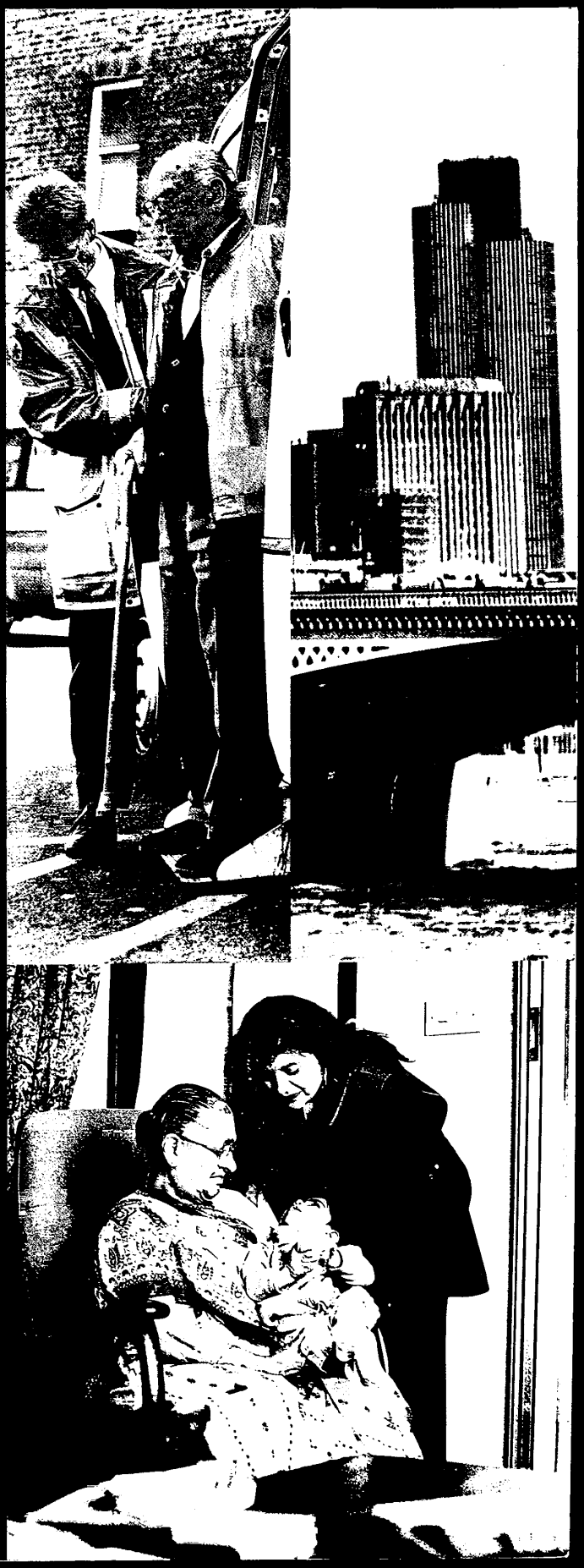
King's Fund

London Health Care: Rethinking Development

A discussion paper prepared for the King's Fund London Commission

David Towell, Gordon Best & Steve Pashley

100 YEARS SUPPORTING PEOPLE'S HEALTH 1897~1997



King's Fund
Publishing
11–13 Cavendish Square
London W1M 0AN

London Health Care: Rethinking Development

A discussion paper prepared for the King's Fund London Commission

David Towell, Gordon Best & Steve Pashley

King's Fund

Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

First published 1997

ISBN 1 85717 168 3

A CIP catalogue record for this book is available from the British Library

Distributed by Grantham Book Services Limited
Isaac Newton Way
Alma Park Industrial Estate
GRANTHAM
Lincolnshire
NG31 9SD

Tel: 01476 541 080
Fax: 01476 541 061

Printed and bound in Great Britain by Biddles Ltd, Guildford and King's Lynn

Cover photographs by Richard Bailey

Contents

Introduction

Faced with rising expectations, shifting patterns of illness, technological innovation and financial pressures, health and social care systems internationally are having to find ways of adapting to the challenges of large scale change. The need for successful adaptation is particularly acute in big cities, which are themselves continually evolving through a dynamic interaction between intended change and chaotic flux. In the developed world there can be few if any places where these challenges are as great as in London. As the home to seven million people with huge diversity in personal resources and needs, as the location for a distinctive pattern of health and related service provision – some key features of which still reflect the capital's much earlier history – and as the focus over the last five years for national policy initiatives aimed at fundamental change, London is at the heart of a difficult struggle to find better ways of doing things.

The King's Fund, through its first London Commission, which reported in 1992, was one very influential advocate for the need to reshape London's health services as part of the wider renewal of the capital, with major implications for acute, primary and community care and the organisation of medical education and research. Taken together, these changes involve radical transformation in service delivery and its institutional support, with many of those receiving care – and many delivering it – doing things in new and quite different ways. Five years on, the second London Commission was established to review progress in the intervening period and identify the agenda for the next phase of development, this time giving more attention to community care and therefore to the contributions of local authority services.

Aware of widespread doubts, not least in the minds of many Londoners, about what has been achieved through the massive efforts to date, this second Commission has been concerned from the outset not only with *what* needs to be done but also with *how* this can best be achieved in the uniquely complex situation of London and its services. The Commission asked us – three of the King's Fund Management College Faculty with particular experience of work on strategies for large scale change in public services – to assist in this area of their enquiries.

We have worked closely with the Commission to understand their emerging diagnosis of what is happening in London. We have had available to us the results of an extensive research programme carried out on the Commission's behalf and currently being published as a contribution to wider debate (see References). We complemented this work through over 50 discussions with people at all levels in the London 'system',

designed to tap their experiences of the processes of change and draw out insights for the future, expressed in the form of a series of *case studies*. Some of these discussions were about 'macro' changes – for example, the reconfiguration of institutions and services in the whole of South East London; the merger of medical schools to create one of the new multifaculty colleges of the University of London; and the functions fulfilled by the London Implementation Group. Others focused on a variety of 'micro' changes, as local leaders sought to bring about innovations in service provision 'near the ground' – for example, to strengthen primary care, pilot 'hospital at home' schemes or respond to pressures for significant rationalisation in acute hospital provision. (This material addresses mainly acute hospital and general community services: another report in this series deals in detail with *London's Mental Health,* Johnson *et al.*, 1997.) We tested hypotheses from these case studies in workshops with a cross-section of London leaders. We also sought to relate these insights to concepts available in the extensive academic literature on service, organisational and system development. This paper is one product of this work.

Much of our usual work at the King's Fund Management College involves us in *action learning,* i.e. assisting managerial and clinical leaders in public authorities and provider agencies as they seek to enhance the capacity of their organisations and wider systems better to serve their populations, at the same time trying to identify lessons of more general relevance. We know that people with leadership responsibilities in London typically bring a high degree of commitment and skill to their roles. As we examined our case studies, we were further impressed with the industry and ingenuity with which many people have been tackling very complex problems: indeed we believe that the 'seeds' of what is required in the next phase of change can be identified in their experience.

Equally, however, as the evidence collected by the Commission accumulated – that the massive efforts of the last five years have so far delivered relatively little gain for Londoners; that even though it is still quite 'early days' in the time-scale for long-term reform, it would be hard to claim that London is yet on the right trajectory; and that the agenda for the coming years is no less daunting – we have increasingly come to identify the need for a radical shift in the approaches to achieving change required in the next phase of development.

The broad agenda now identified by the Commission involves many different kinds of change which need to be tackled in different ways. In essence, however, we shall be suggesting that the transformation in the overall pattern of health and related services required to meet the needs of Londoners into the next century is unlikely to be secured

either through traditional approaches to public sector planning or through the operation of 'internal markets' in their current forms.

A national public service requires that the centre establishes broad directions and that ministers exercise judgement on politically sensitive issues for which they are publicly accountable. However, both the complexity and connectedness of local decision-making put significant constraints on the appropriateness of planning from the top down. Equally, market incentives may add to the pressures for change but the fragmentation and divisiveness associated with the NHS internal market in London have proved distinctly unhelpful to the collaboration across organisational boundaries required for successful long-term development.

Of course, good intelligence (e.g. on needs and effective service responses) and well-designed incentives (designed, that is, to promote superordinate goals) have a part to play in informing and fostering development. At a time of severe resource constraints there is also no escape from the need for hard political decisions. However, we have also concluded that strengthening the capacity of London agencies to tackle current challenges requires much greater emphasis on developing:

- a better understanding of the nature of complex change and the factors which determine how different types of change unfold in different circumstances and over time;
- more creative approaches to achieving fundamental, system-wide change in the pattern and nature of local services by fostering appropriate local alliances capable of working together across existing organisational, occupational and functional boundaries;
- more participative and culturally inclusive approaches to change which take into account and value the contributions of the full range of local stakeholders;
- more effective, locally rooted leaders and leadership coalitions capable of clearly articulating the need for change, challenging old assumptions and behaviour, and building commitment to new identities and forms of practice;
- a new 'negotiating' model of central–local relations emphasising a direction-shaping and context-setting role for the centre, and a more autonomous developmental role for local agencies, wherever possible working in partnership.

At first sight this will seem a rather idealistic prescription, particularly to London leaders locked by their jobs into the particularly difficult struggle to maintain services in the 1997/98 year. But our aim in this idealistic formulation is to set up a creative tension

between these requirements and current reality. With the new Government considering major change in London governance as well as a different approach to managing the NHS and also taking time to review decisions it has inherited on London's acute services, we are conscious that there may be a brief window of opportunity in which everyone concerned with London can make the space to reflect individually and together on whether there might be significantly better ways of moving forward.

This paper is intended to serve as one 'resource' to this process of reflection. In Chapter 1 we offer an overview of the challenges involved in the long-term development of London services, taking account of experience over the last five years. (The second London Commission will shortly be publishing its own much more detailed assessment.) We then draw, in Chapter 2, on both the theoretical literature and our interviews to rethink what is now required in more detail, illustrating the emerging propositions from our case studies. This leads in turn to an initial formulation of the practical implications for those with leadership responsibilities at all 'levels' in London's health system.

We hope the ideas and suggestions presented in this paper will be tested and improved through the experience of people in a position to shape and act on the next phase of London's development. In particular we have had in mind the contributions from and relationships between five main sets of stakeholders:

- Government;
- public authorities and their managers;
- provider agencies and their managers;
- clinicians and other staff;
- the public.

Following from the publication of the second London Commission report in July 1997, the King's Fund intends to play its part in facilitating dialogue within and between these interests about the optimum ways of achieving change better to serve the needs of Londoners.

Chapter 1

Contemporary challenges restated

1 Introduction

The report of the first London Commission (King's Fund, 1992) brought together a great deal of analysis to identify the key challenges facing London's health and related care systems, looking forward into the early years of the 21st century. This analysis has been reviewed and significantly extended in the work of the second Commission. Drawing on this work we can summarise four broad propositions relevant to understanding what is involved in achieving positive change.

Nationally and internationally there are powerful pressures for change in health care systems, which make inherited patterns of services and their institutional manifestations unstable. At the same time the complexity of the interconnections between these pressures and uncertainty about the impact of some (e.g. new technologies of treatment) make prediction about their impact more than a few years into the future risky. To quote Klein (1996), 'The only certainty is uncertainty.' Key issues are summarised in Box 1.

Box 1 Widespread trends shaping future patterns of health and related social care

- Recognition that in a situation of massive health inequalities and serious environmental threats to public health, health rather than health services is the proper focus for health policies.
- The considerable impact on health care provision of changes in demography, technology, quality improvement initiatives and public expectations.
- The need for greater transparency and indeed democratic accountability for priority setting in the face of upward pressures on expenditure in slow-growth economies.
- New thinking about the shape of local services, including:
  - renewed emphasis on primary care;
  - the need for community-based services to meet the growing needs of people with chronic illness or disability;
  - movement to both greater specialism and concentration in some acute services while technological innovations assist the dispersal of others.
- Increased attention to the interconnections between services across the boundaries of provider organisations and the need for different professional roles and team-working skills.
- Related changes in the requirements for professional education and clinical research.

All these pressures and trends are of great importance to London as both the home for seven million people and a major health services, education and research centre. Indeed, the need for significant change in the pattern of London services and related institutions has been a recurrent theme of health policy analysis for the whole of this Century – albeit with mostly disappointing results. As with earlier initiatives, the 1990s reform agenda focuses on five main issues:

- modernising London's health services as part of the wider regeneration of the capital;
- rationalising the provision of acute services and particular specialties across institutions and sites to ensure a better distribution of services, greater efficiency, improved quality and the release of resources for community-based services;
- improving primary, community and continuing care in partnership with related local authority services;
- providing the conditions for better medical education and research linked to major academic centres;
- establishing the organisational capacity for continuing development in these inter-related aspects of the London health and social care system.

The changes involved here are more profound than the reorganisation of facilities: they imply a major *transformation* in which, at each level in the service system many people receiving care – and many people providing it – will be doing different things in different ways. Put differently, such recent success as there has been in institutional changes (e.g. in merging different providers of medical education) needs to be understood as only a first step, and not necessarily a guaranteed stepping stone, to the changes in outputs (e.g. in this case, improving the quality of medical education, research and support for health services practice) by which success should ultimately be judged.

This agenda would be highly challenging anywhere but – despite the advantages of London as a capital city, its previous resource base and its capacity to attract some of the most able clinicians and managers in the country – there are a number of reasons why it is considerably more challenging here. These include:

- the size, complexity and tremendous diversity of London itself;
- the related complexity in administrative boundaries, service organisation and cross-boundary flows;
- the parochialism which can follow from the very strength of its institutions, many with long and distinguished histories;
- the potentially destructive competitiveness consequent on proximity among many similar providers;
- the likelihood of conflicts being magnified by the closeness to Westminster and Wapping.

2 Addressing the challenges, 1992–97

At the start of the 1990s, the combination of positive stimuli from new thinking on health sector development and the powerful pressures arising in London from the introduction of the 'internal market' and reducing revenue funding for its health authorities provided the trigger for the latest phase of change, particularly in acute hospital services. Following the first London Commission report, the official agenda for change was set out in detail in the Tomlinson report (Tomlinson, 1992), and the Government's response to this, *Making London Better* (DoH, 1993).

As well as developing a detailed substantive agenda for change, each of these reports also addressed the question of *how* change should be achieved (see Box 2). Given the radical nature of what was being proposed, it is striking in retrospect to see how relatively little attention was given to this question and the correspondingly limited analysis of the different kinds of substantive changes required. The Tomlinson report, for example, dedicated three of its 67 pages explicitly to 'implementation'.

All major change programmes in large scale public services pose difficult dilemmas, for example:

- How can the centre's role in policy-making, required for public accountability and to ensure fairness, best be combined with the peripheral discretion required to ensure appropriate responses to local diversity?
- How can formally recognised leaders exercise authority to secure action while engaging the participation and commitment of a wide range of stakeholders, including the people to be served?
- How can conformity to agreed standards be secured while at the same time promoting widespread initiative and innovation in relation to problems which require new solutions?

Box 2 briefly summarises different responses to these dilemmas in both the *philosophies* of the three reports and in their practical proposals. Philosophically, each identifies the need to combine clear strategic direction with some version of decentralisation: the London Commission seeking the active participation of Londoners and people working in these services; Tomlinson arguing for change from the bottom up, building upon consensus; and *Making London Better* suggesting that the operation of the internal market would enable change to be driven locally by patient needs. In each case, however, it is less clear how these top-down and bottom-up elements are to be combined.

Box 2 Perspectives on achieving strategic change in London

London Health Care 2010 (King's Fund, 1992)

Philosophy:
- *Change on the necessary scale will require 'strategic guidance....and coherent, system-wide implementation' based on clear principles and backed by 'sustained political will'.*
- *It will be essential 'to involve Londoners and those working within the capital's health services in their transformation ... change must build on their ideas for regeneration of health care'.*

Practice:
- Establish a task force accountable to the Secretaries of State, working through existing agencies to deliver the three main agendas below.
- Invest £250 million in a multifaceted primary care development programme based on local plans.
- Reshape acute services on a zonal basis following consultation with agencies and clinicians.
- Reorganise medical education and research in conjunction with the University of London.

Report of the Inquiry into London's Health Service, Medical Education and Research (Tomlinson, 1992)

Philosophy:
- *Change needs to be 'managed firmly and in some cases urgently' to prevent 'serious and haphazard deterioration' in London health services.*
- *It is of great importance to develop 'a programme of change from the "bottom up", building upon consensus'.*

Practice:
- Establish a high-level implementation group with 'executive responsibility to secure effective pan-London co-ordination of a restructured NHS' and follow through over 90 detailed recommendations ranging from ways of improving general practice premises to the closure of specific hospitals.
- Undertake further detailed planning, notably on the rationalisation of acute specialties.
- Manage firmly but sensitively the redeployment of medical and other staff.

Making London Better (Department of Health, 1993)

Philosophy:
- *Government should 'set the framework', principles and timetable for change but it must be 'driven locally and, above all, by patient needs' through the operation of the internal market.*
- *'A better health service will not be achieved by central planning, no matter how skilful is its execution'.*

Practice:
- Establish the London Implementation Group (LIG), reporting to ministers, to secure agreement among interested parties and oversee the implementation of change, including leading work on 16 major tasks to be completed on very short time-scales.
- Secure implementation of ministerial decisions (e.g. on hospital closures) and bring further proposals for ministerial decision.
- Arrange to plan the organisation and location of acute specialties.
- Establish the London Initiative Zone where LIG will promote better primary care through guidance, additional investment and encouraging GP fundholding.

Moreover, it is even less clear how these philosophies are reflected in the practical proposals. The two official reports rely heavily on ministerial decision-making supported by the creation of a high level implementation agency tackling major tasks on very short time-scales. Planning is very much in vogue, despite its explicit rejection in *Making London Better* (in favour of market mechanisms) and it is only in relation to primary care that a more developmental approach relying on incentives and local initiative is actively embraced.

In the event, looking back now over five years, it is possible to identify a wide range of policy initiatives and formal mechanisms which have characterised the official approach to addressing the multiple London challenges. These fall into what might be regarded as three sets of initiatives:

- those *directed* precisely at the distinctive London challenges;
- those *intended* to apply to London but essentially part of national policies to 'reform' health and related services;
- those impacting on London but perhaps with *unintended* consequences.

These categories overlap and there is scope for debate about what was intended and unintended, and by whom.

In the first category is what might be regarded as an (initially concerted) package of top-down planning and promotional initiatives combining:

- quite detailed policy analysis and central planning (London Commission, Tomlinson) leading to *Making London Better* and subsequently the six specialty reviews;
- active political leadership from the Secretary of State;
- ear-marked funds for transitional investment in price support for hospitals, primary and community care development, medical education, staff training and relocation;
- initial hopes for access to capital for site rationalisation;
- new structures for commissioning and providing local services (the merged health authorities and more autonomous trusts);
- new machinery for negotiating change across local boundaries, allocating incentives and promoting local action (London Implementation Group, London Initiative Zone, the Primary Care Support Force and the Mental Health Task Force's London Initiative).

In the second and third categories are the impact of the NHS and community care reforms and a number of more specific national policy initiatives, which are difficult to characterise simply but might be seen as trying to decentralise control in health services through the operation of the 'internal market' while continuing to be strongly prescriptive from the centre on a whole range of issues of national concern. Included here are:

- introduction of the purchaser/provider split and accompanying approaches to 'performance management' in a more fragmented system;
- parallel reforms in community care, including the new arrangements for funding residential care;
- abolition of RHAs as an intermediate planning tier in the NHS;
- merger of DHAs and FHSAs to create the new unitary health authorities;
- creation of provider trusts as relatively free-standing cost centres in the new 'market' and incorporation of special health authorities into these arrangements;
- dispersal of health commissioning power through GP fundholding;
- the Private Finance Initiative (PFI) to access capital;
- the Calman reforms to medical training and staffing;
- the Culyer changes to the funding of research and development (R&D);
- the series of short-term initiatives on mental health services, including central efforts to implement Care Programme Approach procedures;
- downward pressure on management costs.

However, all the above is only 'one side of the coin'. It is easy when discussing 'official' action to de-emphasise the significance of the myriad initiatives taken by individuals and groups throughout this enormously large and complex system on their own authority – some responding to the official agenda, some pursuing other goals –which are arguably just as much the real stuff of sustaining services, making changes or failing to do so. There are tens of thousands of people working in, or using this system who are not so much 'implementers' of official policies as mini policy makers in their own right, acting on their conceptions of the opportunities and constraints to shape change. As our case studies show in more detail, development in London occurs at the interface between official policy and the actions of this dispersed army of conservationists and innovators.

3 Achieving positive change? An initial assessment

At first sight this combination of official measures and the potential of informal initiative suggest a potent mixture, particularly when combined with the investment of political capital by the Government and the undoubted energy of many London leaders.

However, the evidence collected by the second London Commission casts considerable doubt on the extent of progress in tackling the long-term substantive agenda required to serve Londoners better and therefore on whether current approaches to achieving change are likely to be successful. Complementing a number of commentaries by those directly involved (for example, Darkin and Sibson, 1996; James, 1995; Jones, 1996; Lessof, 1996; Levenson, 1995; and Nicholls, 1997), our own empirical work illuminates both strengths and weaknesses in how people at all levels have approached these challenges and highlights the difficulties involved in achieving sustainable development under current conditions. We explore and illustrate these issues in more detail in Chapter 2, as we seek to rethink what might be appropriate in the next phase of development. Our broad assessment of how change has been addressed over the last five years suggests the following as key points in an interim 'balance sheet'.

Strong political leadership, central policies specifically addressed to London, wider trends in health and social care development and incentives arising from the internal market together produced powerful pressures for fundamental change. *However*, while different types of change have different requirements, this mixture of centralisation and decentralisation, planning controls and 'market' freedoms, has in practice appeared poorly related to the real challenges. Political courage is important, but the scope for central planning and decision-making in change of this complexity was over-rated. Insofar as the special policies and implementation arrangements (e.g. LIG) for London have been helpful, most lost impetus quite early in what always needed to be a long-term programme. At the same time we have mostly had the wrong kind of decentralisation: market fragmentation and competition seem poorly equipped to handle politically and professionally sensitive changes over these long time-scales.

Two features of this package might particularly be highlighted. The new commissioning agencies and a sophisticated version of the purchaser/provider distinction in both health and social services offered important vehicles for a new approach to service development, while some of the national policies, for example on medical training and research funding provide conditions for long term progress. *However,* after major reorganisations, the development of sophistication even in more stable circumstances takes time. Over recent years health and other agencies have found themselves hard put to establish a coherent local agenda for change in the face of a plethora of central policies and directives (sometimes as in mental health involving quite detailed prescription on operational matters), many loosely related to local priorities. Meanwhile, the creation of trusts as cost centres, often based on institutional boundaries, has added to the difficulties in securing a systemic approach to service change across institutional boundaries and promoted mistrust.

Something similar could be said about the policies related to the funding and timing of development. It is undoubtedly a strength that considerable amounts of revenue, in addition to mainstream allocations, were made available both to meet bridging costs in the acute sector and promote expansion and innovation in community services. *However,* some of the large scale changes where it is most difficult to sustain a political and professional coalition for change have been indefinitely delayed by Treasury policies on private capital; the investment in community services was begun at such a pace that it is doubtful whether local players were sufficiently well prepared to ensure it was well used; and, at least in retrospect, it seems that some heroic assumptions were being made about both the complementarity of different changes and the speed at which they would be delivered in order to make the total package sustainable (i.e. notably in shifting the balance between acute and community services).

London has considerable depth in the energy and skill of official and informal leaders. At least in some of the philosophies which informed change, there was recognition of the significance of both staff and public involvement in shaping and delivering the transformation in patterns of provision envisaged. Indeed, it has become increasingly clear that in the situations as diverse as those which exist across London's health and social care system, the information, expertise and motivation to develop local solutions are very widely dispersed. *However*, to date only a limited part of this capacity has been mobilised effectively; there have been inadequate arrangements for learning from experience, and public leaders have often turned into hostile bystanders as politically sensitive local changes have become linked to wider dissolution with the political process.

Finally, the simplification of NHS structures in London (e.g. merger of DHAs and FHSAs to cover larger populations) and the continuing ability of London services to attract industrious and able managers are potentially important 'resources' in addressing the change agenda. *However,* it seems likely, at least in the short term, that change in management is the enemy of the management of change, i.e. the continuing turbulence in management structures with organisational change and management cost reductions and the rapid turnover in key managers have sapped the capacity and continuity necessary to build confidence in long-term institutional and service developments.

We turn now to consider how best to build on these strengths and overcome these weaknesses in fashioning the next phase of London development.

Chapter 2

Rethinking approaches to development

1 Introduction

This assessment of the strengths and weaknesses of how change has occurred in London over the last five years suggests that five key challenges are at the heart of successfully rethinking service development in the capital. These are:

- *raising awareness of the nature of complex change* in systems of health and related care delivery and *developing a better understanding of those factors that determine how different types of change unfold* in different circumstances and over time;
- *developing more creative approaches to achieving fundamental, system-wide change* in London's health and social care by fostering appropriate local alliances capable of working together across existing organisational, occupational and functional boundaries;
- *developing more participative and culturally inclusive approaches to change* which take into account and value the contributions of the full range of local stakeholders – not least the public – within politically established boundaries;
- *developing more effective, locally rooted leaders and leadership coalitions* capable of clearly articulating the need for change, challenging old assumptions and behaviour, and building commitment to new identities and forms of practice;
- *developing a 'negotiating' model of central–local relations*, sensitive to the requirements of different types of change and emphasising a direction-shaping and context-setting role (including taking difficult political decisions) for the centre and a more autonomous developmental role for local agencies, wherever possible working in partnership.

While these challenges represent formidable barriers to be overcome, they are neither new nor unique to London. In particular, there is a wealth of research and practical work which suggest that challenges not dissimilar to these often emerge as central to addressing complex change successfully.

However, relatively little of this work has been concerned with large scale change in health care systems. In what follows therefore we:

- discuss these five challenges in turn against the backdrop of this work;
- use examples taken from our case studies to illustrate what the argument might mean for health services;

- draw out practical implications for achieving purposeful development in the particularly complex circumstances of London.

2 Appreciating the nature of complex change

A major difficulty in trying to deliver purposeful development in London is that many of the agencies, groups and individuals involved have been struggling to *understand better the nature of complex change* and to learn from experience what is entailed in delivering change successfully.

There is no one simple phenomenon called change*: there are many different types of change.* For example, Mintzberg and Westley (1992) identify a spectrum of different kinds of change ranging from incremental, or piecemeal change, to discontinuous, revolutionary change. In addition, Beckhard and Harris (1977) stress the importance of distinguishing between changes that are designed to improve how an organisation conducts its existing business (what they call *system improvement*), from changes designed to transform what business an organisation is in (what they call *system transformation*). The case studies describing change in London's health services identified a number of different kinds of change not dissimilar to these.

More specifically, in thinking through how change in London's services may unfold over the next few years, it may be helpful to distinguish between three broad types of change, as follows.

- *Relatively large scale – or macro – change usually intended to reshape the existing configuration of acute services.* Examples of this type of change would include the merger and consequent restructuring of two or more acute hospitals; the rationalisation of tertiary services and other specialist acute services across a number of hospitals; or the merger of two or more medical schools.

- *Relatively large scale change usually intended to create new patterns – or enhance significantly existing patterns – of primary and community-based forms of care.* Examples of this type of change would include the introduction of a network of primary care walk-in services linked to existing A&E services, or the development of a more community-based pattern of local mental health services to replace previously institution-centred services.

- *Local and specific service developments.* Examples of this type of change would include the introduction of localised 'hospital in the home' services; the provision of hospital outreach services in community settings; or the development of 24-hour mental health assessment services.

In describing these as types of *service* change, we are of course using a convenient short-hand. While the focus here is on changes in service delivery (the 'substance'), each type of change typically involves a package of inter-related elements concerned also with organisational arrangements (e.g. joint commissioning; new kinds of providers); human resources (e.g. new roles, competencies and training arrangements); settings (e.g. the design of new facilities); technology and operating systems (e.g. new diagnostic equipment; new information transfer systems); financial requirements; etc.

There are two practical reasons for distinguishing between these three types of change. First, it is clear that much of the change focused on restructuring acute service delivery often needs to *precede* – or at least not lag very far behind – the second two types of change because many of the resources needed to bring these latter changes about must ultimately be found from within the existing acute sector. Put another way, the first type of change is necessary to 'unlock' the existing configuration of service delivery, so that it will be possible to put new forms of service delivery into place.

Second, it is clear that these different types of change need to be *conceived of and achieved in quite different ways*. For example, while the third type of change can often be conceived of, driven and delivered locally, both the first and the second type must take account of central priorities and constraints *as well as* what it is feasible to deliver locally. Similarly, while macro changes in the acute sector (e.g. hospital mergers) are often very 'visible' and therefore sensitive politically, the latter two types of change are *usually* less constrained by *national* political sensitivities. Table 1 summarises some of the key features of these different kinds of change.

A second important distinction in thinking about service change in London is that between those changes that are essentially about *maintaining or improving existing service delivery* (e.g. reducing waiting times; providing 24-hour consultant cover in A&E), and those that are essentially concerned with *transforming or 're-inventing' service delivery* (e.g. the redevelopment of community hospitals to act as new intermediate-level facilities for the management of some emergency medical demand; the introduction of a network of clinics providing walk-in primary care and direct access diagnostic services; the creation of alternative providers of sanctuary for minority ethnic users of mental health services). This distinction is similar to that identified by Beckard and Harris (1977). Examples of these different types of change are set out in Table 2.

One practical implication of looking at service changes in this way is that it highlights the fact that their successful achievement does not depend on conforming to some predetermined formula or sequence of actions but, rather, is more about *understanding the context for change and adopting different approaches in different circumstances.*

Pettigrew *et al.* (1992) develop this point using a number of illustrations drawn from the NHS. Our case study of LIG (see Box 3) provides an interesting insight into how senior staff of this unique agency struggled with the need to find appropriate 'horses for courses' in unfamiliar and ill-defined terrain.

Table 1 Different types of service change

Type of change	*Typical characteristics*
Type 1 – Relatively large scale change intended to reshape the existing configuration of acute services (e.g. acute hospital mergers/restructuring)	• Large scale usually involving multiple authorities and/or institutions • Long time-scale; rarely less than 3 years, often more than 5 • High political visibility; involvement of national politicians/senior bureaucrats • Involves net withdrawal of resources for investment in other services • Local freedom very constrained; local–centre tensions need to be managed • Public involvement/opinion largely seen as a constraint
Type 2 – Relatively large scale change intended to create new patterns – or enhance existing patterns – of primary and community based forms of care (e.g. the introduction of a network of primary care walk-in services linked to polyclinic facilities)	• Large scale often involving multiple authorities and/or institutions • Relatively long time-scale; rarely less than 3 years • Occasionally politically sensitive; relatively low visibility • Usually involves net investment of new resources as well as reuse of existing resources • More local autonomy but constrained by need to co-ordinate multiple authorities • Scope for relatively high public/client involvement
Type 3 – Relatively small scale, very local service developments (e.g. the introduction of local 'hospital in the home' services)	• Small scale often linked to single authority and/or one or two institutions • Relatively short time-scale; 6–24 months, but perhaps longer where critical mass is required • Usually not politically sensitive • Usually involves investment of new resources as well as reuse of existing resources • Relatively high degree of local autonomy • Relatively large scope for public involvement

Table 2 System improvement and transformational change

Type of change	*System improvement*	*Transformational change*
Type 1 Macro change	Reducing outpatient waiting times across a whole sector of London	Rationalising tertiary and specialist services across a number of hospitals and using the resources saved to provide walk-in accident services
Type 2 Macro change	Improving GP facilities and in so doing increasing the proportion of GPs working in group practices	Introducing a network of GP and nurse practitioner-led 24-hour walk-in accident clinics
Type 3 Local change	Increasing the utilisation of acute beds and theatres in the local DGH by reducing length of stay in a number of specialties	Closing a number of wards in the local DGH and reopening them as 'homeward bound' facilities staffed by nurse practitioners in community settings

Box 3 Implementing strategic change – some lessons from the London Implementation Group experience

The main organisational innovation introduced by Government to ensure implementation of its programme for London was LIG (actually a set of mechanisms and processes with the LIG Executive at its core – see below). It is difficult to separate the achievements of LIG from the whole variety of other things happening to shape change in London's health care and the jury is still out on the significance of the LIG contribution, although its chief executive has published an interesting personal review of this period under the title *Seismic Shift or Noisy Tremor* (Nicholls, 1997). Nevertheless, there is a great deal to be learnt from the ways LIG went about its tasks.

Making London Better established LIG (initially for three years from February 1993) with the broad functions of advising the Secretaries of State for Health and Education, securing agreement among interested parties on the detailed ways forward and overseeing implementation of change.

Organisationally, LIG comprised an inner tier, the LIG Executive, and an outer tier, the London Health Service Development Forum. LIG was part of the NHS Executive, of which its chief executive was a senior member; its chair sat on the NHS Policy Board. The latter also chaired the forum set up to promote development in primary health care, particularly in the specially designated and resourced London Initiative Zone (LIZ).

Making London Better defined its agenda in terms of 16 major tasks (mostly on very short time-scales) in the four main areas of reshaping the institutional basis of medical education and research, rationalising acute hospital services and their specialties, improving primary care and tackling the human resource implications of change on this scale.

From the outset the small core staff of LIG (embracing people with civil service and NHS experience and with good links to the Higher Education Funding Council and the University of London) faced the challenge of finding appropriate approaches to these tasks for what in effect was a new and unique kind of London development agency. Guidance here was contradictory (see Box 2).

- Tomlinson had proposed an *executive* agency, but LIG was keen to play down any executive functions (because arguably these already existed in the hands of ministers and relevant public bodies). It did, however, have potentially great influence, reporting directly to ministers and indeed meeting with the Secretary of State for Health on at least a weekly basis during part of this period, having responsibility on behalf of the NHS Executive for allocating over £400 million to the twin goals of supporting transition in acute services and investing in primary health care, and through its wide brief either being present or having access to a wide variety of other decision-making forums.

- The London Commission had proposed a *strategic planning* body but here *Making London Better* was particularly obscure, expressing firmly the philosophy that within the Government's overall framework change must be driven locally through the operation of the internal market. At the same time, the Government's detailed response to Tomlinson's acute hospital recommendations and its proposals for pan-London specialty reviews apparently called for central planning of a fairly traditional kind!

Responding to these confusing messages, the LIG Executive essentially defined itself as a high level intelligence and liaison agency, seeking to bridge national policy-making and field implementation (i.e. 'vertical liaison') and build alliances for change among field leaders and their organisations (i.e. 'lateral liaison'). Its small senior staff had to work very hard to keep abreast of ideas and opportunities emerging across London, ensure all kinds of people were initially aware and later 'on board' with the change agenda, and adopting a form of 'shuttle diplomacy' to ensure that formal proposals were brought to decision (e.g. by the LHSDF or Ministers) only once the informal work had been done to make it likely these would 'stick'.

cont.

Within this general approach, there were significant differences in how LIG addressed the four main areas of its work. In relation to acute sector rationalisation:

- *Making London Better* established a raft of central decisions;
- steering groups for large 'sectors' of London were charged with taking these decisions further with attention to the total pattern of services to large populations;
- LIG staff had a brokerage role in securing the support of key players;
- the funds available to promote transition were allocated on the basis of tough conditions monitored at the ministerial level.

By contrast the investment in primary care in LIZ:

- was shaped by broad guidelines and rapidly developed local (FHSA) plans;
- involved cash for new projects (later to be incorporated into the mainstream) and increased flexibility as to possible expenditure;
- this cash was allocated with rather limited scrutiny (emphasising whether money was spent as much as what it was spent on, despite a philosophical commitment to the importance of evaluation);
- in its later stages the whole programme was encouraged by consultancy and mutual exchange across local initiatives through the work of the Primary Care Support Force.

Further insight into the nature of these change processes comes from reflection on the tensions which had to be managed within LIG between what might be regarded as four 'cultures': the civil service/management division which was built into its composition and the more implicit difference between 'male' and 'female' contributions. On the former division, there was a continuing need to combine a civil service orientation – in which, put crudely, decision-making is by due process at the centre and implementation can be secured by Executive Letter – with an NHS management stance of trying to build support for change first through dialogue with key players and investing heavily in 'talking'. On the latter, it is perhaps revealing that the senior men in LIG were perceived as giving priority to acute rationalisation and the medical school changes, spending much of their time with other top men (e.g. in medical politics), often having important meetings over dinner in the evenings, while the (slightly less) senior LIG women led on primary care, nursing and mental health, gave more attention to 'grass roots' development and did most of their work in the daytime.

LIG was wound up after a little over two years on the 'spin' that it had done most of its work and what was left could more appropriately be carried forward by the new and simpler NHS structures (e.g. the regional offices of the NHS Executive) which followed the functions and manpower review. An interesting footnote on the political culture within which LIG had undertaken its work is that a thoughtful review which LIG staff had prepared on their work (with lessons for their successors) never saw the light of day, apparently on the direct instruction of ministers.

Our further case studies suggest, not surprisingly, that much is already quite well understood and practised where the focus is system improvement (e.g. doing the same thing more efficiently; raising the standards of established clinical practice), although the connections between this and other types of change still need careful exploration. The greater challenges lie in meeting the important but different requirements, on the one hand of politically sensitive macro changes and on the other of the wide variety of transformational changes on different scales necessary to bring about real improvements in the pattern of services to Londoners. These therefore provide the twin foci in much of what follows.

In addition to distinguishing between different types of change, it is also important to recognise *the factors influencing how these unfold (or not) in different circumstances and over time.*

The classic work in this field has been undertaken by Mintzberg (1987) and Mintzberg and Westley (1992). In essence, these authors argue that change may unfold in a wide variety of ways, ranging from that which follows logically from a preconceived plan (*deliberate* change) to that which unfolds emergently given the contingencies encountered as the change develops (*emergent* change). More recently, writers such as Wheatley (1992) and Stacey (1992) have reserved the term 'emergence' to refer to very specific phenomena characteristic of the behaviour of complex adaptive systems in a state of 'constrained instability'. Drawing on this work and using illustrations from the NHS, Best (1997) has suggested that change can unfold in a variety of ways: it may be relatively deliberate or *planned;* it may be relatively emergent or d*iscovered;* or it may simply be serendipitous or *happened upon*. In practice, those trying to achieve change need to be adept at operating in all of these ways and indeed, adaptable enough to move between these different modes as the situation requires.

The case studies make clear that there has been a whole host of different types of service change in London since 1992 which have unfolded in all of the ways identified above. These have included fairly macro changes intended to reflect a preconceived 'grand design', both macro and local changes that have been shaped by a number of contingent factors not foreseen when the changes were being planned; and changes that were fundamentally shaped by serendipitous events (see Boxes 4a and 4b). The case studies also show that in some major instances, the interweaving of these different types of change to produce significantly different patterns of organisation and practice may take many years, even when there is quite broad support for the direction of travel. For example, the case study of one set of medical school mergers suggests that three or four 'generations' of academic leaders (i.e. over 20–30 years) will have played different roles in creating the conditions for a series of mergers, establishing the formal arrangements and then 'crafting' new ways of working in the multifaculty colleges.

Against this analytic background, let us now consider in more detail the 'Type 1' kind of service change concerned with relatively large scale changes that, because they often involve the *reconfiguration of acute services*, have a high visibility and are therefore judged to be 'politically sensitive'.

The case material makes it clear that every instance of change (or lack of it) arises from a unique constellation of forces, constraints and events. However, while the factors that determine how any particular change unfolds are unique, it is nevertheless possible to detect a broad pattern that would seem to underlie the way in which most (all?) major, politically sensitive change has unfolded in London in recent years. This pattern is represented graphically in Figure 1. In addition, Box 5 provides an illustration of how this pattern was reflected in the case of a major hospital merger.

Box 4a Deliberate and emergent approaches to change

One of the cases that best illustrates the difference between deliberate and emergent approaches to change concerns the way one FHSA responded to the opportunity to seek extra resources as part of the LIG organised investment in the LIZ. In this case, LIG, as an initiator of change, was seemingly following a reasonably deliberate approach to change. For example, LIG required all FHSAs in the LIZ to produce a detailed written submission showing how they would make use of additional capital monies to improve primary care infrastructure.

Indeed, once its plans were approved, the FHSA in the case found itself quickly caught up in a series of somewhat onerous reporting requirements, that are typical in deliberate approaches to achieving change, even when fast results were being sought. Essentially, the deliberate change formulator (LIG in this case) wants to know whether the intentions it is funding are actually being fulfilled and if not what rectification arrangements are proposed to re-introduce plan conformance. Of course, accountability for the use of public monies is also a factor in this relationship.

However, in this case things are more complex. In parallel with fulfilling these reporting obligations to LIG, the FHSA general manager began herself to operate a more emergent strategy intended to deliver change of a quite different kind. Rather than being concerned per se with the quality of primary care infrastructure, she saw the new facilities being provided as simply additional levers for her to use in her own strategic intent, which was more about improving the quality of clinical practice within primary care and particularly doing something to remove underperforming general practitioners. In essence the FHSA general manager used the possibility of practising in new facilities as an inducement for some competent GPs to leave partnerships where other partners were not 'up to scratch.' Despite this broad intention, no blueprint existed for a preferred future distribution of practices and GPs. Precise possibilities only emerged as a result of the general manager's one-to-one dialogue with GPs whom she judged to be worth approaching in the first place. Essentially the new pattern of practice distribution and membership emerged out of the conversations she held.

Box 4b The contribution of serendipity

Some of the case studies illustrate well the pivotal role that serendipity can sometimes play in shaping the nature of the change that occurs. Good examples of this influence can be drawn from both the case study on how one Trust responded to the LIG-sponsored neurosciences specialty review and another case study of the rapid introduction of a new 24-hour mental health emergency assessment service.

In the neurosciences review case the chief executive of a hospital was invited by complete mistake to a meeting of LIG neurosciences review experts. On arrival he was allowed to stay, and he heard that his hospital was likely to lose neuroscience services. However, he also heard that, of all the recommendations being made by the review team, the one relating to his service was the one which the review team felt least confident about. Fuelled by this critical piece of information, he went away determined to continue with his already-established strategy of developing a strong, genuine and long-term partnership with his clinicians, in order to try to circumvent the review bodies recommendation. Would he have committed himself to this course of action had he not heard the discussions held at the meeting he wasn't supposed to be at?

In the second case, one of the principal reasons why the proposed development of a 24-hour mental health emergency assessment service went ahead so quickly was due to the unqualified and speedy support of the host purchaser. In turn, a key reason why this support was forthcoming so quickly was because one board member was on holiday when the issue surfaced for consideration, thereby leaving the other most relevant board member – a keen supporter of the proposal – with the decisive voice. Given the doubts expressed by the absent director on her return, it is debatable whether the purchaser would have ever supported the proposal and certainly true that support would not have been forthcoming so quickly (although later experience led those doubts to be put aside).

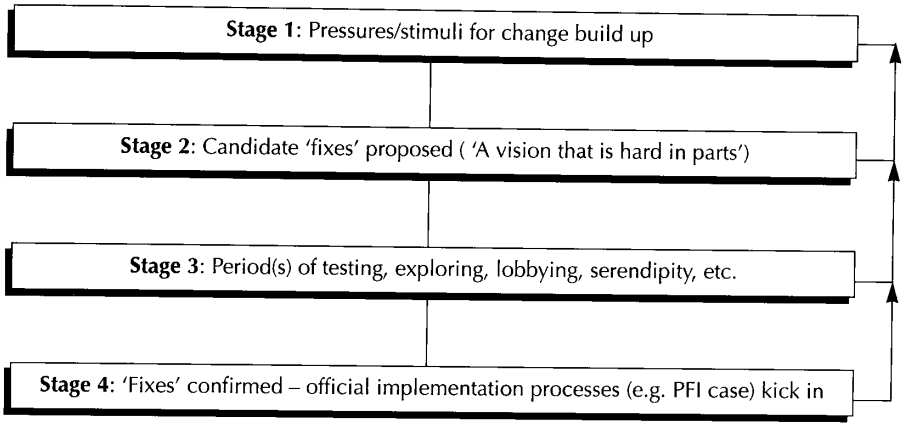


Figure 1 Some generic stages in the process of realising major, politically significant change

Box 5 The Guy's and St Thomas's merger

Although the pressures for change in inner South East London had been building up for a number of years, the key *pressure for change* that triggered the process set out in Figure 1 was the decision by Ministers and the DoH to instruct management at the newly formed Guy's and St Thomas's NHS Trust to 'demonstrate how you will operate from a single site'.

Local management decided that the closure of one or the other of the two hospitals within the trust was no basis on which to create a 'new' organisation. They therefore re-interpreted this instruction as a challenge to 'Create a new university hospital (along with King's and the United Medical and Dental School, UMDS)'. This implied a number of *candidate fixes:* for example, the existence of all four organisations in some form; an assumption that some sensible use would need to made of the considerable investment in capital on both the Guy's and St Thomas's sites; an assumption that it would not be possible to close the A&E Department located directly across from the Houses of Parliament; and so on.

In parallel with the *exploration* of what was implied by these *candidate fixes,* it became clear that the medical school was pursuing an academic strategy that would make the move to one site extremely difficult. This led to the evolution of a new 'hot and cold', two-site strategy implying a new set of *candidate fixes.* This was *tested* with the official view of ministers and the DoH who raised the issue of 'affordability'.

Further *exploration* of this option led to a new set of *candidate fixes.* These were built around the idea that Guy's would be the major 'tertiary' centre with St Thomas's, King's and Lewisham in support. *Exploration* of the affordability of this option, however, made it clear that one *candidate fix* that this implied was the 'downgrading' of King's to a community district general hospital (DGH).

Intense *lobbying* by a number of key players, however, resulted in a decision to centralise neurosciences at King's thereby establishing a *confirmed fix* (i.e. one publicly endorsed by ministers and the health authority) that (a) undermined the *candidate fixes* implied by the previous option, and (b) constrained what alternative options could then be considered.

cont.

At this point a new minister of health (serendipity?) let it be known that he was not in favour of a single site Guy's and St Thomas's Trust, but was convinced of the desirability of a 'hot and cold' option with a full A&E department at St Thomas's. Although these *candidate fixes* were tested and explored by a number of interests (primarily from Guy's and UMDS), it became clear that the decisions taken up to that point (primarily the decisions to centralise some key tertiary services at King's and the need for the medical school to operate across all three sites) meant that these soon became *confirmed fixes* (i.e. were publicly endorsed by the minister).

At this point the official wheels of *implementation* (e.g. preparation of business plans; preparation of PFI case) 'kicked in', thus effectively ending the period of 'macro' testing, exploration and lobbying. (Ministers, the DoH and the health authority were able to determine when this happened largely because all of the options considered required substantial capital investment to implement. They were thus able to defer any moves to implement candidate fixes until they were satisfied that this was what they wanted to happen.)

Although much of this story remains to be told, there is a belief among senior management and clinicians that although 'things could still change', most change henceforth will be marginal in the sense that it will either be (a) 'minor concessions necessary to win over key players', and/or (b) 'adjustments necessitated by changed circumstances'.

An analogous but different story that dovetails neatly with this one could also be told from the point of view of the King's Healthcare Trust. As implied above however, although King's story would be different, it would also reflect the broad process of change set out in Figure 1.

It should be added, as some of the participants themselves pointed out, that in describing these processes schematically, the above seriously under-represents the extent of tribalism, conflict and personal stress which characterised this long period of exploration and testing.

Although the account in Box 5 clearly omits much important detail, it offers a picture of a process whereby local players, once given the official signal that a particular kind of change (e.g. site rationalisation) is highly likely, engage in exploration, testing and lobbying to establish what might be (a) possible and feasible locally, and (b) acceptable in political terms. This process is shaped by a number of considerations, including the probability that appropriate capital, revenue and human resources will be available; the existence or otherwise of relevant, parallel strategies such as that being pursued by the medical school; clinical 'logic'; and the need for discretion. It is also interesting to note that while local management is engaged in this process of exploration, testing and so on, politicians and senior bureaucrats also utilise the same process to see what might be an acceptable course of action from their point of view.

Certainly in the case summarised in Box 5, ministers and others seemed very keen to be kept up to date on any changes in local management's thinking as well as on the detailed rationale for these changes. Finally, it should be noted that while Figure 1 implies, and many of the key players seem to believe, that the merger of the two hospitals is now in its 'implementation' phase, much of the other case material and much of the literature

summarised earlier suggest that 'implementation' may yet turn out to be the first phase of an emergent strategy!

In so far as the examples of change included in Boxes 4a, 4b and 5 above and the diagram shown in Figure 1 are representative of some of the ways in which change has developed in London, they suggest that *while many of the key individuals, groups and agencies involved in London health and social care attempt to address and achieve change in relatively deliberate, relatively emergent and sometimes serendipitous ways, it is nevertheless true that for major, politically significant change, the official position (and the associated mechanisms used) are typically biased towards the assumption that only deliberate approaches to achieving change are appropriate.* (See, for example, the discussion of *Making London Better* in Box 2).

3 Achieving transformation in the pattern and nature of local services

As already noted, it is important to distinguish between changes designed to improve the performance of an existing organisation or system (for example, by reducing waiting times), and changes intended to transform how that organisation or system performs (for example, by introducing 'walk-in' services that do away with waiting times.). The 'macro' reconfiguration of services (Type 1) discussed above may directly contribute to changes of the more radical kind, or establish the framework within which significant changes in the nature of services are subsequently pursued. As we saw in Table 2, there can also be transformational changes in other kinds of large scale change (Type 2) and in more local innovations. Successfully addressing the medium-term agenda for service development in London entails a great deal of such changes but our case studies suggest that the different approaches required have not been well articulated. Much of what follows therefore concentrates on *developing more creative approaches to achieving system-wide transformational change.*

A parallel paper for the London Commission (Harrison, 1997) has explored in detail the need to consider health care as a 'system', i.e. a set of distinct but related activities which interact with each other. A number of writers including Beckhard and Harris (1977), Ackoff (1979) and, more recently, Normann and Ramirez (1993), Senge (1990) and Stacey (1992) have recognised many of the unique challenges associated with achieving system-wide change. These challenges include: the need to focus on the boundaries and connections within the system (for example, the interface between primary and secondary care), rather than on the established institutions or entities that make up the system (e.g. trusts and GP practices); the need to allow for spontaneity and

self-organisation; the need to foster constructive tensions and differences (rather than to seek or impose consensus); and the need to promote and use learning. In addition, what the more recent authors have stressed is that what may be quite appropriate in attempts to improve existing performance, may actually undermine success when the aim is system-wide, transformational change.

For example, most traditional approaches to the management of change emphasise the importance of such factors as:

- *a clear and widely shared diagnosis* of the problems and challenges;
- *consensus* about how, in principle, these are to be addressed;
- *an exciting future vision* that is widely shared;
- *clear lines of managerial accountability* that require management to adopt explicit *success criteria* and to account for their behaviour in relation to these criteria.

What writers such as Stacey (1992) and Best (1997) argue, however, is that these factors are often the enemy of success in fostering and bringing about system-wide change. Rather, in this latter case, what is often required is not a clear diagnosis, but differing interpretations about what might be possible and desirable; not consensus across the system, but diverse groups and cultures representing different points of view; not a shared vision, but ambiguity, open minds and debate; and not tight, prospective forms of accountability but more retrospective forms of accountability that leave space for learning, spontaneity and chance. In other words, because the complexities and uncertainties associated with achieving system-wide, transformational change are so great, it is often necessary to create the conditions within which individuals and agencies 'think the unthinkable', explore new avenues and create new possibilities. Built into this perspective on change, however, is the assumption that these activities take place within a broadly understood framework of 'rules' that (a) promote system-wide learning, and (b) help to ensure that what results is likely to represent a development of the system rather than unstable or random change.

It is also the case that while system transformation may require the exercise of what has been called 'extraordinary management' (Stacey, 1993), this still needs to be complemented by a great deal of 'ordinary management', e.g. to ensure quality and efficiency in the way new services are delivered.

Trying to apply these abstract ideas to the problem of achieving purposeful change in the system of health and social care in London suggests a number of elements, such as:

- the development of alliances and collaboration both vertically between different 'tiers' within the system, and laterally across the different agencies and groups that make up the system;
- the building of 'cultural competence' (Chandra, 1996) and confidence among groups within the population who normally may not engage productively with the system but who may also have new, unfamiliar and often useful perspectives to contribute;
- a greater emphasis on learning from unfamiliar (as well as familiar) sources, on making new linkages across institutional and other boundaries, and on sharing learning;
- the identification of what might be thought of as 'local health communities' capable of providing a meaningful context for, and able to provide support to, the above activities.

While this may seem a fanciful list, the case studies suggest that all of these developments are already taking place in the capital – albeit in an *ad hoc* and largely uncoordinated manner. Two developments seem particularly relevant. As already noted, health authorities and other local agencies in the capital have found themselves hard put to establish coherent local agendas for change in the face, on the one side, of a plethora of central policies and directives, many only loosely related to local priorities, and on the other, of the increasing provider fragmentation associated with the creation of trusts as autonomous cost centres often based on institutional boundaries. As one way of overcoming these (and other) problems, some health authorities and trusts have joined together with local primary care agencies in an attempt to create what was referred to above as 'local health communities' (i.e. meaningful sub-systems of the total London health care system) (see Box 6).

More supportive conditions for this kind of partnership still need to be created (including enhanced arrangements for access to capital and revenue to make 'space' for transition) but the promise offered by initiatives such as these is that the framework established by the local health community (in due course, also engaging more strongly with local authority contributions) will not only support alliances working across existing institutional, professional and functional boundaries to create systems of inter-related services but will also enable these alliances to change their focus and composition over time to take account of changing and/or unforeseen circumstances.

Box 6 Reviewing an outer London health community

This review embraces two health authorities and four trusts (whole district, acute, community and mental health) serving one million people in four London boroughs. Leadership to date has come from the four trust chief executives with encouragement from the NHS Executive Regional Office.

They have collectively agreed that the current configurations in both acute and community services will need to change dramatically to deliver:

- a robust range of acute and specialist services with appropriate infrastructure;
- a redesign of mental health services including much reduced capital stock;
- a dynamic range of primary care services shifting the balance of provision and increasingly allowing for care to be delivered in the home, GP surgery and locality;
- releasing resources of £15–20 million revenue;
- requiring new ways of organising to deliver this agenda.

These emerging organisations will be guided by the following strategic themes and processes:

- *practical primary care development* which is clinically led and clearly focused on shifting resources across the acute hospital boundary, through collaboration among doctors, nurses and therapists in acute, community and primary care;
- *reconfiguring general hospital services* across existing trust boundaries, with a focus on the requirements of each set of core services and leadership from clinicians;
- *partnerships in specialist services* similarly, but with attention to larger populations and neighbouring trusts, again led clinically;
- *coalescing organisational boundaries* first, so that health authority strategies are harmonised to facilitate the change programme and second, so that medical human resources planning, capital investment, financial planning and service development are all done across trusts, with fusion of their strategies/business plans;
- *releasing resources* by establishing which potential reconfigurations are most likely to deliver significant financial returns; health authority pooling of resources to create transitional/pump-priming revenue; delivering efficiency savings across trusts; and a joint programme to manage fluctuations in demand for services.

A second type of development worth noting is more limited schemes (i.e. focused on much smaller systems) aimed at 'individualising' care around the needs of particular patients or clients. These schemes, of which there are many examples, demonstrate in a very concrete way the meaning of such phrases as 'making new linkages', 'working across boundaries' or 'sharing learning'. And while they often develop as a result of the special interests of a particular clinician (or clinicians), in response to an *ad hoc* policy initiative or indeed through advocacy on behalf of service users, they illustrate the potential that might be realised through a more co-ordinated approach to these problems.They also suggest the potential benefits of approaches to service development based on addressing the whole programmes of care relevant to particular sets of patients/clients (e.g. people with diabetes). Box 7 offers one interesting illustration of such a scheme. Box 10 illustrates some ways in which these new approaches can be promoted in improving support to older people.

Box 7 Developing stroke care

This is a case study of change at the hospital/community interface. The origins of two stroke care schemes involving staff from the same community NHS trust are traced back along different routes by people involved. A hospital consultant felt that greater physiotherapy input to stroke patients would improve their care and that became his goal; others emphasised ministerial statements about the amount of stroke care currently delivered in hospital which could be given in the community; others emphasised the background work done by a group of people drawn together by one local purchaser to examine the scope for a hospital-to-community shift in care; a community provider aimed to address current weaknesses in provision – for example, patients who had had a stroke were being cared for on 13 different wards.

After a successful bid for pump-priming money for three years, two neighbouring purchasers began work on the detailed development of a scheme. As it unfolded, however, paths diverged. In one locality the unwelcome reduction in hospital case volume became a cause for concern, and so did ownership of the scheme. In another, with assured hospital volumes and viability, the reduction in their workload was not a problem. In this case the local purchaser perceived the hospital and community provider to have established a shared vision and language between clinicians, which meant that ownership of the scheme was never an issue.

Thus the two projects took different forms. In one a hospital team was established; in the other a community-based team of nurses, paramedical professionals and generic support workers developed.

The purchaser of the community-based scheme reflected on its strong chance of survival and contrasted this with other local schemes which were unlikely to obtain mainstream funds beyond the pump-priming period. One of the scheme's advantages was the strategic context in which it was set. By that managers meant:

- a local examination of the research evidence into treatment of the specific group of patients;
- local recognition that this was an area where care could be organised differently to benefit patients;
- expressions of intent by influential policy makers that there was scope for a shift and that it would bring benefits.

This example of service change illustrates some key issues around the hospital/community interface and handling change of this order:

- the two contrasting forms of the scheme which emerged – hospital or community-based team, illustrate the powerful influence of the hospital's agenda. Concern about its own caseload and viability can produce resistance by a hospital to a shift at the boundary with community health services. If the purchaser supports this agenda, the shift becomes even more difficult. In contrast, if the hospital views the shift as a way to do things differently, not a threat, especially if this is encouraged by its main purchaser, then an invitation to move the boundary is welcome and receives active support;
- community providers may be small enough in budgetary terms to be willing to invest considerable energy in projects at the interface as even a small shift in absolute terms may make a positive impact on their overall viability. Community services leadership will thus be important in effecting such changes;
- alliances are important. A number of players had to rely on each other to achieve what they alone could not do. Community providers looked to purchasers to exert leverage to encourage a shift from hospital to community by making it clear to all providers that they wanted to see different patterns of care emerging. Community and hospital providers needed to work together using a common view of what they wanted to create and a common language between clinicians;

cont.

- collaborative partnerships between providers emerged as a good model to break the mould of health care delivery, in this case being seen by some providers as having clear advantages over competitive tendering;
- as purchasing develops, the need for a strategic context for shifts in delivery of this kind is emphasised, as is the need to eliminate any disjuncture between service review/development and contracting: the two need to go hand in hand. In addition, these providers and purchasers took a critical stance on the pilot project method of achieving innovation and change. To have impact on care delivery beyond the individual projects, it was felt necessary to form a critical mass and to build connections between schemes. (An interesting footnote to this case study is that 18 months after writing these observations and despite local support for the schemes, they were discontinued in the period of great financial pressure in 1997, having not yet established these connections and critical mass.)

4 Strengthening the participation of key stakeholders

Working in these new ways will require more participative approaches to development. This is important if service developments are to be locally 'owned' and are to incorporate the hands-on knowledge and insights of those who actually deliver and receive services.

A whole host of writers in the field of change management have emphasised the importance of involving those who have a stake in a proposed change, in the processes of shaping and delivering it. Indeed, most writers argue that relatively widespread participation in the change process improves an organisation's chances of delivering needed change successfully. Argyris and Schon (1996), for example, argue that because most organisations operate in environments that are increasingly subject to change, they need to develop the capacity continually to adapt to change. This they suggest can only be achieved if the organisation is capable of 'learning' from the current and past experience of the individuals that make up the organisation. Hence the need for widespread participation in organisational change. Similarly, Kotter (1995) has drawn on his considerable experience of assisting large companies in delivering change to argue that success depends on the formation of a 'powerful guiding coalition' that is representative of all key stakeholders in the change process.

Writing in a health services context, Pettigrew *et al.* (1992) and Berwick (1994) both emphasise the uniquely important role *clinicians* have to play in shaping and then delivering service change. Broadly, what these writers stress is the fact that success in delivering service change almost always requires that clinicians change their behaviour – sometimes in quite significant ways. It is but a short step from this observation to the insight that attempts to bring about service change are likely to be more successful if they incorporate widespread clinical involvement. Similarly, Best (1993) notes the importance of distinguishing between 'paper exercises' that simply solicit the views of clinicians (and others), and more active forms of participation that involve clinicians in shaping and managing change (see Box 8).

Box 8 Participation in developing the acute hospital contribution to changing services

A new acute hospitals trust was established in 1993 following the merger of two large DGHs and has an annual income approaching £100 million. A full range of general hospital and specialist services are provided to an outer London local population of 400,000 and more widely.

Since its inception the new trust has faced strong pressures for change arising from national policies – i.e. to rethink inherited patterns of provision, adapt to medical advances and achieve better value for money – and their particular local manifestations, including hospital merger, site rationalisation, the growth of GP fundholding and the London specialty reviews.

Over four years, the trust has made significant progress in responding to these pressures, including:

- it has replaced an inward-looking stance by strong interest in building strategic alliances with GPs, other trusts, local authorities and health commissions, with important benefits in reshaping services collaboratively;
- it has played a strong role in shifting the pattern of local services towards community-based forms of care, including innovative development of satellite outpatient services;
- it has turned round previously poor financial and service performance, achieving modest budget surpluses, 50 per cent increase in day activities and major improvements against *Patient's Charter* standards.

Trust leaders have managed these changes through an approach which started from recognition that the hospitals could not survive as they were and then actively pursued of opportunities to:

- secure the close involvement of clinicians in steering the trust;
- create alliances with other local players;
- engage with the national priority to improve primary care;
- seek constant short-term improvements.

There was not so much a plan behind these aspirations but rather a proactive and judicious crafting of local circumstances which offered opportunities to make gains. Often particular pressures and opportunities could not be anticipated and the whole story of this change process appears events-driven. In retrospect, however, four overlapping phases of activity can be identified, concerned in turn with:

- building trust and mutual respect between trust management and doctors;
- developing a shared sense of direction both inside and outside the trust through dialogue and experimentation;
- creating some short-term 'wins' from these efforts while encouraging further experimentation;
- expanding participation in this coalition for progress.

Two further points are worth underlining. The first is that in the case of politically sensitive change, the role of clinical opinion – and in these cases this usually equates to medical opinion – is often critical. Politicians and others accept that medical opinion is important and that doctors in particular need to be involved in shaping and then delivering significant service change. The second is that the case material makes clear that *service change often happens faster when clinicians are closely involved in leading and shaping change* (see Box 9).

Box 9 Clinical involvement in change

A central London specialist hospital, led in all but name by a clinical director, designed and pursued a change process that, in less than six months, led to it breaking away from a prestigious teaching hospital which had previously managed it for almost 20 years. In parallel, the specialist hospital successfully resisted 'official' plans to relocate it into the teaching hospital's main campus. Instead, the specialist facility was relocated on much more favourable terms, within a DGH more than nine miles away in another part of London.

In this and other cases it seems that the genuine involvement, from the outset, of the most relevant clinical opinion leads to smoother and more rapid change. It seems likely that a non-clinical general manager would have had much more difficulty in establishing the confidence of judgement, the trust of clinical staff and the ability to resist central influence necessary to lead such a 'successful' change process.

Appropriate forms of staff participation – and not just clinical staff – are important in another sense. Health and social care, more than most kinds of employment, rely on staff being committed to the enterprise and not merely regarding work as instrumental. The ways in which caring services treat the paid carers affects this ethic of commitment and the capacity of staff to care for others (and this is true of receptionists, domestic staff and records administrators as well as direct care staff). Yet in periods of change, it is not uncommon for those with least power to be loaded with most uncertainty and given the least support (Marris, 1996). Instead, developmental processes need to offer the people whose work is affected the opportunity to contribute their experience and to find some continuity in the changes so as to sustain their commitment (Roberts and Kraemer, 1996).

Looking more widely, experience in London suggests that far too little effort has been put into developing participative approaches to development and mobilising the contributions of the full range of local stakeholders, including not only professionals but also the public at large. Interestingly, there is increasing recognition in the commercial supply of services that, as Normann and Ramirez (1993) argue, while organisations have traditionally *delivered* goods and services *to* 'consumers', success in future will increasingly depend on their capacity to *co-produce* goods and services *in partnership* with their consumers. This sentiment is particularly relevant to health care where patients are the 'experts' on their own lives and need to be centrally involved in the management of their own health.

Similarly, suggestions put forward earlier in this paper – for example, the formation of local health communities to provide a context for cross-boundary working and co-ordination of service delivery – are premised on the assumption that in future, many beneficial changes in London's health services will require the involvement of a very

wide range of stakeholders, particularly recognising that there is not one but many 'publics' (e.g. with different cultural attributes). The case studies make it clear that this has on occasion already happened (see Box 10). What the case material also makes clear, however, is that these examples of relatively widespread participation are unfortunately the exception, rather than the rule. In other words *while it is possible to point to examples of service change that have been 'owned' by a wide range of local stakeholders, both the broader political climate and the pressures to act quickly have been more conducive to 'closed' approaches that have effectively excluded many of those who have had a stake in the change.* It is probably no exaggeration to suggest that in many parts of London there is a 'mountain to climb' in building public confidence in health service changes.

Box 10 Improving the integration and responsiveness of very local support to older people

As one sequel to the work of the first London Commission, the King's Fund and other funding agencies established the London Health Partnership (LHP) to explore better ways of developing primary health care in London, focusing particularly on the needs of older people. Of course, many older people are fit and lead full lives. Equally, however, many have multiple health needs and chronic ill health, use a wide range of health and other services and may live alone. Moreover, while older people themselves typically raise a range of interconnected concerns about the support they need in order to maintain their independence and presence in the community, this range of services often appears fragmented and at risk of mutual blame for deficiencies in continuity and co-ordination.

LHP work has sought to understand better the challenges implicit in this situation and explore new ways of working locally to improve the integration and responsiveness of the support older people receive as seen from their perspectives.

The principles which have emerged in this work are refinements and elaborations of those already identified here but applied 'nearer the ground' in the everyday delivery of services. These include:

- rather than accepting existing organisational boundaries and the definition of problems to which they give rise, it is often useful to identify the relevant total system of care and to reframe the challenge from this wider perspective;
- people who use services and their unpaid carers are part of this system, not just the focus for its attention. Indeed, particularly in relation to chronic ill health and disability, users and carers are important co-providers of care and the most important co-ordinators of its delivery;
- developing better support to older people requires that new ways are found of bringing together different elements of the relevant system and brokering 'lateral' efforts (i.e. across existing fragments) to organise things differently;
- in these new ways of working, investment in building new relationships and exploring different possibilities underpin the more convergent disciplines of planning and implementation;
- an important asset to this form of exploration is what might be regarded as the 'ordinary wisdom' that all participants bring by virtue of their life experience;
- of course, this way of working is not a 'quick fix': time must be taken to develop mutual confidence, reach common ground (not the lowest common denominator) and allow opportunities to learn from experience;

cont.

- these approaches are only likely to be sustained where the 'higher' leadership within organisations itself engages in exploring common purposes with other organisations and encourages 'lower'-level personnel to find adaptive solutions to system problems rather than merely efficient solutions to the organisation's problems;
- formal mechanisms for co-ordination across organisational and other boundaries at different levels (e.g. multidisciplinary assessment, joint commissioning) are most likely to be useful where they are embedded in these new ways of working.

For example, in one site, an initial meeting which brought older people, clinicians and managers together established clearly the desire of older people not to be 'the problem' but rather to become part of the solution. One expression of this sentiment was agreement that they should contribute to monitoring the quality of services. Some volunteers were trained as 'quality researchers' and began work reviewing residential care homes. An early finding was the importance of meal-times to residents' days and the dissatisfaction there was both with the 'sogginess' of food and the haste of the meal-time experience. On the former point, the researchers noticed that vegetables were served with ordinary spoons, bringing liquid to the plate, whereas 'at home' a slatted spoon would have allowed them to be drained. This simple practical solution for some reason had eluded those regularly involved. On the latter point, it took a little organisational skill, but there was no real barrier to revising shift times a little to increase the staffing ratio at meals and reduce the sense of haste. From this modest start, there has been growing confidence among the older people that their contribution will be respected and among professionals that opening up to this new perspective will not produce a flood of unrealistic demands.

In another site, hospitals and social services have put considerable effort into establishing hospital discharge procedures, particularly for old people living on their own. Nevertheless, an example came to light of serious failure on this front, damaging to the patient and also very embarrassing to the relationship between professional services and community activists. The NHS trust and the social services department carried out their own reviews of this case and both found that the problems lay elsewhere. However, the parties were persuaded to have a second look at these problems and use a different approach based on a joint review with the participation of older community activists (offered some administrative assistance in making their contribution) and other people who play some role in ensuring appropriate support to older people at home. This 'joint enquiry ' aims to reframe the problems in terms of the preparation for people both entering and leaving hospital, establish the importance of giving much more attention to the views of patients themselves in planning the transitions involved, and consider in detail what is required to improve the capacity of community resources to offer support so that inpatients (mostly) still have 'community options' when ready for discharge. (Such initiatives have to create their own ways forward but some of the possibilities identified elsewhere include using the 'over-75' screening to learn more about the neighbourly support available to people living alone, giving relevant training to housing wardens, and adapting more of the housing stock in advance so as to accommodate people who may acquire mobility problems.)

Similar work in a third site organised around a large general practice enabled the practice to become much clearer about the kinds of nursing and physiotherapy help needed by housebound older people and therefore to enhance the 'care packages' available through revising the local contract with community health service providers.

5 Developing and sustaining more effective leadership

Effective leadership can take many forms and originate in many places. Whatever form it takes, effective leadership is almost always regarded as a critical ingredient in determining the success or otherwise of attempts to bring about significant service change.

Given the important role attributed to effective leadership, it is perhaps not surprising that there are a large number of writers with a wide variety of views on the topic in the field of change management. For example, Senge's (1990) influential work, criticises the prevalent view of leaders as 'special people who set direction, make the key decisions, and energise the troops' as rooted in a (Western) individualistic and non-systemic world view. Instead, Senge argues, leaders should be seen as designers, teachers and stewards who are responsible for *building (effective) organisations*. Mintzberg (1996) expresses a similar sentiment suggesting that 'Great organisations, once created, don't need great leaders'. What writers such as these are suggesting is that the old 'heroic' or 'visionary' image of leaders needs to be replaced by a more subtle idea that accepts both formal and informal forms of leadership and appreciates that effective leaders have to play a variety of roles, from fostering a 'restlessness' with the *status quo* to helping others to have the confidence to deal with ambiguity and uncertainty, to building commitment to new identities and forms of practice.

Writing in a similar vein, Nicholls (1993) identifies two types of leadership: *organisational and supervisory* leadership, and *inspirational* leadership. Broadly speaking, he equates the former with 'getting things done' and the latter with 'inspiring the doing'. In the context of health services, this distinction is particularly important in that many of those in formal positions of leadership (for example, chief executives) often have little scope to practise organisational and supervisory forms of leadership (in relation, for example, to clinicians) and must therefore adopt more indirect and informal approaches to leadership in their organisations. Pettigrew *et al.* (1992) recognise this by identifying the '*availability of key people leading change*' as one critical element in an interconnected combination of factors required to provide *receptive contexts* for service development, emphasising that these people may or may not emerge from formal positions of leadership. The case studies provide a variety of examples of different kinds of locally rooted leadership and leadership coalitions emerging in different circumstances, spanning the creative role played by LIG senior staff in building alliances (see Box 3), the FHSA chief executive role in promoting new GP partnerships (see Box 4a), the radical leadership in finding a new future for a specialist hospital offered by the clinical director (see Box 9), and the stimulus to fresh thinking on services to older people provided by the community volunteers (see Box 10).

Leadership in these terms is very important to what has been said above about building the commitment of staff to new ways of working, valuing individual diversity and supporting people in 'working through' the losses involved, even in changes which are generally welcome. Experience suggests that there are two fundamental requirements for exercising this kind of leadership beyond the understanding and skills in different

approaches to development. First, leaders need to be able to ground their own behaviour in a more or less coherent set of values, not least a continual striving for integrity, which in turn derive from careful reflection on the nature of health care and staff roles within it (Towell, 1996). Second, leaders themselves experience the same pressures, discontinuities and disappointments (alongside achievements) as other staff; they need therefore to make space (and seek support) for developing their own personal capacities for *thriving in chaos* (Neubauer, 1995), for example by grieving over past losses and balancing their work and other roles.

There are a number of reasons why both formal and potential informal local leaders find it difficult to contribute effectively to delivering major change in London's health system. One of the more important of these is the *bias in 'top down' approaches towards regarding those operating locally as primarily 'implementers' of central policy*. This means that attempts to provide local leadership can be seen as inappropriate and indeed, in some cases subversive of policy. (For example, it is probable that the 'deviant' local response to the neurosciences specialty review (see Box 4b) was so regarded in some quarters.)

A second handicap for formal leaders (and therefore also for the response from informal leaders) has been the apparent lack of transparency in decision-making, 'a sense that deals are being done behind closed doors which are not communicated to those ... principally affected by them' in Maxwell's (1994) telling phrase, which has made it more difficult to demonstrate integrity (or at least be perceived as doing so).

A third important reason for limitations in effective local leadership has already been referred to: namely, the continued turbulence in management structures and rapid turnover of those in official leadership positions. It might be added that despite the personal resilience of those who have stayed the course, there is a wide sense of key people being over-worked and under stress. Developing and then exercising the kinds of indirect, 'soft' leadership skills referred to above, building confidence and trust take time and patience as does developing the judgement to distinguish between potentially productive 'restlessness' and potentially destructive instability.

Against this background, *effective leadership for the next phase of development in London's health and social care system cannot be established, nor will it emerge overnight.*

6 Establishing a negotiating model of central–local relations

Returning now to the critique in Chapter 1 of the overall approaches to achieving change in London over the last five years, it is easier to understand the limitations of much of what has happened. The different types of change identified in Tables 1 and 2 require different approaches but neither the politically sensitive macro changes nor the need for creative transformation in the pattern of local services can be successfully addressed through the rules and relationships associated with the current combination of central planning, intermediate agencies and internal markets. Given these different requirements, there is no simple way of redefining the new rules and relationships which need to be developed, but the core of these new arrangements can be expressed in terms of a *negotiating model* of central–local relationships which offers a way of recognising legitimate national and political concerns while also promoting the greater local collaboration and autonomy required to respond creatively to local diversity. What follows develops this argument and the new model in more detail.

The two principal ways in which central agencies (e.g. the Department of Health) commonly relate to local actors (e.g. a trust) are either primarily through the market (prevalent in the private sector) or via top-down planning allied to a hierarchy of command and control (prevalent in the public sector). There are, however, a number of other models – of which the NHS 'internal market' and attempts to 'manage' it is one – which rely neither solely on the market nor on simple command and control.

Goold and Campbell (1989), for example, identify four broad ways in which the 'centre' in large, multinational companies relates to peripheral (or local) units of management. These models utilise different combinations of hierarchical control, negotiation, financial and other incentives, as well as market forces, to try to strike the right balance between central control and local autonomy. Goold and Campbell argue that there is no one 'correct' way to handle central–local relations, just different ways that will be more or less appropriate depending on such factors as the level of uncertainty in the operating environment, the extent to which the whole organisation shares similar values, and the nature and complexity of the business. Similarly, writing in a health services context Pettigrew *et al.* (1992), Mintzberg and Glouberman (1997) and Best (1987) all argue that the most successful models of central–local relations are those that strike a balance between a combination of central direction setting, clear rules and shared values, incentives and considerable local autonomy.

There are indeed elements in the official view of central–local relations in the NHS consistent with the idea of the centre establishing a broad strategic framework and combining this with considerable local autonomy, for example in the agreement of

'corporate contracts' with health authorities and in the 'freedoms' available to trusts. This model is clearer in relation to local government where there are autonomous authorities with a local democratic mandate. In both sectors, however, the reality is considerably more confused.

Focusing on the NHS, it is clear that something more akin to 'command and control' is still common, and much of the case material calls into question just what is meant by the phrase 'local autonomy' in the NHS in 1997. Apart from any difficulties there may be in determining what is meant by 'local', the notion of 'autonomy' would appear to be, at least in part, a misnomer in the context of politically sensitive change. More specifically, because such change almost invariably entails the reshaping of the specialist medical workforce as well as access to capital, and because neither of these can be achieved without central approval and support, the scope for 'locally driven' change is extremely limited. The 'local' role in these circumstances appears to be much more one of working with the centre to establish what is feasible and likely to be acceptable politically and, once this is reasonably clear, focusing on the official 'mechanics' of implementation.

This point highlights the often obscure and transitory nature of central–local relations in the NHS. In particular, while these relations are in theory laid down in legislation and official statements of policy, in reality they vary dramatically depending on such factors as the issues at stake, the personality of the relevant minister and/or local chairs, the status and influence of the local 'medico-political' lobby, and so on. And while it could be argued that these sorts of factors simply reflect the 'realities' of change in London, they can at the same time be seen as a significant yet haphazard influence on how change actually unfolds.

While it is understandable that in the case of politically sensitive change politicians and others near the top of the NHS hierarchy will wish to exert considerable influence over how change unfolds and, therefore, what changes are actually realised, the case studies suggest that this may result in:

- attempts to adhere rigidly to a preconceived plan even in the face of evidence that the plan has major defects; and/or
- the process of local consultation being reduced to a 'rubber stamping' exercise (often the case, for example, when the decision to close an A&E department is taken in advance of consultation).

In addition, it is clear that the combination of factors, events and phenomena that influence whether and how change occurs are so diverse and complex, that the scope for

detailed, externally imposed control is, in reality, very limited (see Box 11). It follows therefore that any specific direction from the centre must be exercised judiciously and the scope for traditional planning on these complex issues of institutional and service change is very limited.

Box 11 Some factors influencing change in London

Any number of factors, events and phenomena have influenced whether and how change has occurred in South East London. These include:

- the existence or not of an 'official' strategy (e.g. the *Making London Better* recommendations);
- service or clinical 'logic' (e.g. the presence of an A&E department requires a certain critical mass of associated services);
- the availability of capital, facilities and specialist personnel;
- the revenue position of the relevant organisations;
- the degree of unanimity of relevant 'clinical opinion' in favour or opposed to the change;
- the ability of the relevant clinicians to form themselves into an effective coalition;
- 'horse trading';
- serendipity;
- medico-political lobbying;
- the electoral cycle;
- the involvement of national politicians /senior civil servants from the centre;
- the involvement of national politicians with relevant local constituents (e.g. local MPs);
- public opinion and the effort put into mobilising it;
- the aspirations and strategies of the relevant local organisations (e.g. trusts);
- the proximity and pace of relevant, parallel change (e.g. the medical school mergers);
- ignorance of the plans and behaviour of other relevant organisations (e.g. health authorities adjacent to London);
- relevant 'extraneous' phenomena (such as the unexplained rise in inpatient admissions among men aged 15–44);
- the degree of specificity with which the proposed change is described;
- the degree of match between assumptions made about the needs and behaviour of the relevant population, and the actual needs and behaviour of that population;
- political will;
- the energy and care local 'implementers' put into trying to realise the change;
- the quality and persuasiveness of the 'evidence' that the change will yield a net benefit;
- the personalities of health ministers; and so on.

Beyond these politically sensitive issues, there is. as we have seen, a whole world of issues which require local intelligence and creativity to change the nature of service delivery in order to respond to local diversity. Here the centre's role needs to be about setting broad directions for local interpretation, defining relevant parameters and promoting the conditions for flexibility and local adaptability. In particular, as the discussion in the preceding chapters makes clear, the transformation of services requires a shift away from the fragmentation and perverse incentives of the internal market towards a new set of rules and incentives which foster local collaboration (e.g. among agencies in the local health communities) in achieving medium-term aspirations.

Without denying this complexity, we have identified the need for a reconceptualisation of central–local relationships most simply expressed in terms of a *negotiating model* – which emphasises the critical role of negotiation over how relevant local alliances can best respond to central intent, within the context of a London (or wider) overview.

The early formulation of this model is due to Miller (1995, first published in 1976). Working on the challenge of establishing appropriate national approaches to community development, he reviews the conflict between 'top-down' (i.e. national control) and 'bottom-up' (i.e. driven by local initiative) methods, and suggests a negotiating model as a 'middle way'. In essence this requires:

- a broad context and direction-setting role for the centre;
- a more active change management role for local agencies;
- a 'business style' based primarily on negotiation and mutual adjustment (i.e. in which the different parties share a commitment to '*Getting to Yes*' (Fisher *et al.* 1991)).

In the NHS context this is likely to involve:

- a central role in defining key parameters (notably finance) and setting direction, communicated through a broad set of strategic themes concerned, for example, with quality, equity, the integration of services around individuals and shifting the balance of provision in favour of primary and community care;
- enhanced efforts at the centre to ensure the consistency of different policies (e.g. relating to strategic priorities, human resources, access to capital and medical education), as these impact locally, and to establish rules and incentives which foster appropriate joint action by local agencies;
- complementary efforts locally to establish partnerships of both 'purchasers' and 'providers' at the appropriate level to pursue concerted development in the interests of local populations;
- acceptance that both the centre and local interests will have certain requirements that, if not met, will make change unfeasible: for the centre these are likely to be around political 'hard edges' and standards relevant to equity; for local interests these are likely to be around implementation problems and particular local aspirations;
- considerable investment throughout the system in promoting dialogue, building common values and encouraging greater transparency.

(This pattern of conditions, relationships and activities needs of course to be reproduced – like a 'nest of tables' – in systems of different sizes, e.g. government/health districts; health and local authorities/providers and localities; trusts/individual directorates).

Like much else, establishing this new pattern of central–local relationships will take time and may be influenced by either 'vicious' or 'virtuous circles' (Senge, 1992) of activity. For example, the evidence to the London Commission on mental health services suggests a damaging cycle (for example, relating to implementation of the care programme approach) in which local 'failures' generate central concern; the centre issues directives on operational procedures; local agencies facing different pressures respond defensively; the centre increases the pressure for implementation and seeks to monitor performance; local agencies provide less than accurate feedback; and so on. Conversely, a number of our case studies (e.g. of medical school mergers; of improved performance in acute services; and of the involvement of older people in reshaping local support to themselves) show how at different levels 'success breeds success', i.e. early delivery of results consistent with an agreed framework both increases confidence in local capacities and generates stronger central support for pursuing more ambitious aspirations with greater local discretion.

Chapter 3

From reflection to action

Both the preceding analysis and the 'positive' examples identified in our case studies suggest a very wide range of practical implications, taking account of the different kinds of change required by the current agenda for developing London services, the different levels of action in a health and social care system serving seven million people, the diversity across London and the interests and contributions of the wide variety of relevant stakeholders. We identify in this chapter what on the basis of this analysis we believe are likely to be among the most important of these practical steps. However, it is of course the philosophy underpinning much of the preceding argument that better ways of achieving development can only be created by the reflection, interaction and action of people with different responsibilities within this system. This paper is offered therefore as a resource to:

- individuals and groups reflecting on their own experience of change in London;
- interaction among different sets of stakeholders seeking to find better ways of working together;
- continuing reflection-in-action designed to promote learning from further experience as the next phase of change unfolds.

People with leadership responsibilities within the system already have heavy responsibilities for maintaining current provision during a period of great pressure on London's services. However there is also a 'window of opportunity' for exploring fresh approaches and establishing a new climate for action, created by the change of Government, their review of some aspects of the London agenda (and longer-term intentions to renew the NHS) and the publication of an independent 'diagnosis' by the second London Commission. We believe this opportunity could be used to establish greater confidence in the capacity of Government and local leaders working together to deliver positive change in health and related care and establish a 'virtuous circle' of growing success. There is an act of faith here: that a wide range of participants – in Government, in the public authorities, in provider agencies, among all kinds of staff and in the public – will be willing to set aside, at least temporarily, current sectional interests and inherited positions in order to reflect critically on how well current ways of working are serving the public interest and to explore new possibilities.

Of course, the new Government has the prime responsibility here. However, our analysis suggests that it would be a mistake to 'leave it to them'. Rather, it is important for potential partners seeking to address better the local agenda for service development to engage Government in exploring what conditions would need to be established for greater success and what progress could be made towards the Government's objectives under these conditions. In the same way, managers, clinical staff working 'near the ground' and community representatives might seek to generate similar dialogues with 'higher level' leadership in the local public agencies.

Within this broad framework, we use the five main themes from Chapter 2 to suggest key issues for practical attention.

We have argued that a key challenge is to *widen appreciation of the nature of complex change*, distinguishing different types of change and their implications for the ways in which development is achieved. This paper is itself a limited contribution to this endeavour, but of course there is considerable scope for further work here, both to consider a wider range of substantive agendas (e.g. mental health services) and to deepen the analysis in the light of other experiences and perspectives. Thus,

- we hope that further discussion among a wide variety of people involved in addressing change will refine and amend our analysis – and lead to the production of a fuller taxonomy as a practical tool for people leading development.

In consultation with field interests, the Department of Health and NHS Executive need to take the lead in clarifying the centre's role in the next phase of change in London and *establishing the negotiating model of central–local relations.* Key issues for consideration include the following:

- the centre should re-emphasise its strategic role as being concerned with identifying broad themes (consistent with political intent) and relevant parameters as the main input to negotiation over the local agenda for service change; at the same time being clear as to what is intended to be 'tight' and 'loose' in this formulation and providing a continuing drive for development;

- the political nature of some macro changes needs to be recognised and taken into account in these negotiations. If a dialogue between local agencies and representatives of national politicians is a necessary condition for identifying acceptable local 'fixes', this dialogue should become a more explicit part of strategy development;

- listening to the field, the centre should accept responsibility for regular reviews of the compatibility of different central policies. For example, evidence presented to the London Commission suggests the urgent need to develop alternatives to existing PFI arrangements for access to capital; on a longer time-scale there is also a need to promote more radical approaches to role definition, professional training and reward systems better to prepare and attract staff with skills for the challenges of professional practice in the inner city;

- the centre needs to encourage, and at different levels (depending on the substantive challenge) local agencies need to develop, partnerships for change (e.g. bringing purchasers and providers together) both to contribute to the negotiation 'upwards' and increase the prospects for joint action locally on a concerted agenda for service development. For example, more flexible rules are required to facilitate joint commissioning (across health authorities, between health authorities and GP fundholding arrangements, and between health authorities and local authorities) as well as new flexibilities on the provider side (e.g. like those canvassed in the recent primary care White Papers);

- if the centre seeks to promote both significant rationalisation of existing services and transformation in the patterns of local services, it will need to find better ways of meeting the capital and revenue costs of transition (e.g. during the 'double running' of old and new services) to increase the 'space' for local action;

- the negotiating model also needs to be reflected in a redefinition of 'performance management' around monitoring how change is addressed and what outcomes (in changed patterns of services) are delivered, tailored to each local situation.

Complementing this central initiative, the main public agencies need to come together to consider how better to *achieve transformation in the pattern and nature of local services* at different levels of aggregation (e.g. at a 'zonal' level for major reconfigurations; at borough level for new patterns of community care; and more locally for innovation in primary care). Key issues for consideration include the following:

- the renegotiation of lateral relationships to promote joint action on local challenges:

  - commissioning (including joint commissioning) needs to move away from emphasising the 'purchaser/provider split' and control through contracting to refocus on promoting alliances, working across boundaries and involving key stakeholders in discovering and testing better ways of delivering services as well as providing better intelligence on local needs and effective practice;

  - competition among agencies providing services to the same population needs to be replaced by collaboration – for example, in shaping large scale reconfigurations, in redesigning programmes of care and in creating more user-centred service delivery;

  - change partnerships at various levels need to ensure the creative involvement of clinical leaders, both within and across organisational boundaries, in shaping new forms of practice.

- in London, larger scale changes are likely to be facilitated by renewed attention to the zonal approach, but with greater emphasis on establishing 'local health communities' (see the example in Box 6) to pool agency effort in securing the best use of public resources in the interests of quite large populations (e.g. of one million people or more); in turn, these partnerships will need to create their own development agencies (involving key local leaders) to focus effort on achieving system transformation (rather than system improvement);

- the emerging multifaculty medical centres need to consider with local partners how they might better use their combination of educational, research and development roles in supporting zonal development (for example, by their contribution to developing the orientation and skills of practising clinicians – across the primary/secondary divide – in new ways of working).

Taking one of the intractable problems of the last five years, the reorganisation of acute specialties, Box 12 (overleaf) brings several of these points together to suggest how these same challenges might be addressed in the next five years.

Critical to the success of these new ways of working is the need to *develop and sustain more effective leadership,* both formal and informal, across the relevant stakeholders. Government, public agencies, professional bodies and training agencies all have a potential contribution here. Key points for consideration include the following:

- personnel policies (i.e. both on individual rewards and what is valued in career advancement) need to give greater emphasis to rewarding continuity and the commitment to 'seeing things through', while also promoting learning opportunities which improve understanding across different kinds of agency (e.g. through job exchanges and secondments);

- London has a particular need for investment in high quality leadership development programmes – available to politicians, public sector leaders and managers, clinicians

Box 12 Ten requirements for the reorganisation of acute specialties

1. Ministerial leadership to define the need for change, its key parameters (including what is politically acceptable/not acceptable) and provide the umbrella for Executive action.
2. Creation of an intermediate development agency with the functions of promoting wider analysis and round-table examination of the frameworks which might guide local alliances, liaising centrally on the need to adapt national policies (e.g. on access to capital, medical training and R&D reforms) to reduce barriers to local progress, and negotiating incentives (e.g. to meet transition costs and to assist with redeployment issues).
3. Identification of the clusters of local agencies (both purchasing and providing) appropriate to the nature of the challenges, willing to collaborate in developing new configurations consistent with this guidance, make better use of commissioning leverage, and create financial space for change.
4. This will include increasing the permeability of trust boundaries so that service issues (and their financial implications) can be tackled across trusts and aspects of specialty organisation can be addressed on a wider canvass (so, for example, to share out 'hub-and-spoke' roles across institutions and foster clinical appointments to the specialty – with sessions in different institutions – not to the trust).
5. Looking to the new medical centres to support these processes (while ensuring that services to the population remain the central consideration).
6. Pursuing different specialties in parallel so that institutional implications can be both connected and balanced.
7. Using change methodologies which mobilise relevant intelligence in support of collaborative problem-solving in which secondary clinicians are centrally involved.
8. Complementary involvement of primary care clinicians, particularly where organised into locality commissioning or other collective arrangements, to input their perspective into dialogues.
9. Active engagement with public representatives to build understanding of the need for change and get feedback on public concerns.
10. Investment in the managerial and clinical leadership required to support these processes over the significant time periods required to see new patterns implemented, including ongoing opportunities for key people to reflect and learn from experience.

and community representatives – which promote systems thinking, inclusiveness, mutual aid and the sharing of experience as the next phase of change unfolds;

- supporting these programmes and other local development activities (e.g. the zonal initiatives) there is a case for creating an independent resource with the functions of providing intelligence, brokering and facilitating new relationships, promoting innovative change methodologies, including those which strengthen the user and public voices in local developments, and sponsoring opportunities for learning from experience across zones.

Finally, the next phase of London development needs to *strengthen the participation of key stakeholders* in achieving responsive change. The importance of clinician involvement has been referred to above. Equally important, given the hostile public responses to the visible changes of the last five years, a sustained effort is required to rebuild public confidence in health and related care development and better involve

people (in their different roles of potential users, citizens and tax-payers). Local public agencies in consultation with community health councils and community organisations need to take the lead here. Key points for consideration include the following:

- the need to establish a more outward-looking public service orientation which demonstrates commitment to openness and building public understanding of the London and local agenda;

- the more specific need to invest in more varied and effective means for public and user involvement (e.g. citizens' juries, 'whole system events', focus groups, development of advocacy) while seeking revision to the formal NHS consultation procedures to refocus attention on shaping service responses to population need, rather than commenting on institutional changes;

- renewed attention to ways of increasing the involvement of community leaders in the governance arrangements for public services.

A particular feature of this stakeholder approach is the importance of increasing the 'cultural competence' of public services in London (i.e. their responsiveness to population diversity). Further points for consideration include the following:

- the need for ongoing commissioner and provider engagement with relevant community representatives (e.g. from significant black and minority ethnic populations) around needs and the appropriateness of current services, with the intention of promoting specific service development initiatives which reflect the agenda from these consultations and what is known about 'differential' epidemiology in these communities;

- the adoption of personnel policies which promote staffing patterns reflecting the communities diversity at all levels;

- more public investment in the black and minority ethnic voluntary sector both to strengthen advocacy and widen service provision.

It is in making connections across reflection and action in these five areas that aspirations for substantial progress in tackling the huge agenda for substantive change in London's services are most likely to be realised in the coming years.

References

Key publications on evidence to the second London Commission

Boyle, S. & Hamblin, R. (1997), *The Health Economy of London,* London, King's Fund

Harrison, A. (1997), *The London Health Care System,* London, King's Fund

Johnson, S. *et al.* (1997), *London's Mental Health,* London, King's Fund

Other publications

Ackoff, R. (1979), 'The future of operational research is past', *Journal of the Operational Research Society*, 30 (2)

Argyris C. & Schon, D. (1996), *Organisational Learning II,* Addison-Wesley, Reading MA

Beckhard R. & Harris, R. (1977), *Organisation Transitions: Managing complex change,* Addison Wesley, Reading MA

Berwick, D. (1994), 'Eleven worthy aims for clinical leadership of health system reform', *Journal of the American Association,* Vol. 272

Best, G. (1987), *The Future of NHS General Management: Where next?* King's Fund Project Paper No 75, London, King's Fund

Best, G. (1993), 'Keeping the doctors below deck', *Health Services Journal*, 17 June

Best, G. (1997), *Managing the Emergence of Emergence: Some ways in which managers devise, discover and happen upon strategies for delivering change*, London, King's Fund

Chandra, J. (1996), *Facing up to Difference: A toolkit for creating culturally competent health services for black and minority ethnic communities,* London, King's Fund

Darkin, A. & Sibson, L. (1996), 'The building of appropriateness', *London Monitor 3*, London, King's Fund

Department of Health (1993), *Making London Better* London, HMSO

Fisher R., Ury, W. & Patton, B. (1991), *Getting to Yes: Negotiating an agreement without giving in,* London, Business Books

Goold, M. & Campbell A. (1989), *Strategies and Styles*, Oxford, Basil Blackwell

James, J.H. (1995), 'Reforming the British National Health Service: implementation problems in London', *Journal of Health Policy, Politics and Law,* Vol. 20, 1, Spring

Jones, K. (1996), 'The London Ambulance Service: recent progress and future prospects', *London Monitor 3*, London, King's Fund

King's Fund (1992), *London Health Care 2010: Changing the future of services in the capital,* London, King's Fund

Klein, R. (1996), *Coping with Uncertainty in Hard Times: Political and social factors in health futures,* London, King's Fund

Kotter, J. (1995), 'Leading change: why transformation efforts fail', *Harvard Business Review*, March/April

Lessof. M. (1996), 'Treating a rash of predictions', *Health Services Journal*, 16 May

Levenson, R. (1995), 'Involving the community in decisions about change', *London Monitor 2*, London, King's Fund

Marris, P. (1996), 'The management of uncertainty, in Kraemer', S., & Roberts, J., *The Politics of Attachment: Towards a secure society,* London, Free Association Books

Maxwell, R.J. (1994), *What Next for London's Health Care?* London, King's Fund

Miller, E.J. (1995), *Integrated Rural Development: A Mexican experiment,* London, Tavistock Institute (First published in Spanish in 1976)

Mintzberg, H. (1987), 'Crafting strategy', *Harvard Business Review,* July/August

Mintzberg, H. (1996), 'Musings on management', *Harvard Business Review,* July/August

Mintzberg H. & Glouberman S. (1997), *Managing the Care of Health and the Cure of Disease,* London, King's Fund

Mintzberg H. & Westley F. (1992), 'Cycles of organisational change', *Strategic Management Journal,* Vol. 13

Neubauer J. (1995), 'Thriving on chaos: personal and career development', *Nursing Administration Quarterly,* 19(4)

Nicholls, R. (1993), 'The paradox of managerial leadership', *Journal of General Management,* Vol. 8, No 4

Nicholls, R. (1997), *Seismic Shift or Noisy Tremor? A personal perspective of changes and the processes of change in London, post Tomlinson,* London, King's Fund (in press)

Normann R. & Ramirez R. (1993), 'Designing interactive strategy', *Harvard Business Review*, July/August

Pettigrew A., Ferlie E. & McKee L. (1992), *Shaping Strategic Change,* London, Sage

Roberts, J. & Kraemer, S. (1996), 'Introduction: holding the thread', in Kraemer, S. & Roberts, J., *The Politics of Attachment: Towards a secure society,* London, Free Association Books

Senge, P. (1990), 'The leader's new work: building learning organisations', *Sloan Management Review*, Vol. 32, No 1

Senge, P. (1992), *The Fifth Discipline*, London, Century Business

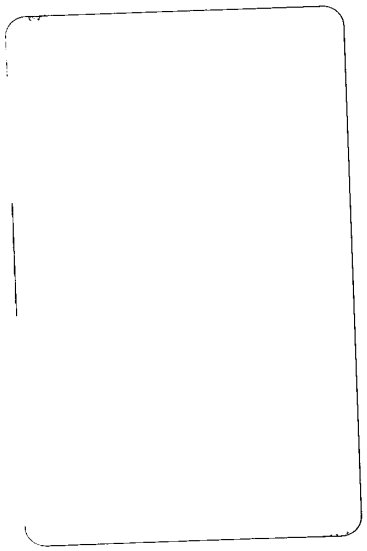
Stacey, R. (1992), *Managing Chaos*, London, Kogan Page

Stacey, R. (1993), *Strategic Management and Organisational Dynamics,* London, Pitman

Tomlinson, B. (1992), *Report of the Inquiry into London's Health Service, Medical Education and Research,* London, HMSO

Towell, D. (1996), 'Revaluing the NHS: empowering ourselves to shape a health care system fit for the 21st century', *Policy and Politics,* Vol. 24, No 3

Wheatley, M. (1992), *Leadership and the New Science*, New York, Berrett-Koehler



London Health Care: Rethinking Development is the fourth in a series of reports prepared to assist the work of the second King's Fund London Commission. The Commission's own report – to be published in July – will set out an agenda for transforming health care to meet the needs of Londoners into the next century and make recommendations about ways forward.

London Health Care: Rethinking Development focuses attention on the question of how this challenging agenda can best be addressed in the complex situation of the capital. Reviewing the experience of the last five years, it argues that transformation in the overall pattern of health and related services and the many different types of change this requires are unlikely to be secured through either central planning or quasi-market mechanisms. Rather, government and health agencies need to work together to establish fresh approaches to development which combine political leadership on tough issues with much greater emphasis on local inter-agency collaboration and participation of the full range of relevant stakeholders.

There is now a window of opportunity for wide discussion about better ways of achieving progress which needs to involve politicians, managerial and clinical leaders, other staff and the public. *London Health Care: Rethinking Development* aims both to stimulate and inform this discussion.

ISBN 1-85717-168-3

9 781857 171686