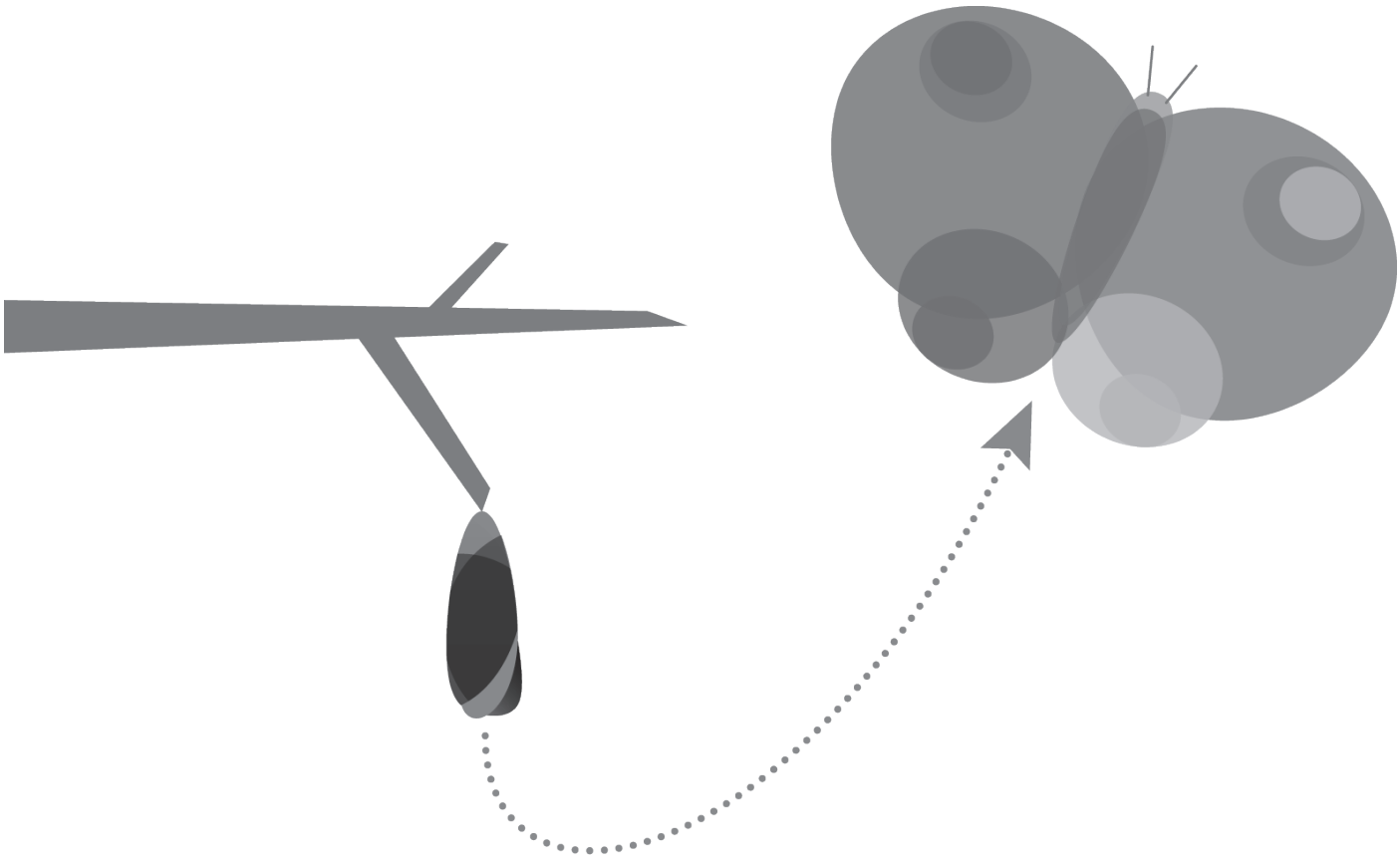
The King's Fund

The Health Foundation

Making change possible: a Transformation Fund for the NHS

Appendix 1: Case studies of large-scale transformation



July 2015

The appendix was produced as part of the work by the Health Foundation and The King's Fund on the report *Making change possible: a Transformation Fund for the NHS*.

For more details, see **www.health.org.uk/makingchangepossible** and **www.kingsfund.org.uk/makingchangepossible**

Contents

Introduction

The King's Fund and the Health Foundation both support the concept of a Transformation Fund for the NHS in England. The two organisations came together to undertake a programme of work detailing the key aspects of such a fund.

This appendix provides details of six case studies of funding other transformations, in the health sector and beyond.

Introduction

The future of the NHS depends on its ability to understand 'what works' to provide a high quality sustainable service. The approach to transformation and how to support it should be no different. The English NHS is no stranger to transformation and there are a number of past examples to draw on, while internationally many other health systems are tackling challenges not dissimilar to those in England through processes of transformation. Furthermore, transformation is not unique to the health sector and, arguably, there is much we can learn from other sectors. Examining these examples provides invaluable learning on the key requirements of transformation, the processes involved, and where improvements can be made.

Our work on the case for a Transformation Fund for the NHS in England* draws on six case studies of funding other transformations, in the health sector and beyond. This appendix provides details of these case studies and the key lessons from them. Our analysis in each case focused on the context of transformation, its intended benefits, the process and management, workforce considerations, funding arrangements, outcomes and challenges.

* See the full report, Making change possible: a Transformation Fund for the NHS.

Case study 1: Deinstitutionalisation in UK mental health services

Overview

Mental health services have gone through a radical transformation over the past 30 years – perhaps more so than any other part of the health system. This process began with a wholescale transformation process known as deinstitutionalisation – that is, shifting care and support of people with mental health problems from psychiatric institutions into community-based settings. At the start of the process, these institutions housed approximately 100,000 people; by the end, all had closed. The replication of mental health deinstitutionalisation across the UK and subsequently in a number of other countries has resulted in a volume of international and cross-comparative research to inform learning on the processes involved in transformation more widely.

Context

The primary agenda driving deinstitutionalisation was one of public and moral necessity. This was based on a growing emphasis on human rights as well as advances in social science and philosophy critiquing psychiatry and the boundaries of what constituted mental illness, which reached its height in the 1950s and 60s. A series of scandals in the 1970s around ill-treatment of mental health patients and a strong, vocal service user movement provided harrowing stories of people's experiences of care, which contributed to this critique.[1] As one of our interviewees, who was involved in the process of hospital closure, noted: '*The over-riding fundamental reason was that it was the right thing to do.*'

This moral agenda, however, was supported by a number of other developments that facilitated the possibility and opportunity for transformation. Clinically, developments in medical treatment demonstrated that people with severe mental illness could be treated and that institutionalisation itself was iatrogenic (ie the treatment itself caused harm), resulting in the subsequent growth in outpatient treatment. New legislation restricted who could be admitted to institutions and set a precedent that the community was the most appropriate place for treatment. Politically, there was consensus among parties about hospital reconstruction, and further legislation set a vision for the provision of mental health services as part of this. Alongside this, Enoch Powell, then Minister for Health, announced the intention to halve the number of hospital beds for people with mental health problems.

Although there was little overt financial impetus for deinstitutionalisation, it was generally acknowledged that institutions were financially unsustainable and, in many cases, represented prime estate.

Intended benefits

Improving the patient experience was implicit in the moral argument for deinstitutionalisation. However, beyond this, the overt intended benefits were limited. A number of indirect benefits were envisaged within the planning process, including release of funds from estate. More generally, the impetus for hospital reconstruction (which accompanied deinstitutionalisation) was geared towards achieving greater integration of health and social care provision within the community.

Process and management

Internationally, deinstitutionalisation has had three main components:

- the discharge or movement of individuals from hospitals into the community
- their diversion from hospital admission
- the development of alternative community services.[2]

In the UK there were several concurrent programmes of change. Under the 1962 Hospital Plan,[3] acute psychiatric inpatient services were developed on district general hospital sites as part of national reconfiguration. Local authorities were developing community mental health teams and there was an increased outpatient role.

In each area in which there was a long-stay psychiatric institution or asylum, senior NHS and local government managers were required to develop a financial project plan for closure of hospitals over a five-year period. This had to contain a detailed projection of revenue to be released from ward closures and land sales, re-investment, NHS capital programmes, and new sources of funding.

New organisations were set up to manage the process and subsequently deliver services. Many of these were charities, including housing associations; in some cases existing charities took on this role. With involvement from each stakeholder group (including the district health authority, local authority and voluntary sector), a key function of these new organisations was to broker relationships to ensure that no one organisation had sole ownership, and to manage the power dynamics. An added benefit was that they enabled people to connect around a new organisational form with its own identity and purpose, underpinned by a board and trustees who were accountable for the process and outcomes of transformation.

These new organisations led on aspects of the transformation. Planning required an understanding of the needs of those people being cared for in institutions at the time, and the funding available over the long term. This was used as a basis for identifying the requisite settings, staffing and provision, and to ensure that new services were sustainable. These organisations subsequently received the majority of funding, led on developing new services, and created systems and structures to manage the transition, including workforce management and training.

Workforce

The deinstitutionalisation process involved a significant focus on managing the workforce. Where it resulted in the closure of individual wards, staff were absorbed into the wider organisation. Where it resulted in complete closure, staff had three options:

- to move into community mental health teams
- to move into new residential care provision replacing hospital-based care for those patients who had severe mental health problems and could live in the community with support
- to leave the service (retirement; voluntary redundancy).

There were some key issues that workforce planning had to address: NHS nursing staff were effectively going to be joining non-NHS providers; there was a substantial change in their role, from nursing to providing residential care; and there were changes in terms and conditions around work and pensions. The new organisations led substantial negotiation with unions and staff to agree terms and conditions (including pensions), with negotiations taking up to two years before staff were transferred over. These organisations operated with a dual management structure for the first two years: staff who had transferred over from the NHS were managed by a director of nursing, while residential staff were overseen by the management of the new organisation.

Training and staff development were key factors in setting up the new services. Re-training and re-skilling was a requirement before or at the same time as redeployment. New training structures were established to ensure that staff from the nursing and residential care sector could move up the managerial ladder without nursing qualifications. The lead of one organisation interviewed described to us how they invested in sending staff in management positions on dedicated courses and applied for Investors in People accreditation to demonstrate that they were serious about staff development. A core aim of the staff development strategy was to change the mindset of staff around expectations of care. Staff themselves had become institutionalised by the asylum system. Organisations provided a strong focus on learning together, developing a shared understanding of what they wanted to do, and identifying behaviours that were not appropriate for the new setting.

Timescale

The impetus to close asylums began in the 1960s. This may have resulted in reduced admissions but, in practice, few community services were developed and large-scale closures did not start until the 1980s, with the first closure in 1986. For hospitals that were completely closed, the process took around two years. This included developing new structures and systems as well as planning the transfer of staff and patients.

Funding arrangements

There were four main funding avenues for deinstitutionalisation, as follows:

- Social security payments were initially used for people living in the community to pay for long-term residential care.

- Dowry payments allowed transfer from hospital budgets to local authority budgets, providing a pool of semi-protected resources for former long-stay patients.
- Joint finance initiatives funded provision of social care for patients who would otherwise be the responsibility of the NHS. Money was made available from health to fund community care. These initiatives sped up the running down of hospitals and diverted people from entering hospitals.
- A Mental Illness Specific Grant operated from 1991 to provide ring-fenced funding to local authorities, to help them develop social care and community services.

In addition to government funding, the National Housing Federation provided funding to the new transformation organisations so that they could lease properties from local housing associations for residential care. Where hospitals were being closed as part of the process, funding for transformation was also linked to subsequent sale of estate.

Taking into account the funding available to individuals through social security payments and dowries in the development of new services was important in ensuring that provision of care would be sustainable in the long term.

As charities, these new organisations were not able to make a profit. In the case of one of our interviewees, their organisation only broke even in the first couple of years, a situation that was not seen as unique in the process of transformation.

Outcomes

Where community services were available and comprehensive, the consensus is that most patients significantly benefited from the process of deinstitutionalisation.

The movement of staff – particularly the loss of staff due to voluntary redundancies and the switch from nursing grades to residential care – meant that local health authorities saved up to 20% of their total staff budget within the first year.

Although the closure of asylums eventually released significant funds, studies of deinstitutionalisation internationally have demonstrated that shifting care from institutions to the community does not generate cost savings.[4] This is because the care provided subsequently tends to be of greater quality, and these improvements in care require additional investment.

Longitudinal studies of deinstitutionalisation demonstrate that outcomes of transformation were not always easy to predict. In some cases, the process produced unexpected results, new demands and a different set of risks. For instance, analysis of deinstitutionalisation in the USA found unexpected higher mortality among elderly patients (particularly those who were physically frail and had severe cognitive impairment) when they moved out of institutions.[5]

Challenges

Timescale of transformation

The slow pace of closure resulted in institutions that were expensive to maintain and often in a poor state, which meant capital could not be released, which in turn obstructed investment to create new facilities. Many of the large institutions were not sold until five or six years after closure; some have yet to be sold.

Overambitious aims

Although many stakeholders perceived the process of deinstitutionalisation as one of shifting care and support in line with patients' needs, some organisations saw it as their role to ensure access to other components of community living such as occupation and social networks (some of which had been inherent in the asylum system). This ambition of transformation was always going to under-deliver.

Wider systemic considerations

The focus of transformation – to move mental health patients from hospitals to community settings – largely excluded primary care. Indeed, this was often a conscious decision, reflecting a belief that general practitioners (GPs) would not want to be involved in managing people with mental illness in the community. Evidence suggests that the failure to engage and consider the role of primary care practitioners has had a negative impact on subsequent provision.

Case study 2: The National Service Framework for Mental Health in England

Overview

In the early 2000s, mental health services in England underwent a further period of significant transformation. This was underpinned by the development of a 10-year national modernisation plan, the National Service Framework for Mental Health[6] (subsequently referred to as the NSF-MH) and the mechanisms for implementing it.

Context

The NSF-MH emerged as a result of public and political pressure to reform community mental health care. During the 1990s, media coverage of a series of high-profile adverse events involving people with mental illness contributed to a public perception that community care had failed. The incorporation of the European Convention on Human Rights into UK law provided further impetus for reform of mental health legislation.

A government white paper followed which outlined a process of transformation.[7] The transformation process had three key aims – to provide:

- safe services – to protect the public and provide effective care for people with mental illness at the time they need it
- sound services – to ensure that patients and service users have access to the full range of services they need
- supportive services – to work with patients and service users, their families and carers to build healthier communities.

Although clinical and financial factors did not overtly drive the case for change, it was recognised that community services were insufficiently adaptive to meet the diverse needs of service users. On the one hand, community services were often unable to manage the complexity of some patients; on the other, young patients were being held back by limited expectations of what they could achieve. As such, ensuring services delivered both appropriate care and value for money played a core role. These factors were influential in the subsequent process of identifying service delivery models.

Intended benefits

The NSF-MH aimed to improve quality and remove wide and unacceptable variations in service provision. It defined what mental health services should aim to achieve, how they should be developed and put into practice, and how they should be measured.

The intended benefits were inherent in the development process. A series of guiding values and principles as to how care should be delivered were agreed and used to shape decisions about future models of care. Each area of focus had clearly defined aims, such as increasing access to primary care and providing support close to home in a crisis. Many of these became minimum standards for the new models of care and mental health services.

Each of the quality standards outlined the intended benefits (which would be subject to performance assessment at a national level), alongside the models of care and guidance on good practice.

Although there was little overt focus on cost effectiveness in relation to each standard, provider transformation plans anticipated reduced bed days as a result of crisis intervention and assertive outreach teams.

Process and management

An External Reference Group of health professionals, service users and carers, health and social service managers, partner agencies and other advocates was convened to develop the NSF-MH. The group distilled existing research and knowledge and considered a number of cross-cutting issues, such as race and gender.

The group also considered the mechanisms by which systematic change would be achieved. The resulting NSF-MH:

- set national standards and defined service models for promoting mental health and treating mental illness
- put in place programmes to underpin and support local delivery
- established milestones and a specific group of high-level performance indicators in order to measure progress within agreed timescales.[6]

The focus for delivery was on local health and social care communities. Five national programmes were established to underpin implementation, covering: finance; workforce planning, education and training; research and development; clinical decision-making support systems; mental health information strategy.

The NSF-MH standards were elaborated and specified further in the NHS Plan,[8] which included specific targets for numbers of new services (200 assertive outreach teams, 335 crisis resolution teams, 50 early intervention teams), numbers of people who would be supported by such services, and deadlines for implementation. The subsequent Mental Health Policy Implementation Guide[9] set out specifications for each of the three services. These included staffing levels and roles according to population size, prevalence and admission rates, and length of contact as appropriate to the care model.

A national body was established to oversee implementation and develop future mental health policy. The National Institute for Mental Health in England (NIMHE) was supported by leadership at a local level through eight regional development centres.

Each local authority had an NSF-MH local implementation team, with broad membership (including service users). They were required to draw up plans identifying which of the specified national and local milestones they would report against. Trusts were also required to have an NSF-MH implementation lead and team.

Workforce

The NSF-MH required substantial increases in the workforce, particularly for the three mandated services. Some estimates were as large as 18,000 – an increase of nearly 80% over the 10 years.[10] Sub-groups were established on workforce planning and it was recognised that new models of care would require workforce diversification and new roles. NIMHE and the Royal College of Psychiatrists developed policy to support these changes. For example, *New ways of working for everyone*[11] examined staffing roles, skill mix and the role of allied health professionals, while *Creating capable teams*[12] provided best practice guidance to enable teams to assess staff numbers and skill requirements.

Timescale

Deadlines were a key feature of implementation in relation to the three key models of community provision. The NHS Plan 2000 included a target implementation deadline of 2004.

Funding arrangements

The majority of funding for the NSF-MH/NHS Plan was from central government. Funds available were hypothecated or 'earmarked'. They included £700m over three years to implement the NSF, and £120m distributed via a Mental Health Modernisation Fund.

Half of the modernisation fund was distributed as part of unified allocations, mainly for services. Some was held centrally for Department of Health initiatives; the rest was allocated via a mental health grant comprising (variations of) a core grant to support existing services, a target fund to improve provision and, for specific initiatives, a partnership fund. The latter was for revenue expenditure only; it was not to be used to finance any capital needs or as a substitute source of finance for social care already being provided.

The Department of Health held funds for centrally funded initiatives, including the provision of secure beds, and for the establishment of regional mental health development programmes and NHS Beacons to encourage innovation in mental health.

Local authorities were required to contribute 30% to the core grant and partnership fund; they were expected to invest 15%-30% of the core grant (years 1 and 2) in additional training.

During the main period of implementation (1999/2000 to 2005/06), expenditure on adult mental health services increased in real terms by 47% – an annual rise of 6.7% – with around a third going on development of

community-based teams (particularly those set out in the NSF-MH). It is important to note that there was substantial investment in the NHS at this time and the funding allocated was in line with these rates of investment.

Outcomes

It is undeniable that huge transformation was delivered across community services and in a relatively limited period of time.

The focus on workforce and skill mix resulted in large increases in the number of clinical psychologists and support workers, and moderate increases in the number of psychiatrists and mental health nurses.

However, full implementation was never reached and there was limited data on how many patients were being looked after by the new specialist teams (see Challenges below). A request under the Freedom of Information Act revealed that 14,882 people were being looked after by the assertive outreach teams (at 31 December 2004).[13] This fell short of the target of 20,000 'adults with severe mental illness and complex problems' thought to be in need.[14]

The expected benefits of community care, combined with evidence for some of the service models, led most providers to reduce their inpatient bed provision. Some closed beds in anticipation of the reductions in need; others closed them in parallel with community service development or afterwards, as a result of over-capacity. However, the new models of care often failed to deliver the anticipated reductions and, in some cases, cuts in bed capacity were overly optimistic.[1]

Some care models were found to be poorly adapted to the settings in which they were implemented. Assertive outreach proved particularly difficult to implement in rural settings.

The plan missed a crucial opportunity to create continuous evaluation of how the NSF-MH standards were being implemented. Key questions remained about how far the transformation delivered improved outcomes for mental health services and users.

Although top-down implementation was very effective, not all providers, commissioners and staff understood or agreed with the rationale for the specifications where supporting evidence was more limited. Over time, services implemented under the NSF-MH were reconfigured and dismantled. Current policy is restating the need to implement at least two of these models.

Challenges

Workforce logistics

The sheer numbers of staff required within the timeframe and diversification of roles was ambitious. It was estimated that to implement the NSF-MH in full by 2010/11, aggregate staff numbers needed to increase by 38% relative to the numbers employed in mental health care in 2005/06. Particular pressures arose in relation to those services that were more clearly mandated, where an estimated increase of 80% was required over the 10 years. Staff for assertive outreach teams were often drawn from rehabilitation services, decimating existing provision, and gaps in early intervention staffing were particularly large.

Retrospective studies suggest that funding and workforce requirements were underestimated. Estimates suggest that total annual spend on adult mental health services needed to increase by 8.8% a year in real terms for full implementation.[10] The 2002 Wanless report estimated that spending needed to increase by 9.6% a year.[15] Between 1999 and 2002, estimates put the total investment needed at around £623.25m – falling short of the promised £700m. In practice, budgetary constraints hampered implementation locally.[16]

Transparency and accountability

Funding for the NSF-MH was often part of unified allocations. The Department of Health did not require trusts to record spending in a standard way, and sometimes extra funding was not specifically identified within these allocations. The lack of transparency, alongside financial pressures and insufficient priority afforded to mental health, left spending to local organisations to argue over.[17] Experts judged that some local health authorities 'disinvested' from mental health during this period.[18]

Wider systemic considerations

Assertive outreach was underpinned by a case management approach providing for every aspect of an individual's needs. However, this was not always within the power of the service, and a lack of access to appropriate supported housing has been noted as an important limiting factor.

The focus on implementing particular models of care within the NHS Plan led to concerted attention on new functional teams, but resulted in a lack of investment and consideration of existing community mental health services. Staff from community mental health teams furnished the new teams, resulting in a loss of skills and expertise.

Case study 3: Canada's Primary Health Care Transition Fund

Overview

The CAD800m (£360m) Primary Health Care Transition (PHCT) Fund was in place from 2000 to 2006 and provided transitional costs to support the transformation of Canada's primary health care system. Most of this funding was allocated to the provinces, but a proportion was retained centrally to be distributed for specific projects and initiatives.

Context

Canada's health care system is publicly funded, and mostly free at the point of use, based on a regionally administered public insurance programme that funds mainly private provision. Canada is made up of 10 provinces and three territories. The provinces receive federal funding for health care and have to agree federal mandates (such as universal access to essential care) but each has jurisdiction over health care. This means that provinces are able to determine what is considered essential care, as well as how it is delivered, leading to variation between provinces.

The development of primary care in Canada is an ongoing process driven by a number of policy initiatives and financial incentives, as well as by the political environment and demand for change. The fund was put in place by politicians in response to growing political and public concern about access and quality of primary care, given that its performance and infrastructure was lagging behind those of its international peers.[19] There was also growing dissatisfaction among family physicians with their working conditions and ability to provide high quality of care.[20] During the same period, economic downturn led the government to focus on efficiency, and provinces were integrating health services (including community, acute and residential) within their regions.[21]

The PHCT Fund was one of a number of initiatives implemented to strengthen and develop primary and community care. This included a CAD16bn Health Reform Fund targeted at home care, drug coverage and primary care, and a national target for 50% of Canadians to have 24/7 access to multidisciplinary primary care teams by 2011.[20] There have also been initiatives to develop electronic health records and a human resources (HR) strategy.

Intended benefits

All initiatives funded by the PHCT Fund had to be linked to one of five aims:

1. To increase the proportion of the population with access to primary health care organisations that are accountable for the planned provision of comprehensive services to a defined population
2. To increase emphasis on health promotion, disease and injury prevention, and chronic disease management
3. To expand 24/7 access to essential services
4. To establish multidisciplinary teams, so that the most appropriate care is provided by the most appropriate provider
5. To facilitate coordination with other health services (such as specialists and hospitals).[22]

Process and management

Provinces were required to submit a proposal to a national working group (which included provincial representatives), which assessed whether it met the objectives and eligibility criteria. If it did, a Contributions Agreement was signed, with a yearly budget that outlined how and when the money would be spent. It is not clear to what extent provinces were held to account for these agreements, and the PHCT Fund has been criticised for not holding provinces to account.

Provincial governments took different approaches to distributing their allocations. Some developed their own proposals process, accepting applications and giving out grants. In some provinces these were focused on certain areas, such as developing electronic health records or developing teams. Some provinces also took a directed funding approach and invested in research. Ontario's approach is outlined in the box below.

Ontario's programme of administration

Ontario split its provincial envelope (CAD213m) into operational grant funding and capital grant funding. The capital grant funding was to support one-off capital costs associated with the integration of primary health care practitioners into interdisciplinary primary care models. These were generally awarded to practices and were used to fund projects such as:

- increasing capacity by equipping a new treatment room or setting up a new nurse practitioner clinic
- upgrading practice telephone or computer systems such as patient database management systems or electronic health records
- renovation or construction of office space – for example, to enable a nurse practitioner to be available on site.

The operational grant funding (CAD75m) focused on developing interdisciplinary primary health care. Funded projects included academic research to develop or evaluate programmes, demonstrations or pilots of projects (particularly for mental health and rehabilitation), developing multidisciplinary teams and integration, training and education, and investment in IT systems.

Medical associations were engaged in the PHCT Fund from the outset, which meant that transformation was, in many cases, physician-led. For example, in Ontario, the College of Family Physicians received funding for a workshop to develop the research agenda for the fund and to hold stakeholder meetings with organisational leaders.

Funding arrangements

The fund comprised CAD800m and was aimed specifically at transitional costs. It was split into five envelopes. The provincial envelope accounted for 75% of the fund (CAD600m) and was used to support provinces to reform their primary health care systems. This was allocated on a per capita basis, and smaller provinces received an additional CAD4m each to ensure sufficient funding for initiatives on significant and sustainable scale.

The remainder of the fund (CAD200m) was split into four envelopes to support cross-province initiatives, pan-Canadian initiatives and specific envelopes for minority groups (one for aboriginal health care and one for language minorities). These national and minorities envelopes were available for federal, provincial/territorial governments, health organisations and not-for-profit organisations to apply for. Initiatives for any of the five funding envelopes had to support at least one of the five key national objectives.

The fund was used to cover costs of (for example): pilots and demonstrations; workshops and knowledge sharing events; project management staff; IT systems; retro fitting (such as equipping a new treatment room); research and evaluation. A set of eligibility criteria aimed to focus the money on the transitional costs and ensure that money was not spent on things that would require ongoing investment. For example, funding new buildings was not allowed, nor was funding additional clinical personnel, unless it was to backfill a secondment to a project management role.

Outcomes

Many provinces were already taking steps to improve primary care and it is difficult to determine what can be attributed directly to the PHCT Fund, because the literature often focuses on primary care reform in Canada more generally. However, there are some ways in which the Fund is considered to have had more of an impact than others.

As one of our interviewees highlighted, first and foremost, the Fund focused the attention of policy makers, system managers and researchers on primary care. It brought together academics and policy makers from different fields, such as health and the social sciences, and established some long-lasting connections and partnerships. The Fund provided an opportunity to bring about change in primary care, following a period of austerity.

Second, involving clinicians in the Fund and transformation proposals from the outset enabled quicker implementation and aided buy-in. The need to involve patients as part of the decision making process was also noted.[23]

Third, building collaborations and relationships enabled continued sharing of knowledge and provided support for cultural change, leadership and knowledge sharing. The importance of evaluation was highlighted throughout, with part of the Fund earmarked for knowledge sharing

and evaluation. The national evaluation synthesis of the PHCT Fund[24] highlighted the importance of sustained effort to support knowledge transfer and dissemination to ensure that best practice is adopted.

Finally, the Fund led to a rise in collaborative and multidisciplinary primary care providers, such as Family Medicine Groups in Quebec. It enabled investment in primary care IT systems. In 2013, the Health Council's annual report found that the use of electronic medical records had more than doubled since 2006 (one of the aims of the PHCT Fund), and electronic prescribing had increased from 11% in 2006 to 43% in 2012. An evaluation of primary health care reform highlighted positive developments in Canada's primary care as 'an increase in collaborative practices, openness to change and quality improvement, more patients being registered, changes in remuneration to more blended forms of payments and improvements in chronic disease management'.[25] However, it found little evidence of positive change in accessibility, in the use of emergency services or in access for vulnerable populations.

Overall, some provinces may have taken better advantage of the opportunities brought about by the Fund than others, leading to uneven progress.[19]

Challenges

Time and resources

The PHCT Fund has been criticised for funding a large number of short-term initiatives without strategic planning or oversight. In many cases it took a while before funds were actually being spent, leading to tight timescales in which to complete projects and some poor investments being made. In Ontario, for example, guidelines for applicants were published in May 2003, with application deadlines a few months later; all projects had to be completed by 2006.

Engagement, accountability and evaluation

At a national level, having a set allocation per province led to complacency, with some provinces assuming they would receive funds regardless of the quality of their proposals. There was a requirement for provinces to produce update reports, but it was not clear what happened to these or how they were used. Matched funding was suggested as a means of ensuring engagement and accountability. At a provincial level, governments lacked the capacity to monitor initiatives or check on delivery. Difficulty in developing indicators to monitor impact was highlighted as a challenge; ensuring that initiatives were outcomes-focused, with improvements in patient care as the ultimate goal, was seen as key.

Sustainability

Although the Fund was aimed specifically at transitional costs, many stakeholders raised concerns about sustaining changes after the Fund had closed.

Case study 4: Denmark's hospital transformation

Overview

In 2007 the Danish government introduced a 'Quality Fund' (*Kvalitetsfonden*) as part of a set of wide-ranging reforms of health and local government structures. This was a DKK42.7bn (worth £5.9bn in 2015/16 UK prices) initiative, with DKK25.5bn (£3.5bn, 15/16 prices) core fund to build new, modern hospitals as a central feature of a new health and care infrastructure. With the initial commitment made in 2009, the projects are currently in progress and are expected to finish in the next few years.

Context

Denmark is divided into five regions, which contain 98 municipalities. The Danish health care system is currently managed by the regions, with populations ranging from 600,000 to 1,700,000. They receive 80% of their funding from the state and 20% from the municipalities. The regions manage all secondary and tertiary care while the municipalities cover elderly care and rehabilitation. Primary care is provided by independent private practices, which are separate from secondary care, but funded from the regions' health care budget. This structure has been in place since the 2007 reforms.

With a trend towards more out-of-hospital care, and reducing length of stay, there was political and clinical will to change the way care was being delivered. An expert panel was established to define and specify what an acute hospital should be. This hospital construction goes hand-in-hand with new plans and concepts for emergency care (including a nurse-led telephone service). These new hospitals would then be constructed based on the plans developed by each region. The *Kvalitetsfonden* (Quality Fund) was established as part of the 2007 reforms to fund construction.

Intended benefits

The aim of the Fund is not just to change the way health care is delivered in Denmark, but also to improve quality and productivity by doing so. While it was decided that it would not be appropriate to decide on quality metrics to assess the projects, some productivity requirements have been set out. These were agreed after reviewing the type of construction (building on greenfield sites or renovation of existing provision), the different baselines, and the evidence of improved productivity from previous major hospital construction. The productivity requirements are expected to be realised within a year of the new hospitals being completed, although it is

acknowledged that this is ambitious.

Process and management

In 2007, the government set up a panel of experts to assess the regions' applications for grants to the Quality Fund. It also made preliminary commitments to support 16 projects. The expert panel evaluated the specific hospital projects and made recommendations to the government as to which projects should receive funding from the Quality Fund.
The expert panel has evaluated the regions' hospital plans as well as the individual construction projects. A preliminary commitment of funding for successful applications determines the scope of the investment. Subsequently, the regions must specify the project within this framework and apply for final commitment. The final commitment of funds includes approval of the project plan on certain conditions.

The productivity requirements for the new hospitals reflect the relationship between a hospital's operating budget and its activity. There is, however, some disagreement about the appropriate baseline and appropriate way of measuring productivity.

Since the hospital and health care systems in Denmark are governed at the regional level, the regional councils are responsible for planning and managing the construction within budgets and inspecting the hospital construction projects. The Danish Ministry of Health, which has a department to monitor the projects, is responsible for approving and supervising the construction projects.

Funding arrangements

These construction projects represent the largest capital investment ever made in Denmark (totalling DKK42.7bn over 10 years). Of this, DKK25.5bn is earmarked for government co-financing, and the remaining 40% by the regions. The total investment budget is also financed by expected productivity gains and loans. This figure was based on the amount that central bodies felt could be used to support the ambition to modernise hospitals.

The funding is given to the projects at intermediate deadlines, of which there are four or five for each project. In principle, the Ministry of Health can choose to withhold the funding at any of these points in time. In practice, in all but one case (where the auditors had not yet submitted their report), the money has been committed at each deadline.

In January 2009, the government followed the expert panel's recommendations and made a preliminary commitment to 11 projects.

Challenges

Managing costs

While the Fund's commitments matched the DKK42.7bn figure, the original plans were more than double that. Negotiations were therefore required to reduce the proposed budgets.

However, this has proved challenging in terms of delivery of the plans. The terms of plans are such that no more money can be put into the projects over and above the amount agreed. Given that large capital investment projects inevitably contain uncertain cost fluctuations, this has been problematic. Nonetheless, it is important to note that the amount of funding has not changed over the past eight years.

A further area of critique from the *Rigsrevisionen* (the national auditors of public spending) is that the Ministry of Health has not done enough to ensure that the new hospitals will achieve the efficiency gains. Their concern is that the due to the decision not to judge projects on their quality of care, hospitals may increase operational efficiency just by cutting spending.

Case study 5: The London Challenge

Overview

The London Challenge was a secondary school improvement programme that was implemented in the capital between 2003 and 2011. It was subsequently extended to other cities around the UK in 2008, having already been deemed to have made a positive impact on London's schools. It was jointly run by the Prime Minister's Office and the Department for Education and Skills (DfES) (although this department ceased to operate in 2007).

Context

The Labour Party came into government in 1997, bolstered by the slogan 'education, education, education'. Over the first few years, it implemented a number of new initiatives and policies to improve failing schools. But by 2001 the reforms had not gone as far as had been hoped and some areas, particularly London, were being left behind. The number of underperforming schools in London was not decreasing in line with the rest of the country, leading to discontent among parents, teachers and politicians, and criticism in the local media.

Intended benefits

The challenge focused on three clear and measurable objectives:

1. to reduce the number of underperforming schools, especially in relation to English and maths
2. to increase the number of schools rated as 'good' or 'outstanding' by Ofsted
3. to improve educational outcomes for disadvantaged children.

Process and management

The London Challenge was developed and implemented at a policy level, with responsibility allocated to the Minister for London Schools, a new post created within DfES. A team of civil servants subsequently led on different strands of the policy. In addition to this team, a London Schools Commissioner was appointed, supported by a team of London Challenge advisers, who were all senior practitioners with considerable expertise in education and a successful track record in improvement. This team was further supported by a private firm that provided project management expertise.

The London Challenge represented a combination of approaches:

- the provision of pan-London leadership development resources and programmes available to all schools
- individualised support for 70 of the most disadvantaged schools
- intensive work with schools in five London boroughs to help them reform their secondary school provision.

The policy team identified the priority group of schools with the worst performance and assigned each a London Challenge adviser, who worked with the school (in close liaison with the policy team) to develop an action plan and broker a package of support from DfES. The policy team worked with key boroughs to develop a vision for improvement that was aligned with local plans, and outlined the resources required from DfES to deliver that vision.

Key elements to facilitate improvement included: support with effective use of data; support for leadership; and support for teaching and learning. Teaching and learning support included the Outstanding Teacher Programme and Improving Teacher Programme, which took place in teaching schools, and coaching which took place in the supported schools. The sums of money involved in most projects were quite small, particularly at first, meaning that a collaborative approach was easier and there was less pressure for immediate success, allowing flexibility and informal approaches at times.

In supporting leadership development, the policy team sought to establish clusters of schools to encourage them to work together. Headteachers from good and outstanding schools were chosen as 'consultant heads' who could share experience and expertise with other headteachers in the area. This evolved into the London Leadership strategy, which was overseen by a non-departmental government body and run by headteachers.

A key feature of the London Challenge was its support for innovation and learning. Data formed a core part of this, and schools were supported to both collect and use data in order to determine where support was required and whether interventions were successful. Schools also received additional support in project management. This was integral to creating an environment in which professionals took the lead in making decisions, but where there was a clear mechanism to hold them to account. Accountability was seen as an important part of the process, particularly for larger sums of money; routine meetings between schools, local authorities, project managers and members of the policy team were vital mechanisms for supporting implementation, identifying drivers of change, and addressing problems quickly.

Funding arrangements

The overall funding for the scheme was £15m for the first three years and £80m in total over the full eight years. The initial £15m was drawn from underspends within the education department. In subsequent years, specific money was put aside for the scheme. This was focused almost exclusively on secondary schools (similar schemes in Birmingham and Manchester included primary schools).

The sums given to each school varied greatly, from £1,000 for staff to attend a conference (for example) to £60,000 for classroom refurbishment. Funding was brokered by expert advisers and officials at DfES. Smaller sums of money could be agreed and signed off by more junior officials, up to approximately £25,000, where they were passed to senior officials; sums of £50,000 and above were approved by the Minister for London Schools.

Matched funding was used in some areas to encourage buy-in and accountability. Funding also came in return for evidence of improvement and sustainability.

Schools used the money in different ways. Many used the funding to backfill staff absences, allowing their own staff to visit other schools and attend courses. Some appointed new staff to work on improvement schemes directly, while others used the fund for building work. The use of data was deemed really important in some places, and so money was used to employ a data manager. Resources were also an important expenditure for some schools, such as IT equipment or classroom refurbishment. Funding was particularly welcomed by schools that were running a financial deficit. Although the money had to be used for improvement rather than plugging gaps, it meant a school could undertake improvement initiatives while still running in deficit.

Outcomes

The London Challenge received strong support from the then Prime Minister, Tony Blair, and ongoing political support throughout its duration from the Education department. Despite changes in key posts, strong programme leadership was maintained. At a practical level, both the London Schools Commissioner and the policy lead were former teachers, with substantial experience and strong credibility in their fields. The leadership was integral to sustaining the political will for, and developing and maintaining the approach of, the London Challenge.

A review of London schools undertaken by CfBT Education Trust and the Centre for London found dramatic improvement in London's schools between 2000 and 2014.[26] They identified four main contributing factors, one of which was the London Challenge: 'The superior performance of London schools is apparent using both government-imposed key indicators and other metrics that are less susceptible to "gaming" by schools.'

Another analysis of the London Challenge highlights a number of factors that contributed to its success.[27] These included:

- bringing in the right people to lead and manage the Challenge
- understanding the nature of the problem and context for improvement
- linking the aims to other government policy priorities
- framing and communicating the purpose
- having a wider team that reflected the ways of working required and a second group of people with relevant expertise
- implementing change and developing policy through practice
- ensuring buy-in from local stakeholders

- drawing on assets in the system, building on existing good practice
- managing expectations and creating space for ongoing learning
- learning from experimentation
- developing and sustaining a culture and ways of working coherent with the role of the Challenge
- mobilising and empowering practitioners to develop professional ownership and accountability
- establishing project management disciplines
- using data to monitor progress
- adapting to and celebrating success.

Although individual interventions had the greatest effect in each objective area overall, the most effective aspect seemed to be that it was a 'highly supportive and encouraging intervention in which head teachers and teachers came to feel more valued, more confident and more effective'.[28]

The new funding stream enabled schools to enact new and sometimes long-held improvement ambitions, regardless of the state of their overall finances.

Challenges

Stakeholder engagement

The Challenge experienced difficulties in managing external stakeholders, including local authorities, parents and the local media. Different approaches and strategies were used to engage and manage stakeholders. These included making sure that, where required, organisations and individuals were kept informed, and aligning work streams and goals with those of the local education authority. The London Challenge took a stance of aiming to avoid the media spotlight in order to manage adverse criticism and enable change.

Administering the fund and resources

Ensuring that resources were used to greatest effect was not always straightforward. During the process, it was found that schools receiving smaller amounts felt less enthusiastic about the programme.

Access to expertise

The London Challenge experienced difficulties in ensuring access to credible professionals who could provide the appropriate support for underperforming schools but also remain accountable to the Department. There were also challenges in ensuring that those involved had access to quality resources and models of improvement.

Case study 6: Girls' Education Challenge Fund

Overview

The £344m Girls' Education Challenge (GEC) Fund was set up by the Department for International Development (DFID) to run between 2012 and 2018, with funding focused on a four-year cycle, 2013–2017. It is the UK's main contribution to the Millennium Development Goal of eliminating gender disparity in primary and secondary education – one of the Millennium Development Goal (MDG) targets agreed by UN Member States in 2000.

Context

The Fund provides grants or subsidies to projects designed to achieve a social objective. Projects are selected through a competitive process and recipients share risk in some way with the funding body. The UK government mostly uses the Fund in its international development work but it has also been used to support domestic development goals.[29]

DFID's business case sets out the rationale behind its design decisions.[30] It opted for a challenge fund design because it can provide strong incentives for innovation in service design and delivery methods. It opted for an external fund manager to ensure a tight strategic and technical focus, while it retains the final say on major funding decisions so that the Secretary of State can manage political risk.

Intended benefits

The GEC Fund has two primary objectives:

- to help between 650,000 and 1,000,000 girls into primary and secondary education
- to find new interventions that can be proven to increase participation and quality of schooling for girls in low-income countries.

Process and management

The GEC Fund is administered by a consortium led by the management consultancy PwC UK, which is the 'prime provider' responsible for delivering administrative functions for the Fund. PwC UK sub-contracts three other organisations to provide the administration function:

– Social Development Direct provides education and social impact expertise

– FHI 360 provides infrastructure in many countries within which the GEC operates

– Nathan Associates provides measurement and evaluation expertise.

The Fund managers are supported by a steering committee, which informs decisions to support individual projects and is tasked with setting the strategic direction. As Fund managers, the consortium is required to focus purely on outcomes, rather than prescribing what types of intervention are acceptable. But at the same time, it is expected to seek out and provide support for the development of proposals.

In addition, an internal GEC team in DFID provides strategic oversight. An independent provider is contracted to monitor and evaluate the functions of the Fund and assess its effectiveness.

The DFID contract for the GEC sets out clear design principles for the Fund, with justifications. It is supposed to be administered in a way that is:

– **competitive** – to drive high performance

– **responsive** – so the GEC can adapt to emerging evidence and fund a variety of projects

– **structured** – with clear criteria and incentives to derive the full benefits of scale

– **straightforward** – with a clear rationale for its model and approach, keeping the level of complexity to the minimum compatible with achieving the Fund's aims.

The GEC Fund operates three funding windows, in which recipients and projects of distinct types are funded:

1. **Step change** – grants and support for projects to quickly expand proven approaches to increasing girls' participation.
2. **Innovation** – grants and support for projects testing new approaches to increasing girls' participation, including technological solutions, new partnerships, adapting approaches for new contexts, and novel societal interventions.
3. **Strategic partnerships** – subsidies for partnerships with private companies.

The GEC Fund managers have an explicit expectation that limits the step change projects to nine countries that DFID prioritises – some of the most challenging states in the world, including Somalia, Afghanistan and Sierra Leone.

Officially, recipients apply for funding during the window that applies to their project. Applications are judged against a set of criteria published before the window opens. In practice, the Fund administrators and their subcontractors seek to stimulate interest in the fund among likely applicants. Many of those who would apply for the step change window have received DFID funding before developing their intervention.

Less-established organisations with untested ideas or project proposals appropriate for the innovation window may not have been involved in development grant applications before. The Fund managers are expected to support potential applicants appropriately and to continue to support their organisation's development after any grant has been awarded.

Learning and evaluation

Each project has to have a clear theory of change by which their intervention will deliver and specify a number of realistic outcomes over a given timeframe. These outcomes form the basis of a payment by results (PbR) framework. Projects are kept under regular review to ensure that inputs in their project application's theory of change are in place. These take the form of quantitative measures like the number of school textbooks purchased and qualitative measures like gender-specific teaching. Innovation window projects and partnership projects are not subjected to the same PbR requirements, because they focus on discovering new approaches that could be scaled up and rolled out in the future.

The Fund managers set criteria for the baseline and subsequent mid-line and end-line evaluation of all the projects awarded funding. Baseline and progress evaluations are commissioned independently by recipients. These substantial evaluations seek to understand how much of an improvement the project is making in the outcomes concerned. The criteria set out by the managers include required sample sizes, target setting, and acceptable methodologies for measuring the key outcomes. They also provide support and capacity-building for projects to build their designs for measurement and evaluation.

Funding arrangements

The DFID contract specifies how the overall funds are allocated between the different types of activities. Two-thirds of the Fund are spent on the 'step change' scaling window, reflecting DFID's assessment that effective solutions already exist and just require support to be adopted and implemented elsewhere. The remaining third is spent on the innovation window and strategic partnerships (which run concurrently).

The entire £344m for the GEC Fund was provided by DFID. However, to ensure that risk is shared with recipients of funding and to maximise the capital it can unlock, match funding is encouraged. Each window had a different approach to match funding, reflecting the objective of that window and its risks. As such:

- match funding for the **innovation** window may be 'in kind' capital.
- a spectrum of match funding is related to external risk for the **step change** window.
- in the **partnerships** window, recipients compete on the level of match funding they pledge over and above a 50% minimum.

A proportion of funding (10%) is withheld from step change recipients until their projects can be shown to have delivered their objectives as part of the PbR framework, defined in terms of expanding girls' education opportunities or eliciting lessons about what works.

The contract for the GEC places an upper limit for individual projects' funding needs of 10% so that the portfolio can be more diverse and risk is balanced across the Fund.

Outcomes

Although outcomes are directly related to the projects funded, in practice a high degree of emphasis is placed on learning and development of the GEC Fund as a model in its own right. The Fund completes an annual review of the projects it has supported and of how the Fund is managed, which includes a focus on progress and results, costs and timescale, evidence and evaluation, risk, and value for money. As a result, Fund managers have adjusted the proportion of investment in different types of activity, as well as the criteria for funding and the required outcomes. The baseline data, support and evaluation of projects provides a key mechanism for optimising and informing future management of the Fund.

Challenges

Understanding context and access to expertise

One of the main challenges encountered is that many projects setting up at the same time can mean that demand for support – in particular in establishing the appropriate baseline evaluation for projects – cannot be met. The Fund's managers have had to ensure the development of sufficient capacity in the evaluation market to carry out these baseline evaluations.

References

1. Gilburt H, Peck E, Ashton B, Edwards N, Naylor C. *Service transformation: lessons from mental health*. The King's Fund, 2014.
2. Bachrach LL. A conceptual approach to deinstitutionalization. *Hosp Community Psychiatry.* 1978 Sep;29(9):573-8.
3. Great Britain, Ministry of Health, National Health Service. *A hospital plan for England and Wales*. London, HMSO, 1962. Cmnd 1604.
4. Knapp M, Beecham J, McDaid D, Matosevic T, Smith M. The economic consequences of deinstitutionalisation of mental health services: lessons from a systematic review of European experience. *Health Soc Care Community*. 2011 Mar;19(2):113-25.
5. Goplerud EN. Unexpected consequences of deinstitutionalization of the mentally disabled elderly. *Am J Community Psychol.* 1979 Jun;7(3):315-28.
6. Department of Health. *National Service Framework for Mental Health. Modern Standards and Service Models*. Department of Health, 1999.
7. Department of Health. *Modernising mental health services.* Department of Health, 1998.
8. Department of Health. *The NHS Plan: a plan for investment, a plan for reform*. Department of Health, 2000.
9. Department of Health *The mental health policy implementation guide.* Department of Health, 2001.
10. Boardman J, Parsonage M. *Delivering the government's mental health policies. Services, staffing and costs*. London: The Sainsbury Centre for Mental Health, 2007.
11. Department of Health. *New ways of working for psychiatrists: enhancing effective person-centred services through new ways of working in multidisciplinary and mulit-agency contexts: final report 'but not the end of the story'*. London: Department of Health, 2005.
12. Department of Health. *Creating capable teams approach (CCTA): best practice guidance to support the implementation of new ways of working (NWW) and new roles*. London: Stationary office, 2007.
13. The King's Fund. *An independent audit of the NHS under labour (1997–2005)*. The King's Fund, 2005.
14. Department of Health. *Priorities and Planning Framework 2003–2006.* London: The Stationery Office, 2003.
15. Wanless D. *Securing our future health: taking a long-term view.* The Treasury, 2002.
16. Rankin J. *Developments and trends in mental health policy.* Institute for public policy research, 2006.
17. Appleby L. *The national service framework for mental health - five years on*. Department of Health, 2004.
18. Peck E. New Labour's Modernization in the Public Sector: a Neo Durkheimian Approach and the Case of Mental Health Services. *Public Administration* 82 (1) 2004
19. Hutchison B. Reforming Canadian Primary Care – Don't Stop Half-Way. *Healthcare Policy*, 9(1) August 2013: 12-25.
20. Aggarwal M, Hutchison B. *Toward a Primary Care Strategy for Canada*. Ottawa: Canadian Foundation for Healthcare Improvement, 2012.

21. Health Canada. *Laying the groundwork for culture change: The legacy of the primary health care transition fund*. Health Canada, 2007.

22. Health Canada. *Primary health care transition fund*. http://healthycanadians.gc.ca/health-system-systeme-sante/services/primary-primaires/transition-adaptation-eng.php (accessed 10 July 2015)

23. Ministry of Health and Long-Term Care. *Primary Health Care Transition Fund Workshop Report*. Ministry of Health and Long-Term Care, 2004.

24. Bergman J. *Primary Health Care Transition Fund: Evaluation and evidence*. Health Canada, 2007.

25. Levesque J, Pineault R, Grimard D, Burge F, Haggerty J, Hogg W, Katz A and Wong S. *Looking Backward to Move Forward: A Synthesis of Primary Health Care Reform Evaluations in Canadian Provinces.* Gouvernement du Québec, 2012. Available at www.inspq.qc.ca/pdf/publications/1439_RegarderArriereMieuxAvancer_SynthEvalReforSoins1Ligne_VA.pdf

26. Baars S, Bernardes E, Elwick A, Malortie A, McAleavy T, McInerney T, Menzies L, Riggall A. *Lessons from London schools: investigating the success*. London: CfBT Education Trust, 2014.

27. Kidson M, Norris E. *Implementing the London Challenge*. Joseph Rowntree Foundation and Institute for Government, 2014.

28. Hutchings M, Greenwood C, Hollingworth S, Mansaray A, Rose A, with Minty S, Glass K. *Evaluation of the City Challenge programme*. London: Department for Education, 2012. Research Report DFE-RR215.

29. O'Riordan A-M, Copestake J, Seibold J, Smith D. *Challenge funds in international development*. Bath: University of Bath, 2013. Working Paper No. 28.

30. Department for International Development 2012. Business Case: Girls' Education Challenge V.4 Accessed from this web page in April 2015: http://devtracker.dfid.gov.uk/projects/GB-1-202372/documents

The Health Foundation wants the UK to have a health care system of the highest possible quality – safe, effective, patient-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the health care system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change that are all essential for real and lasting improvement.

The Health Foundation
90 Long Acre
London WC2E 9RA

T 020 7257 8000

Registered charity number: 286967
Registered company number: 1714937

For more information, visit:
www.health.org.uk

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

The King's Fund
11–13 Cavendish Square
London W1G 0AN

Tel: 020 7307 2400

Registered charity number: 1126980

For more information, visit:
www.kingsfund.org.uk