since 1989. He renews the strategy every five years and has an internal transformation team to drive improvement. Staying a high performer requires continuous improvement, and Frimley Park is 'ahead of the pack' in many areas, for example it has high theatre productivity and was an early adopter of seven-day working.

The trust faces a new challenge to integrate Heatherwood and Wexham Park, which is in special measures.

What made a difference?

- **A leader with exceptional longevity at the hospital and strong relationships with staff.** The chief executive has been at Frimley Park for over 25 years. He makes himself highly visible: 'I go into A&E every morning and at the end of every day,' he explains. Having worked with the trust's senior consultants for many years, he has long-established relationships. There is no question of staff thinking 'here today, gone tomorrow'. He is prepared to stand firm when changes may be unpopular with the workforce, for instance, bringing in seven-day consultant-delivered services in advance of most other hospitals.

- **The workforce is committed to high standards.** Clinicians are very engaged with the management of the hospital. The trust actively recruits for staff who will 'go the extra mile'. The culture of innovation is evident in performance and working practices, such as five-hour theatre sessions, and a pathology service that has been described as 'by far the most productive and highest quality in the country' by a private sector pathology provider.

- **Funding and resources for improvement.** A financial surplus has enabled investment in facilities (for example, a new emergency department) and the trust has an internal transformation team of approximately 10 people.

- **Autonomy through performance.** Frimley Park's strong financial and clinical performance means it has greater autonomy than many others.

How the system could help providers more and hinder them less 5

Provider transformation efforts are affected by the system context. While hospital leaders acknowledge that the success or failure of a transformation is primarily down to them and their staff, the system can make their jobs more or less difficult and success more or less likely.

What providers want

Providers have found some interventions helpful and some were positive about the new CQC inspection regime, but many were also critical of system interventions. In general, trust leaders wanted the system to give them more support, time and autonomy to pursue longer-term improvement programmes.

Support and autonomy, not 'command and control'

Providers recognise that there are times when 'command and control' can be helpful. At a whole-hospital level, the threat of special measures, losing autonomy or undergoing special administration that may lead to the closure of core services all provide a mandate to the board to drive forward uncomfortable changes. Clinical standards and guidelines, if credible, set a clear performance benchmark.

However, the most common request from chief executives was for less 'command and control' and more autonomy; for time and space to run their organisations. Real transformation takes years. Leaders who succeeded had headroom to pursue their agendas over a sustained period of time, usually as a result of past strong performance as an organisation or an individual leader. 'Keeping stakeholders off our back' was described by other executives as a critical skill.

Relentless pressure to hit short-term targets takes attention and resources away from longer-term improvement. At a very basic level, many hours are spent managing and responding to regulators and commissioners; in general, hospital leaders feel the time and energy demanded is disproportionate to value. Chief executives are pleading for regulators, commissioners, the secretary of state for health and others to take a step back, and recognise that improvement takes time.

While trusts in trouble feel huge pressure to turn themselves around, those doing well feel little encouragement from within the system to go 'from good to great'.

'Build a coalition of people on a burning platform with a commitment to change, and let them get on with it – permission and time.'

Chief executive, NHS community provider

Inspections that look at improvement over time, not just at a point in time

Providers were generally positive about the improvements to the CQC inspection regime and some described this as helpful in supporting their mandate for improvement. But they also spoke about the administrative burden in responding to requests, particularly if commissioners' and regulators' requests were not coordinated. The biggest concern with assessment was the tendency to look at a snapshot of performance at a moment in time, rather than assessing improvement.

Workforce and organisational incentives that support transformations

Misaligned incentives make hard changes even harder. Providers feel they are incentivised to prioritise short-term 'fixes' over long-term improvement, and solutions involving multiple providers can conflict with financial incentives. Clinicians are weakly incentivised to take on leadership roles, either financially or in terms of professional recognition.

Providers want NHS England and CCGs to resolve conflicting incentives between NHS organisations, and would like both commissioners and regulators to incentivise transformational improvement over hitting short-term targets. They are looking to medical educators and royal colleges to recognise the importance of clinicians leading change at the front line.

Support for learning across the system

Many providers spoke about the difficulty of accessing truly meaningful, timely benchmarking data and learning from other organisations both within and outside the NHS. They also want to see central bodies make use of their position spanning multiple providers to invest in understanding and solving common problems.

The system to help develop and deploy top talent in the NHS

The right top team is vital for transformation. Providers want the system to do more to attract top talent into the NHS, identify and nurture potential leaders, keep track of people with the skills to help providers in difficulties and 'match-make' for board roles, interim positions or advisers.

Within the clinical workforce, providers question why system-level shortages (for example, lack of A&E doctors, health care scientists, nurses and midwives) are not being tackled effectively at the system level, and why pervasive problems of morale and disillusionment are not being investigated on a pan-NHS basis.

Particularly challenging for many trusts is the gap between what they want from their doctors, in terms of commitment to the organisation and willingness to step into leadership roles, and the expectations and capabilities of their medical workforce. This is seen as one of the biggest barriers to improving performance in many hospitals, suggesting it is something the system needs to invest in overcoming.

A more positive tone and rhetoric about the health service

NHS staff feel the service is overwhelmed by a blanket of continual criticism that saps morale from board to ward. Specific criticism for unacceptable failure is accepted, and problems of complacency and lack of candour are acknowledged, but providers want to see this balanced by appreciation of achievements and a positive vision for the future.

'The only things that are important to TDA are delivering A&E, delivering the RTT target and delivering cancer target. Putting effort into anything else is therefore a massive risk.'

Chief executive, NHS acute provider

Improving the odds   6

In this section, we set out some thoughts on what can be done to improve the chances of successful transformation.

How providers can make transformation more likely to succeed

There are many ways in which providers can help themselves. Although the success factors described in section 4 are not a recipe for transformation, by focusing on doing them well, providers can improve their odds of a successful transformation.

Words of wisdom

Transformation leaders and experts gave us the following advice for those embarking on leading a provider transformation:

– Work out upfront, or very quickly, what you need to fix.

– Don't underestimate the importance of developing your change story.

– Invest in a fact-based case for change to establish 'one version of the truth' and share it widely and repeatedly until you start to hear it from others.

– Being visible is more than just doing a weekly walkabout or dropping into wards from time to time. You need to spend much, much more time 'on the front line' listening to staff and patients and finding out what's going on.

– You get so much value when you or staff 'go and see', so do more of that.

– Identify the skill gaps in your organisation and work out how to plug them, whether through training, recruitment or bringing in external help.

– Make sure your whole board supports and drives the transformation, including the non-executives.

Looking ahead, and in the context of the Forward View, transformation leaders would also do well to:

– work out how best to use technology, and go and see it working in practice

– work out which future models of care are going to make most sense for your patients and your organisation, as this will dictate what you transform into.

How 'the system' can help providers transform

At a system level what is needed is a change in emphasis from the current mode of interacting with providers through pressure, to one of support. In practice, this shift involves system organisations acting differently in six areas to drive and enable successful transformation.

i. Invest in leadership teams and encourage them to be bold

The calibre of the board, and the chief executive particularly, is the most critical 'internal' provider factor for successful transformation. Chief executives need to be capable, courageous and inspiring to succeed in challenging situations.

Ways the system could help

- **Make the most of the best people currently at board level in the system**, by supporting them and helping them fulfil their potential, and through structures which increase the scale over which a top-class leadership team operates.[7]

- **Talent-spot people with board potential**, build their experience (possibly through secondments), and help them succeed in their first board role.

- Support the development of **more effective non-executive directors** and active boards, through recruitment, mentoring and training.

ii. Support workforce change

There is growing consensus that clinicians, and particularly doctors, should be playing a much greater role in the way hospitals are run. In the words of one of our interviewees, the deputy chief executive of a large acute trust: 'Fundamentally, the whole of health care is driven by doctors… I need to pass the responsibility for running the trust to those individuals. Instead of having the token doctor at the table, I need to be the token manager.' Yet the biggest challenge in transformation is often engaging clinicians, especially doctors.

Some national **workforce policies and standards** are also a barrier, limiting development of alternative workforce models that have worked in other countries. Organisations are frustrated that alternative models, even if they are demonstrably safe, are 'against the rules'.

Ways the system could help

- **Support trusts in developing alternative workforce models**, including more innovation on incentives, enabling personnel changes and updating national contracts.

- **Examine the role of the NHS doctor overall**, including how well medical training prepares doctors for their role in the modern health care system (both in terms of skills and mindset), incentives, contracts and work patterns.

- **Give greater flexibility on workforce policies**, provided the approach is safe.

iii. Provide practical support to make the most of the scale of the NHS, harness knowledge and capabilities, and inject change expertise

Many people we spoke to were adamant that **we are not making the most of the NHS's scale and experience**. There are hospitals doing great things about which the wider NHS knows little. Providers could learn much more from one another as well as from other systems.

Although there are documented improvement methodologies and case studies,[*] hospitals find it hard to implement this sort of codified best practice. Our interviewees talked about the shortcomings of relying on 'how-to guides', compared to 'going to see' and also getting practical help. Despite the barriers to 'going and seeing' being much lower in the NHS than in systems with more competition between providers, we heard several times that this is 'just not in the NHS culture'.

– NHS non-executives looking across from other industries are amazed not to see more standardisation, more common approaches on use of technology, on data, on identifying what works and rolling it out across the system. Standardisation is well understood as part of the success of US hospitals and health systems such as Virginia Mason and the Mayo Clinic.

– Providers lack improvement expertise, with only small improvement teams (or sometimes no central team at all), when what they need are people in every division with strong change management skills and all staff to have a good grounding in the basic improvement toolkit. There is also much more scope for using data to understand problems and drive improvement.

Ways the system could help

– **Help providers use performance frameworks** to understand better how they are doing against peers.

– **Identify examples of great practice and rapid improvement**, 'package' what they are doing and the journey to get there.

– **Establish 'working examples'** to make it easy for staff to **go and see** what 'good' looks like, and understand how a similar hospital got there.

– **Establish transformation support teams**, which can be 'embedded' at a trust to help them launch and run both an overarching transformation programme and common transformation initiatives.

– Build a pool of board-level **trouble-shooters** who can inject expertise, drive and challenge during the intense phase of turnaround.

– **Support development of standard operating models and processes**, potentially by supporting some providers to become designated centres of operational excellence. Another model is through the development of hospital chains and networks with sufficient scale to do this effectively.

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* See, for example, the NHS Improving Quality website: www.nhsiq.nhs.uk

iv. Co-fund transformation

Hospitals under severe financial pressure do not feel they can spend any money on improvement. Transformation requires manpower (and expertise), demonstrable 'quick wins' that show commitment, and service changes which may involve double running and up-front investment.

Ways the system could help

– **Enable trusts to bid for funds for transformation** over a one- to two-year period, full funding dependent on impact and sharing learning.

– **Co-fund transformation support teams** as described in iii above.

v. Incentivise improvement over realistic time frames and across organisations

Meeting short-term targets diverts attention away from longer-term improvement. Misaligned incentives hold back improvements across organisations. Although regulatory regimes like special measures are not universally popular, most leaders we spoke to recognise that a strong and clear external mandate makes a difference. We also heard of a lack of incentives at the other end of the scale, to encourage good hospitals to do better, and to maintain high aspirations.

Ways the system could help

– **Track, incentivise and support improvement over longer time frames**, and expect good hospitals to do even better, not just those in difficulties.

– **Allow flexibility in system structures and payments.**

– **Continue regulatory regimes like special measures in serious situations** but make sure these really have teeth so that they are taken seriously, and thereby give provider leaders an effective mandate for change.

– **Continue to increase transparency to raise awareness of unwarranted variation.**

vi. Support in word as well as deed

Leaders need to hold on to a bold vision and inspire their staff in the face of huge day-to-day pressures, yet they often feel ground down by criticism and negativity. Public backing from the system would help strengthen their resolve, as well as their negotiating position in the change process.

Ways the system could help

– **Change the balance of messaging** in speeches, interviews, etc, to include successes and achievements as well as highlighting problems.

– **Change the tone and questions asked** in conversations between the system and provider leaders.

Conclusion 7

We began with a talented and experienced manager considering taking on a chief executive role for the first time, asking themselves, 'Do I feel lucky?'

This report sets out seven success factors for provider transformation that, if done well and done together, increase the chances of success. We have also discussed what the system can do to change the context and conditions for transformation to happen, and so change the odds. For our undecided chief executive candidate, understanding these success factors, coupled with more support from the system both in practice and in rhetoric, could tip the balance in favour of taking the job, and being successful in it.

At a time when we need the best people to step up into leadership positions and be bold and courageous leaders, making that option seem worthwhile is valuable in its own right. It is critical, however, that this is not just about having the right people in the top jobs – it is about helping them succeed systematically in transformations across hundreds of NHS organisations.

The importance of 'going with the grain' cropped up several times in our interviews. Surely the 'grain' of the NHS is patient care, and transformation ought to align well with that – with quality of care, not finance, being the primary objective. But there are also important differences in local context and culture and working out how to tap into that and 'go with the grain' locally is important, and requires a relatively sophisticated, two-way engagement process characterised by effective listening. We need to believe – and trust – that transformation rooted in quality and patient care will resonate with the intrinsic values of a workforce of more than a million people and motivate them to participate in change at a scale that is hard to conceive.

The actions and policies of the system players could have a powerful effect in amplifying the best efforts of providers undertaking transformations. If done well, they can increase the odds of the future NHS developing the kind of high quality and affordable model that is capable of meeting the rising demands and expectations placed on it.

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