

Transformational change in health and care

Reports from the field

Durka Dougall
Matthew Lewis
Shilpa Ross

May 2018





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1 Introduction

The King's Fund has been calling for transformational change in health and social care since 2012 (Ham *et al* 2012). We have argued that transformation is best brought about 'from within' rather than through targets and performance management and other external stimuli (Ham 2014). The new care models programme is a recent example of how the NHS has used reform from within, and there is evidence of the benefits (Naylor and Charles 2018). It demonstrates what we have argued for in our other work – for example, in reports on quality improvement, stressing the important role of frontline staff, supported by organisational leaders, in bringing about change (Ham *et al* 2016). Previous research by the Fund and others has analysed the factors at work in high-performing health care systems that have undergone transformational change (Ham 2014; Baker *et al* 2008). We have described the need for collaborative leadership practice that works across boundaries to bring about transformation (Hulks *et al* 2017).

This report builds on that research and The King's Fund's previous thinking by telling the story – from the perspective of staff and service users – of how transformational changes occurred in four organisations that have been recognised for their innovation: The Bromley by Bow Centre in east London; Birmingham and Solihull Mental Health Trust; Northumbria Healthcare NHS Foundation Trust; and Buurtzorg (from the Netherlands). It provides a rich understanding of the everyday experiences of people involved with, or experiencing the impact of, transformational change, and highlights a number of key considerations that can strengthen current efforts to transform health and care.

What is transformational change?

Transformational change is defined as the emergence of an entirely new state, prompted by a shift in what is considered possible or necessary, which results in a profoundly different structure, culture or level of performance (Ackerman 1997). It is different from correcting or enhancing an existing process, which is described as incremental change. Transformational change requires a fundamental rethink to create completely different, more effective ways of addressing the same problem. The leap from candles to light bulbs, horse-drawn carriages to motor cars, 35mm



film to digital cameras, or landlines to mobile phones often springs to mind when thinking about transformational change. In health and care, few striking examples of transformational change come as easily to mind. While there are many good examples of change at the individual, team, organisational and cross-organisational levels, these changes often struggle to compare in terms of their transformational nature. Still, transformation remains a firm aspiration within health and care services.

Why is it needed in health and care?

This year the NHS turns 70 – an important milestone for this widely celebrated entity (Duffy 2018). But as the NHS ages, an important debate about its optimal state continues to dominate headlines and policy discussions. Created in the post-war period, it was a revolutionary concept in 1948 to provide health care that was free at the point of contact. But 70 years on, resources are heavily constrained and demand on services continues to grow. The impacts are clear, with recent analysis showing delays in accident and emergency (A&E) assessment, prolonged waits for elective treatment, problems with nursing recruitment, and a predicted financial deficit of more than £500 million for 2017/18 (Murray *et al* 2018). Additional funding could help, but key questions are how much, by when, and most importantly how these resources will be used (Ham 2018).

There have also been advances in our understanding, recognising that health is not just the absence of disease or only the remit of the NHS. Health incorporates ‘mental, physical, and social wellbeing’ (World Health Organization 2018) and thus many factors contribute to good health (Dahlgren and Whitehead 1991): quality housing, education, access to affordable healthy foods, community networks, employment, and more. The NHS cannot work alone to solve these issues impacting on health (Buck 2018). Genuine partnership approaches that engage the whole of the system are critical (Ham 2017). This requires collaborative and distributed leadership, working across boundaries, to achieve collective progress for and with local communities (Hulks *et al* 2017; Seale 2016).

Thus, the world of health and care is a dynamic environment. There are opportunities, challenges, new ways of thinking, and rich insights from the past. But almost universally those operating within it recognise the ongoing need to transform ways of working. It has been said that ‘radical change is needed to transform the delivery of health and care services to meet the challenges of the



future' (Ham 2014). This need to 'future-proof' the health and care system underpins much of the *NHS five year forward view* (NHS England *et al* 2014) and the many efforts to transform health and care (Ham 2018).

Why is this relevant now?

Numerous attempts are under way across England to transform health and care, including new care models, evolution into integrated care systems, devolution, and more, with many positive results so far (Ham *et al* 2017). However, A&E remains a major challenge for the system (Anandaciva 2018); mental health continues to be an important area for ongoing focus (Gilbert *et al* 2014); there is a need to review the role of community services (Charles *et al* 2018); our leadership and organisational development work shows the great value of support (The King's Fund 2018a, b); and our networks demonstrate the power of sharing experience from UK and international models to help enhance local efforts (Walsh 2017). Combining these insights, we wanted to delve further into experiences of transformational change to support the individuals, organisations and partnerships that are working hard to deliver this.

Our study

We designed our study to better understand the personal experiences and reflections of staff and local people on being involved with the transformational change process, based on five questions:

- What motivated people to get involved with such projects?
- What problems were they trying to solve?
- How did it feel to be part of this process?
- What factors acted as enablers and what hindered progress?
- What is the lived experience of people involved in or impacted by the change?

Methodology

We shortlisted sites that were externally recognised as successful transformational change projects and selected four that represented a diverse range of health and care perspectives, including community, mental health, primary care and acute care.



They covered different timeframes (two started in the 1990s and two in the 2000s), and geographies (three sites originated in England; the fourth started in the Netherlands and is being piloted in England for potential rollout). Sites were asked to nominate key individuals involved with, or experiencing the impact of, the change. For example:

- **change leader** – person(s) who had the idea and took it to implementation.
- **change sponsor** – senior colleagues who enabled the change to happen by providing support or resources (eg, board member, politician, commissioner).
- **change participants** – people who were involved in delivering the change (a diverse group, eg, clinical, non-clinical, frontline, middle managers, senior tiers).
- **change recipients** – public, citizens, patients and service users who provided a narrative of their experiences of receiving transformed services.
- **change bystanders** – individuals outside of the organisation who will have observed and noted the site's transition over time.

All 42 people nominated by the sites were interviewed by one of three researchers, either in person or over the telephone. Recorded transcripts were analysed thematically. An independent advisory group consisting of 12 experts representing the change categories and four areas of study (see Sections 6 and 7) was consulted in January 2018 about key findings and how best to interpret and disseminate them.

Limitations

As with any piece of research, our study has some limitations. The sites selected had a relatively high profile, were well-established and were generally considered to be successful. It is possible that we would have found different experiences if we had studied sites that were less prominent or less successful in their attempts at transformational change. Also, in some of the interview categories, it was difficult to identify adequate numbers of participants, especially among recipients of change. This was partly because some of the change programmes had started 20–30 years ago, so fewer people were available who remembered the whole process.



A storytelling approach

The interviews elicited the subjective thoughts, memories and experiences of those taking part. With more than 40 interviewees and 700 pages of material, we could not include everything in this report, and it is possible that some input may have been contorted in memory or seen differently based on the perspective of the individual concerned. With this in mind, we carefully pieced together the narratives – where possible, verifying content with sites and cross-referencing with published material. The four stories in this report represent the collective perspective of the interviewees involved in each site. We have not used people’s real names to ensure anonymity.

These case studies illustrate contrasting aspects of transformational change and show how it evolves unpredictably over time. According to Pettigrew *et al* (1992): ‘For the analyst interested in the theory and practice of changing, the task is to identify the variety and mixture of causes of change and to explore through time some of the conditions and contexts under which these mixtures occur’. We hope that these diverse stories convey the wonder and magic of transformational change.



2 The Bromley by Bow story

The Bromley by Bow Centre is an innovative community organisation in east London that was set up more than 30 years ago (see [Bromley by Bow Centre undated](#)). It works in one of the most deprived boroughs in the UK aiming to improve the lives of local people by addressing their social needs first and is a remarkable example of how services can be built around individuals and a community, rather than trying to make people fit into a system.

Since 1997, the Bromley by Bow Centre has been working with the Bromley by Bow Health Partnership, offering holistic support to people by bringing together primary care, public health, social care and non-clinical services, ranging from opportunities to set up small businesses to literacy classes, creative arts, welfare benefits and debt advice, and vocational training and employability programmes. People are referred to social programmes through social prescribing.

This award-winning centre currently employs 270 staff and has many volunteers. The buildings have been designed around a three-acre community park to promote access, interaction and empowerment for the local population. The partnership won the Best Community (Legacy) Project at the National CSR (Corporate Social Responsibility) Awards, and the Community Impact Award at the Third Sector's Business Charity Awards, both in 2017.

The Bromley by Bow story has been told many times over. Many people have visited from the UK and abroad to see for themselves its good practice in supporting people to change their lives. But despite this publicity and considerable interest, people who helped to create the centre question whether its message is really being understood. According to them, the story is often heard in one of two ways: that change happened through the leadership of the NHS or that heroic individuals changed the lives of people. In fact, the story of Bromley by Bow emerged from the community. It is a story of shared leadership. An 'act of generosity' is what catalysed the possibility of the Bromley by Bow Centre.

In telling this story, we have pieced together interviews from 13 people who were nominated by Bromley by Bow Centre and its Health Partnership as some of the key individuals involved with the work or experiencing its impact. This is the story of Bromley by Bow as viewed through their lens.



A set of challenging circumstances and a choice: to run away or to act?

Imagine the scene in Bromley by Bow in the 1980s – painted through the eyes of two local residents at the time:

It was desolate.

Everything was dire. The quality of schools was dreadful, the quality of housing. There was nothing around. No energy. No dynamism. No excellence. In terms of health services: poor quality and poor premises. It wasn't just the local authorities. A lot of the voluntary sector had tried to copy the local authority and were obsessed with process. It just didn't work.

It was a scene of poverty likened by some interviewees to poor regions in India. A place where tensions between different cultural groups were rife. Yet, this was a small area in London, a capital city. One man recalled:

When I first arrived, one of my first experiences was of a white East End mother pulling a pregnant Bengali woman by the hair along the streets. All that tension was very real for me. I found myself landing in this thing. My instinct initially was 'get out of here', this is all too much for me.

But a group of people did not walk away. A bystander noted:

A lot of people, if they saw that situation, wouldn't go and live among it. They'd be trying to get out to the leafy suburbs and educate their children in nice primary schools. They wouldn't necessarily commit to being there. This group of people actually came rushing into a situation which lots of people were trying to get out of.

They chose to stand firm and look more closely into the situation. What they found was a range of rich and deeply moving stories, of high levels of poverty, unemployment and racial tensions within the community that were not being adequately addressed. And they saw a wealth of assets, ideas, energy and passions within that community as well:



You [had] a virtual global community living there. When you began to listen and watch, you began to realise that different mothers from different [backgrounds], all have a point of view and actually none of them are daft. This is all part of a picture.

Some say it is this mentality that enables transformational change: the ability to see the challenges, to look deeper, and to choose to act.

An act of generosity that sparked the transformation process

The church in Bromley by Bow was a small dilapidated building, whose minister was a Yorkshireman – the son of a milkman, the brother of a mental health nurse, and someone with an interest in social enterprise. His life experience gave him a unique approach. He says:

I'm not into top-down or bottom-up. I'm into inside out. If you get on the inside of situations, you see stuff. My view was that people were good and had something to contribute. The question is, how do you channel that energy?

At that time, the congregation was mainly made up of older people. The minister recounted:

These 12 people at my congregation, good people, hadn't been to university, had lived through a war and seen a bit. I discovered an East End grandmother called Edna who used to wear a grey woolly hat, 73 in her body but 17 in her head. That's what I noticed. Age had nothing to do with how many years she'd lived.

An important part of his 'inside-out' approach was 'loitering with intent': he spent time getting to know the community. He met Sarah, a 17-year-old woman living in a squat. She told him she'd been promised housing but it had never materialised. She felt she had potential but had never found the means or support to reach it. She felt invisible. The minister reflected:

So you can imagine, you got a sense of those kinds of human 'disconnects', with promises made by politicians that never happened.



Sarah dreamed of building a boat; not a little model boat, but a life-size one. She described her vision in colourful detail. This dialogue prompted her to think further and to make a request. He recalled:

She said: 'Look, I want to build a boat. I need to do it somewhere dry. You've got an empty church hall. Could I just move it there?' I said: 'It's more complicated than that. Me and 12 people have a democratic committee, we decide things together'. She thought that was quaint because no one else was using the hall at the time.

The minister took the discussion back to his congregation, not quite sure what they would say. To his surprise, it resulted in a very interesting and rather unpredicted conversation:

Well, oh, we've seen that woman...

...she's a different generation...

What does she do?

Can you trust her with a key?

And then, unexpectedly, Edna spoke up and said, 'Hang on a minute, Noah built a boat, why shouldn't Sarah?'

The group liked her line of argument. They all agreed that nothing else was happening. So they opened the door to the church – maybe a symbol of an opening of mindsets – and began the process of inviting the community in. Sarah started to move the wood into the hall, and the boat-building began.

One interviewee said:

This is a really vital bit of the Bromley by Bow story – an act of generosity that allowed the Bromley by Bow Centre to be born, when one of those elders said: 'Yeah, you can come and build the boat here'. A group of people who had nothing and gave away what they didn't have was the thing that catalysed the possibility of the Bromley by Bow Centre.



An unpredictable and organic journey: it's the mindset that counts

With this began a rather magical story – a blending of ideas, with intersecting generations forging new relationships that changed all their lives and lives for generations to come. Sarah, Edna and the others – initially unsure of each other – began to bring life and energy, hope and inspiration to each other's lives. They became great friends over time and shared many happy memories. They felt like a family and forged a decade of transformation, impacting far more than just their own lives.

Sarah's story reiterated to the congregation the importance of diversity, humility (to really listen, without being biased by assumptions or attitudes). It also reinforced the value of trying to support others, however unconventional their ideas may sound. Arguably, the process of building the boat proved more valuable than the boat itself. This ethos is likely to have contributed to setting up the café...

We needed to put a decent kitchen in the church. One of the mums pops up, saying: 'I've always wanted to run a café'. I'm thinking: 'I'm going to back you'... We bought a red Rayburn from Wales and got it delivered for £50. Carlos, an artist carpenter, built a little café. The mum started to run it, and all sorts of people started to join us around food. You then discovered she left school at 16. After three years she came to me and said: 'I need to get an education, will you help me?' So, I helped her get into a university. She got a first in social psychology. I'm thinking, 'hang on a minute...' and that led to a whole university project, which ended up having 120 people. The point is it's an organic thing. It's about what people bring with them: passions and opportunities. This is what health's about. How do we create things where we recognise that everyone has a contribution to make here?

...and the nursery:

This is where Bromley by Bow began, of a mixed community. The state would say, 'Can we fund something to bring lots of single mums together in a room?' But, when you get to know single mums, they don't want to be in a room with other screaming kids and single mums; [they] want to be in a room with Edna. When you began with that mindset, opportunities pop up that no policy document's ever going to notice.



Sparks that ignited a collective sense of leadership

The minister identified other ‘disconnects’ that continued to spark his interest – for example, between the local authority, tenants’ associations and residents. Attempts by the local authority to consult with the community were not always seen as legitimate or worthwhile, and a sense of lack of understanding and mistrust on both sides was hindering dialogue and progress.

Normally the processes of the local council were, ‘Let’s consult people’. But, if you talked to a local mum she would say, ‘I never go to the tenants’ meeting. I’m not going to join in. They’ll take over our area and we’ll not be here in 20 years’ time’.

The minister became aware of his own prejudices too. A new superstore had opened in the area; some local people saw it as a ‘greedy, capitalist’ venture and did not see the potential benefits it could bring in terms of employment. Mindful of his own upbringing and the impact of big business on small industries (like his father’s milk business), he too was unsure about the potential benefits of a large company setting up in the area. But he chose to keep an open mind and find out more. He talked to the manager of the store and found his assumptions challenged. The manager was a local man who had achieved a lot in his career, was quick-witted and wanted to do more. The minister was impressed and invited him to meet with local residents. Bringing together a representative of big business and local residents created a dialogue and promoted more openness to what could be achieved through partnership. The effects were praised by others:

[The minister] was fantastic at bringing in industry, breaking down barriers between big corporations and getting them to help kids off the street to do programmes or get experience of working... Sometimes it wasn’t about money. There were some examples where people interested in engineering would go and work, for example, with [an energy company]. It wouldn’t cost the company anything, but it would just open these doors that would enable individuals to get just one foot on the ladder to get out and move on.

At around the same time, a woman moved into the area. She noted the contrast to the small town she had come from:



I remember arriving in London and expecting my neighbours to speak to me, because that's what we'd have done if new people had arrived next door. They didn't. When I went to speak to them in the garden, they scurried back in. They were frightened of us. Just that breakdown of community...

She was drawn to the church, and joined others who were working there on a semi-voluntary basis exploring how to use the few resources they had available to make things better for their community. She brought ideas and insights from her work in India and in Pakistan, where she had lived and worked in a leprosy community:

I quickly realised the main function of me being in that leprosy community. These people often had missing fingers or severe disfigurement, but still had much to offer. But, when they went to the well to get water or when they went to collect firewood, they were stoned or chased away. I found that when I was with them, that didn't happen. So my main purpose was to walk with them wherever they needed to go, to avoid them being stoned or being on the receiving end of the stigma.

When I came to Bromley by Bow I met people that I couldn't help but equate to. Some of those people were incredibly broken by their life experiences, not really through any fault of their own. My assumption was that, in order to build the community - which is the thing I've learned in that leprosy community - you have to assume that everybody's got something that they can offer: that there's a role for everybody in a community, and that it's our collective responsibility to find a way to build a community where that's possible.

The woman used these insights to help set up the community care programme. She sought to uncover what people could offer – enabling, mobilising and advocating for the community. Rather than 'doing unto', she was guided by them.

Also drawn to the church was a refugee from Chile with a background in religious and political leadership, and art. He inspired others at the church:

He helped us understand what it might mean to be human in this context. Somewhere like Bromley by Bow, where people were incredibly brutalised and had internalised all that dehumanising stuff, including the impact of the physical environment, his thing was if you want to restore a sense of humanity, you have to restore a sense of creativity. That became one of our mantras, one of our maxims.



The group worked to further transform the local community using their collective belief that everyone has something to offer, starting from the inside out, using creativity, with a sense of shared responsibility for building a community. And this is how the Bromley by Bow Centre began. The small group of people sparked ideas and energy off each other, and this in turn inspired others to join too. One member recounted:

I spent a lot of time talking to people, doing what [the minister] had done actually, building relationships. On one of those occasions I met this group of people with disabilities, a self-help group. I asked: 'If we were to do something, what could we do?' And they said: 'Well, we like to do gardening'. And I thought: 'We've got this space at the front of our building, in front of the church, which is just a horrible little space. We could build a garden there. Nobody would stop us from doing that'. So, this little group came together and started building a garden.

The gardening activity attracted the attention of mothers dropping their children off at school. Soon, they too began to volunteer and together they built a garden.

This process of sparking off each other and of collective leadership did not always mean things were easy or comfortable. Members recounted the nature of their transformational relationship:

Our lives were intertwined. Our families grew up together. We were all working late together, so we would eat together. We were a community of people whose lives were very interdependent. We lived, we worked in that community. We were trying to create some change for it. So yes, we were a massive support to each other. But we also disagreed. We had huge power struggles. But we still managed to stay good friends and keep relationships. This was a fundamental aspect of our work at Bromley by Bow.

And they described the considerable uncertainty at the time:

None of us then had any idea about whole systems ideas or complexity, which is all based on the interdependencies between people and the relationships between things. I understand that now. We were intuitively building connections, building relationships, exploring interdependencies, trying to create an integrated context for people to live their whole life in a whole community. Not separating off bits.



Interviewees described the ups and downs, feelings of insecurity and turbulence, uncertainty and chaos as important features of their journey. They also explained that embracing diversity and having healthy attitudes towards conflict helped.

Their collective passion and leadership led them to explore local issues in more depth. Interestingly, this resulted in a dual effect – both a sense of understanding from group members, but also a sense of trust from the community that these were people who cared to listen. These were people ‘prepared to walk along with them’, regardless of the circumstances, to ‘start working outwards’ to address the issues, using what they in the community could offer, not what they themselves wanted to bring. But they were not necessarily prepared for what they would encounter and the struggles that they were embarking on, or indeed the enormity of their achievements that lay ahead.

Uncovering a complex ‘soup’ of issues

The more these people worked with the Bromley by Bow community, the more they saw a depth and complexity of issues, and the need for more joined-up, holistic approaches across health and care:

As we built relationships with local people, we came into contact with the reality of people’s lives in what I think was the third most deprived community in Europe at that point. What was problematic for them was their health and the way their health was being addressed, their health needs were being met or not met. It was a thick, complex soup of reasons why that was difficult.

The way the NHS was set up, the interface it set up, made it very difficult for people who didn’t speak English or who culturally had a whole set of assumptions about what it was like to talk to professionals, whether they were housing professionals or health care professionals.

When you say you’re a doctor and I’m a patient with a particular condition that you’re specialist in, we have to project our trust on to you, which means we have to give up something of ourselves in order to allow you to take on that role. If you’re somebody who’s got poor literacy, or a mental health condition, had very limited experience of getting outside your own four corners of your community, deprived, suffering from all sorts of things, the nature of the power dynamic is even more powerful. So people were very disempowered.



The physical infrastructure was another issue. People were going to see their GPs in the ground-floor flats of horrible deprived inner-city flats. I lived in this community. I was a service user too. Just the physical design of the building was a statement of the low value that was placed on the lives of people who lived in those communities.

As we started to become aware of all these things, we started having to often pick up the pieces for people who were falling through the cracks of mainstream health, social care, education services. We were often taking up a bit of an advocacy role.

Others were feeling the same. A local NHS general practitioner (GP) recounted:

I've been a GP in Tower Hamlets for a long time. When I started, general practice in inner-city areas had been really under-developed and was often a model of single-handed GPs working from shops or flats, so a really poor provision. We were trying to bring general practice up to a modern, high-quality standard. But one thing that became really apparent to me was: what we were trying to do in terms of primary health care wasn't really meeting people's needs. People had needs around their social health, so around the wider determinants of health. Thinking back to that time, we didn't really have a language around this particularly – that's evolved over the last 15–20 years. It was really hard for us to work with patients around their physical health when the thing that was troubling them most about their wellbeing was often more to do with things like housing, employment, education, money and debt.

Sharing the same passion for joined-up provision and quality services, and refusing to allow people's needs to continue to go unmet, these individuals eventually met and joined forces. They realised they could not meet the needs of local people by continuing to work in silos; they knew a collaborative effort was needed, and had already begun seeking opportunities to do this. They recognised the real issues affecting people's lives and saw the power of the community to influence health and care: through healthy lifestyle choices, managing conditions, supporting friends and neighbours, and, over time, much more. By empowering the local community, they were unlocking a tremendous force for transformational change. Some say, in many ways, this was the real measure of their success.



Organic growth around a core purpose to improve local lives

The group persevered with their efforts to address local issues in partnership with local people, rather than enforcing change or imposing solutions on them. Community-focused initiatives flourished: the garden, the nursery, the café, a dance school, a community development project, and much more.

By the 1990s, the centre had grown in terms of services available and as an employer of local people. It drew a mixture of people: local residents, volunteers and staff from diverse backgrounds such as art, teaching, finance, civil service, and so on. People described their motivations for getting involved:

I got involved as a volunteer. I was working at that stage with people with mental health problems, I was working afternoons and an evening, so I was often around at lunch. I would go and help with the café... and on a good day, I got lunch [laughs].

It was their attitude towards the people living in the area. It was about friendship, smiling, everything was very warm, very positive, always a nice atmosphere.

It was like finding a home. Lots of people move into the East End that don't belong and lots of people have been there for generations. It gave new people like me an opportunity to talk and be with people who had been there for a long time.

Conversations were slowly bubbling up. We made time to just sit and discuss what we would dream about, what we would want to do, what our ambitions were for getting involved, what we felt we needed and wanted to do.

This was not a linear sequence of events and it would be too complex to recount in precise chronological order; by this time, many initiatives were growing and being nurtured from the same core principles outlined in earlier sections, and that continues to be the way today.

Continuing the theme of converting space for communal use, the centre acquired a derelict, adjacent plot of land with the help of a lawyer (a friend of the minister), who negotiated with the local authority to buy the land at a very low price and with a 30-year lease. Full of needles, rubbish and broken furniture, this piece of parkland was a hazard to walk in, let alone use. The task of transforming the park



proved to be a daunting venture and to make it more manageable the group chose a small starting point: they decided to paint the park bench. Spotting the hub-bub, it sparked the curiosity of an artist who had wandered into the park. Drawn by their story, he was invited to contribute and decided to join the group, and started transforming the space even more.

The work also drew attention from some trouble-making local residents who were keen to disrupt the group's activity and challenge their actions. They were quickly stopped from spoiling the work by the volunteers, not in anger but with warmth. 'Don't ruin our efforts, instead why don't you help us?' With some encouragement, they soon did. The piece of land became known as 'Bob's park' (named after the park-keeper).

A team was forming, with a collective passion for change.

The power of a community to forge a completely new beginning

Sadly, not all stories from this time were positive. In fact, one tragic story changed the fate of this group of people more than any other – the death of a young mother called Jill. She died at the age of 36, having fallen between gaps in the health and care systems. The community had tried to support her, champion her needs, fight for quality services and bend rules to help her, but to no avail. This emotional trauma burned deeply into the fabric of that local group, igniting a blazing anger that such things could occur.

Having advocated for Jill towards the end of her life, some group members met with health service managers to seek answers. That encounter was pivotal in developing the vision for Bromley by Bow and driving a health service focus:

We ended up in a senior-level boardroom meeting at [hospital]. Everyone was going around the table justifying what they'd done or not done for Jill. I listened to it for about three-quarters of an hour and then banged the table. I don't normally do that, but Jill wasn't a client, she was a friend of ours. I said 'I'm sorry. I've had a real problem with this conversation. The whole conversation is about your professional interests. Jill and her children are any other business'. After this, four directors privately rang me up or came to see me, and said: 'Do you know what? I agree with what you're saying but I can't agree with you in a public meeting'.



This is about doing things to people rather than people having power to do things for themselves. The sad thing is, years later I was sat around a similar meeting about Baby P [who died in London in 2007 aged 17 months after suffering more than 50 injuries]. Nothing had changed, only this time there were computers to hide behind.

The death of their friend and the lack of accountability had a profound impact on the group. They could also see that other aspects of health and social care, including primary care, were not working as they should for local people.

I suppose a primary driver [was] around a belief in social justice – an inherent desire not to collude with a society that privileged some people and disempowered others. It was fundamentally wrong what was happening to people in that community. How could you stand by and watch that?

Stimulated to act and fuelled by their fury, the group decided to create a new way of approaching health and care. Building on the evidence about social determinants of health outcomes, the premise was to empower people to live healthy lives. They would build an integrated health and community centre (a healthy living centre) that was owned by local residents. There was no ‘model of care’ *per se*; instead, the ethos was based on social and economic factors being as (or more) important than medical factors. This may be the greatest transformation of the health service that they undertook: to integrate medical care with non-clinical care provision in order to help address the social and economic needs of the person they were serving – something they recognised was often the biggest concern, and inseparable from the person’s physical health needs:

We made [a] conscious decision to step beyond the work that we were doing in the community development context, to build that community to care for itself, to step in to the world of mainstream services, health and care services to try to change the system. We wanted to work with a group of GPs to explore how you could develop a different kind of integrated model to deliver health and care in a community, where a community was right at the heart of it.

The centre’s leaders placed very high importance on how the physical layout of the centre would make people feel: something ‘mediocre’ was not wanted. The buildings (the original church, Bob’s park and the new café) and the quality of the



materials used would create a sense of worth and importance for everyone who used the space. Social interaction was foremost on people's minds.

However, the plans met with strong opposition, particularly from statutory health care organisations. Health services were commissioned and delivered in very specific ways and, moreover, there were fundamental differences between the mindsets and cultures of people from the centre and those working in statutory bodies. Powerful allies became important in providing local and national political leverage. The group gained some unexpected support from a minister for health, which helped them to move some things on locally and turn the vision of a healthy living centre into a reality. But there were many obstacles to overcome and the centre's leaders felt they were not being treated as equal partners by the local health authority. They found themselves being left out of key decisions they felt they had an equal stake in, such as the design of the building that was to house the primary care centre, and the appointment of GPs. The group persevered and drew in the support of a commissioner in the local health authority. Backed by the emerging policy around reforming health care in London, the commissioner and others in the health authority used their enthusiasm about the group's plans and vision to influence the levers they had at their disposal. The commissioner recalls:

It was an incredibly exciting thing to be involved in. We were learning at the same time as the centre's leaders. What was amazing about the Bromley by Bow vision and the ideas starting to come out of this was that they wanted to look at things and take risks, sometimes within the structure of the health service, [which was an] area where it was very difficult to fail, very difficult to take risks and test things. [The Healthy Living Centre] was a bit of a disruptor. We took some chances by using seed money to test new ideas alongside fulfilling what we had to follow within our structures and systems.

The Bromley by Bow Healthy Living Centre was officially opened in 1997, the first of its kind in the UK. Since then it has been visited and admired by people from all over the world. Maybe rather less obvious, but nonetheless poignant, is that it is also a monument: a tribute to a young woman who passed away and a community who cared for her. It is a symbol of the power of a community to take ownership of a health service and forge a completely new beginning – to deliver transformational change – despite the considerable challenges and obstacles they may face.



A new model of primary care and a primary aim to care

After a few false starts, two GPs were found to be a good match for what the centre's leaders had envisaged: they bought into the centre's ethos and understood the need for a different kind of relationship with patients and the public. They were open to new ways of working and to a partnership with the centre, its staff and patients. Reflecting on how she became involved, one of the two GPs recalled:

I started to hear about the Bromley by Bow Centre which, at that time, was moving into the field of health. Through their experience of working with the community, they had almost come from the other side of it. They realised the inter-relationship between people's social health and their physical health, and wanted to try and model primary care differently. The opportunity came up to take on the practice here, so we did. We started to think about how we might jointly do work across both traditional 'health', and also the wider definition of holistic health and how we might start working more closely with the charity. When I started here, it was as a GP with a very strong involvement of how we were developing joint work together, how we were thinking about the model of care, developing that and building relationships between the different disciplines there.

The centre became a major hub of activity in the local area and still is to this day. But Bromley by Bow's story does not end with the opening of the Healthy Living Centre. Challenges and dilemmas remained, around a clash of cultures between staff from the community centre and those working in health care.

GPs and health visitors have very strict rules around patient confidentiality, and this often jarred with how the centre space was being used by other staff and members of the public. As they were from a tight-knit community, many people who attended the centre were used to sharing information openly with each other as a way of looking out for each other. This did not sit comfortably with some health care staff who questioned the value of these types of insights.

Health visitors found it very difficult to be in the same room as the mums on equal terms. They found it hard not to be in their professional role. I suppose they acted out a power dynamic, which led them to not necessarily value the things that the community mothers were saying.



These professional and cultural differences took many years to work through. Some people overcame them through perseverance and sheer force of will, continuing to advocate putting local people's needs first. Others have taken an organisational development approach, building an integrated team with aligned values and beliefs.

A couple of years ago we started something called 'the Blend'. We think of it as the induction module for a mixture of people from the centre and the practice. It's run over something like five half-days over a period of about three weeks. We introduce people to the ideas of social determinants of health. We help people just be more observant and look at what's going on around them: observe the way people are interacting, the issues, walk around the local estate, understand what this might be like, think about conversations, what creates the context for a good conversation with somebody, whether that is clinical or employment advice or the sorts of conversations when people are seeking support and you're trying to work out how best to help them.

Another challenge lay in overcoming the constraints of traditional NHS or community roles, which did not enable those involved to meet people's wider needs. For those who craved a more joined-up system, Bromley by Bow was attractive because it presented opportunities to offer that kind of service. At a service level, there were challenges due to the different systems, ways of working, funding methods and approaches:

The community mothers' scheme was an NHS-funded initiative, it [was deemed to have] 'failed' and funding was pulled from it. As a community organisation we still carried on working with those community mothers, supporting them, enabling them to take up their role in the community. So, the work continued; it just wasn't recognised as being valid work. It failed in the NHS's terms because it didn't tick all the boxes, but in our terms and the community's terms it worked incredibly well. I can give lots of examples of this attempt to blur the boundaries of relationship and role between health care professionals and local people who weren't just local people who just came off the street. They were part of our team. They were part of our community. They were given huge amounts of support and lots of training to be able to take up support roles.

This raised interesting questions about what success means and how formal health and care structures that had not embraced a more holistic notion of health could



impede improvement efforts: a clash between new and old worlds that was forcing the team to choose between providing 'quality' in accordance with old-world, ineffective 'requirements' or providing 'quality' based on current (or new world) understanding about people's needs. The Bromley by Bow team had to find ways to work around the system – growing and evolving and innovating as they went along. As such, Bromley by Bow made (and continues to make) impressive achievements for the local community and beyond – a far-reaching impact that we will now describe.

Continuing to grow and inspire others

The individuals in the team formed a tightly knit group over many years as friends *and* colleagues. Although the leadership of the centre has changed hands over time, more than 30 years later, many of those involved early on are still linked to the centre through roles or relationships. The friendships have endured, more or less – another element of the Bromley by Bow 'magic'.

I don't think it would have happened if you had a job description and you'd interviewed for a job, because I think that the willingness with which we entered into it was more like the willingness that you enter into with your own family and your own friends... People didn't really see it as a job. They saw it as something that they absolutely loved doing and the excitement of what more could develop.

The centre has physically shaped the local landscape into something very different from the barren wasteland it once was. Through partnerships with public, private and voluntary sector organisations, the centre has played a significant role in local regeneration. But it has also shaped how people in the local health and care systems conceptualise health and wellbeing. It continues to be actively involved with community development – each week supporting numerous families, young people and adults to learn new skills, improve their health and wellbeing, find employment and develop the confidence to achieve their goals and transform their lives. At its core is a belief in people and their capacity to achieve amazing things. Its range of initiatives remains impressive.

But beyond this, it also has a focus on research and development, to understand and evaluate the work and share insights about its methodologies. The Healthy Living Centre has been the source of inspiration for others who wanted to adopt a similar way of addressing social determinants of health alongside traditional



health care. The model has challenged commissioners to think differently about quality and inspired new ways of regulating services based on quality rather than tick-box methods. For a health system that is accustomed to measuring outputs and targets, Bromley by Bow offers a different kind of challenge: How do we know if people are really healthier and more productive in their lives? How can we measure the direct impact of its projects? It has prompted a scientific study to assess impact on the wellbeing of the local population, commissioned in 2016 by Public Health England, with additional support from Wellcome Trust, the Health Foundation and others. It is envisaged that this will continue for several years.

Those who have understood and learnt from the principles of the team at Bromley by Bow have already achieved impressive results – for example, the Robin Lane Health and Wellbeing Centre in Pudsey and others in Tower Hamlets. They have not succumbed to the allure and temptation of excess focus on the structural model; though seemingly easier, it would not work. The Bromley by Bow story shows why this is the case: it is not possible to replicate the exact combination of circumstances, interpersonal relationships, entrepreneurship, determination and acts of generosity that helped make Bromley by Bow deliver such transformational change. But neither did they give up or dismiss the possibility of achieving similar results by labelling it as ‘a unique’ set of circumstances. Instead, they saw the possibilities of applying the Bromley by Bow principles, for that is what can help others to move on:

People would say: ‘It’s unique, you could never replicate it’. It’s true, you can’t take that model and just say, ‘We’ll just take all of that and plonk it somewhere else’. As an example, we thought long and hard about networks, the population, geography, neighbourhoods when developing a network strategy for improving primary care. We were developing the Barkantine in Isle of Dogs at the time and it influenced our thinking. It has different services, but we were keen to get public health into the building, the principle of integrated care, thinking about how to connect to local schools, which is a model that Bromley by Bow had. Barkantine is a bit like Bromley by Bow as a community anchor organisation with the resources that it had at its disposal. So, you can’t entirely replicate, but you can take some principles and ways of working and replicate some of that.



This challenge to apply the Bromley by Bow principles in a joined-up and meaningful way is one that interviewees wished to leave us with:

When you go to the North West or into Bradford or Cumbria you see dependency cultures: the same stories, change a few names, it's the same thing that we discovered years ago in the housing estate in Bromley by Bow. Institutionally, often none of the lessons learnt, despite thousands of visitors to Bromley by Bow, despite endless research...

There's a story that comes to mind: in Bradford, there's a very large woollen mill called Lister's Mill. The entrepreneur that built that was Samuel Lister. Whenever they tried to find Samuel Lister you couldn't find him in the boardroom talking policy, you couldn't find him in his office writing strategy documents, but on the Mill floor you'd see a set of legs pointing out under the noisy machinery. He would be looking up at the machinery and noticing that this wire wasn't connected to that, if he did that rather differently and connected that thing to that... He invented 120 (I think it was) patents that changed the woollen industry.

So, a conversation is needed about the machinery question and how broken it is. Throwing money into them will be good money after bad. There is a fundamental problem across institutions, political parties, universities – all busy talking policy, research and theory, but not grasping practicality. There's a need to look under the bonnet and take a close look at what is happening underneath.

Hence, the story of Bromley by Bow beseeches each of us to stop and carefully reflect on our individual and collective practices. Are we seeing the needs that surround us? Do we choose to act or walk away? If we choose to act, do we understand the fundamental shift that is needed to enable transformational change that genuinely improves people's lives? Are we prepared to face the hard work and challenges that are often encountered on the way? It questions our sense of humility, and our humanity, and says, please, 'Do it properly, or not at all'.



3 The Birmingham story

Mental and physical health have historically developed as two different disciplines, resulting in a separation that can be detrimental to individuals' health and wellbeing. Rapid Assessment, Interface and Discharge (RAID) is an innovative service that has transformed mental health care across a whole city and more widely as well. It was set up in 2009 by clinicians at Birmingham and Solihull Mental Health NHS Foundation Trust in partnership with Sandwell and West Birmingham Hospitals NHS Trust. It brings together a multi-skilled team who provide timely assessment, diagnosis, and management of a person's physical and psychological wellbeing, within one hour in A&E, four hours in an acute medical unit, or 24 hours on the ward. The RAID team also support staff working in general hospitals to better recognise and treat common psychiatric, psychological and emotional problems (see [Birmingham and Solihull Mental Health NHS Foundation Trust undated](#)).

Analysis by the NHS Confederation and the London School of Economics and Political Science showed that RAID has improved patient care while also reducing costs by preventing unnecessary admissions, reducing length of stay and reducing readmissions ([Parsonage and Fossey 2011](#)). RAID was subsequently expanded into all other acute hospitals in Birmingham and Solihull. It has also been implemented in other parts of England – for instance, in east London, where an external review of RAID services indicated that more than 2,800 bed days had been saved in one year, largely through reduced stays for patients with dementia, substance misuse and severe mental illness (Becker *et al* 2016). It was voted best innovation in mental health practice in the 2010 *Health Service Journal* (HSJ) awards and has attracted much national and international interest as a mental health service exemplar ([Albury *et al* 2018](#)).

To tell this story, we have pieced together interviews from nine people who were identified by the foundation trust as playing a key role in the transformation work or experiencing its impact. This is the story of Birmingham, as viewed through their lens.



A tale of two perspectives

Our story begins some years ago with a junior doctor at the start of his career. Like many others at that stage, he was a 'generalist', enjoying learning and not yet sure what he wanted to specialise in. One day he was helping with an operation for a young woman with breast cancer and recalled the moment that sparked his whole career:

I was a junior doctor... working in surgery. The then professor picked me to assist him. He was doing a radical mastectomy on a young woman. The whole thing was absolutely awful and bloody and smelly and everything. But he was very proud of the art he was doing – though in my mind, this young woman was just going to be disfigured. Remember, that was before reconstructions and all these kinds of things. At the end he asked me: 'Do you have any questions? Look at the beautiful work I've done'. I said: 'Well done, sir'. He said: 'You have a question?' And I said: 'Just how would this young woman with disfigurements feel after she wakes up? How would she cope with life?' And he got absolutely angry and he said: 'This is not my business, she can go and see a bloody psychiatrist'. And it just came to my mind: 'Well, I could be that bloody psychiatrist. All that I'm interested in is how can I help her, rather than how I can cut bits off her body'. Obviously, surgeons are very important and obviously each one does what suits their skills. But from very early on I was very interested in human beings and the value of people and how they feel and how we can support them.

It is likely that this encounter underpins the whole of the Birmingham RAID story.

Seeing a great need

This young doctor went on to pursue a career in psychiatry, over time becoming a renowned expert in the field. Through his career journey, he realised the meaning of the situation he had witnessed as a young doctor: not merely two clinicians with two different passions, but a personification of the wider reality – mental and physical health care professionals working in silos in the broader health and care system – and the adverse impact this has on patients and staff. This separation, it occurred to him, happens in medical school, postgraduate training, regulation, and throughout people's careers:



Psychiatrists sit in a hospital which is usually a few miles away from the acute hospital. Their training is different. So, the culture became different. It became like, I speak a language that other people cannot understand. I have datasets which other people do not have access to. My case notes are different from other case notes and I need to have my time for reflection and thinking about it.

He saw it again in care attitudes and working practices – not just on the ‘other side’, but in his own field too:

I’m going to exaggerate a bit now, so forgive me. But the psychiatrist will tell the medical team how they have done everything wrong and how the psychiatrist can’t see the patient at all till they are fully medically fit. If they have delirium they can’t see them. If the patient had any alcohol they can’t see them. So we put barriers and made ourselves different from all other specialties and hindered our chance.

On both ‘sides’ he found biases that did not help, and he realised that patients attending acute hospitals were often poorly served as a result. Even in places attempting to provide more integrated care, like Birmingham City Hospital, there was still no fully co-ordinated system. He was not alone in seeing this; other doctors, nurses and managers saw it too:

Nurse: *There was no single model of liaison psychiatry so there were specialists coming in on certain days of the week, nurses doing self-harm assessments in A&E, on-call doctors coming in at night, home treatment teams going to other areas, and other parts of hospitals that had bought into certain specialties. It was all quite ad hoc. There were some really good principles, but what was quite clear was that there was no single model, and nobody really co-ordinating.*

Manager: *Historically, there was always an issue out of hours. If somebody went into A&E after 5 o’clock in the evening who had a mental health problem, they potentially could wait there until the next morning to be seen by mental health services, because if we were very busy in the community, there was no dedicated person to go into the hospital to do the assessment. If it was an extremely urgent situation where somebody required a Mental Health Act assessment, the organisation of it was very chaotic.*



Doctor: I was a community old age psychiatrist. We had to go and see patients in the acute hospital where seeing them wasn't part of our job plan. So we go whenever we can go, just to discover the patient has been waiting for us for a long time. Sometimes the patient's been waiting for two weeks for a psychiatrist to come to see them. That leads to delayed discharge, poor quality, no communication between us and the team.

Wanting to improve care provision, the nurse, manager and doctor began to speak to each other about what they could do.

A glimmer of a possibility

At the same time as this was unfolding, City Hospital was struggling to achieve the A&E four-hour target – partly because there were psychiatry patients waiting to be assessed in A&E, but also due to problems discharging ward patients who had been found to have mental health problems, and because some beds were occupied by patients with drug and alcohol issues. The mental health trust realised that it was providing a patchwork of different services across the city and wanted to rationalise the service line agreements (SLAs) that were in place.

This created an opportunity to transform the provision of liaison psychiatry. Spotting this glimmer of an opportunity, the three professionals that had begun talking to each other chose to look a little further. The doctor says:

I discovered actually psychiatry has been working at a different pace from the rest of the specialties. What was needed was a psychiatric team that worked 24 hours, 7 days a week, with response targets, like in cardiology.

The doctor, who also had an academic perspective, reviewed the literature and found that the evidence seemed to support the role of liaison psychiatry; though it was not conclusive, it did suggest some benefits. This motivated him to look further. He started drawing up alternative models of care to address the shortfall in services. He collected raw data from the studies and used this to analyse further options. Together, the group considered their options in the context of the local landscape and decided what course of action to take:



I was part of the group of people who said: 'If we were to start from scratch, what would the needs be in the acute hospital around mental health provision and what sort of model might we come up with to try and demonstrate that that could make a useful difference? At the time, the drivers were around quality and trying to support the acute hospitals to give some parity of esteem around the mental health aspects of people presenting, but also arguing that financially we could improve things as well because there was a lot of discussion... about people with either primary or secondary mental health issues languishing in hospital, being admitted, taking longer to get to the bottom of things, delayed discharges, and obviously that would create a cost. So there was a thing around cost, a thing around quality and a thing around supporting the acute hospitals.'

With their shared passion, an idea (supported by evidence) and based on their knowledge of the local situation, that glimmer of an opportunity was too good to miss. So they seized it.

Seizing the opportunity to make a difference

The group put together a proposal explaining their vision – outlining not just their aspirations, but a practical plan based on local priorities which proved, convincingly, that it would make good use of valuable resources. Fortunately, they found a receptive audience at City Hospital:

I would absolutely say that getting senior buy-in from the start was really important, so the fact that we got a chief exec and board who really wanted it to happen, they'd spoken to commissioners, and the acute hospital and mental health commissioners were nodding, saying 'this is a good thing' – that was great.

And as well as authorisation, the executive group provided insights that helped further shape the plan:

We said we'll have a psychiatry team that will work from 9 til 5, and the medical director said: 'Which 9 to 5 do you mean? Because from 9 at night til 5 o'clock in the morning, this is when my A&E is busy.'



They created a model of care that attempted to address clinical needs, and to help the acute and mental health trusts with their performance and financial concerns. This multi-focused approach enabled them to get senior buy-in:

In a nutshell, the model brought together three aspects of mental health care: (1) needs around acute mental health issues; (2) the ward challenges; and (3) substance misuse, predominantly alcohol, and acknowledging that acute hospitals struggled with alcohol. Combining those three aspects and having a service that was consistent so there was a 24/7 presence in the acute hospitals could save money and improve quality. Initially we thought that it would be a really expensive model, but then when we looked around, we looked at how much the acute hospitals were already giving to the mental health trust in terms of a bit of a doctor here, a bit of on-call there, a couple of nurses here, and we realised that actually it wouldn't take that much more to augment that into a single model and bring those people together.

Just as mental and physical health are closely interconnected, the group recognised the close relationship between patient care and staff experience:

If you get the patients' value right, if you get the staff value right, you get the financial value right. It helps get everything in the right way. If all the focus is on the target and the finance rather than the patient journey and the staff support, we will struggle halfway through.

Thus, the team were careful to include a focus on improving staff working lives, in turn supporting better patient care, and also making best use of the funds available.

Understanding and embracing the associated risk

Seizing the opportunity also meant making a difficult choice. The doctor at the heart of this proposal had a settled and comfortable job in the community that he had spent years building up: he had a nice office, resource centre and parking space, his work was being published, and he had lots of trainees – things that many aspire to. He could see that to pursue transformational change in delivering psychiatric care to patients in acute hospitals, he would need to give all this up and instead embrace more intense working, hard targets, and whatever personal impact it held



for those depending on him. Was he naturally a risk-taking person? 'No, not at all', he laughed. So what made him decide to take such a big risk?

...it just sounded like the right thing to do. If I really believe in it, I'll take the risk. I can't expect anybody else to do it. So it was the choice between three things really – whether I let go of the opportunity to develop something good for people; or I become a hypocrite and actually ask other people to do it because I don't want to do it myself; or actually to try to be true and take the risk. So, I took a big risk.

Why did his colleagues take the same risk? A nurse leader who came on board explained:

I felt it was an opportunity to improve things, because I felt the same frustration as other people in terms of inequity of service and poor commissioning and lack of real vision and description of the model, and beyond that it was the sense of actually, if seniors want this to happen, then it's much more likely to make it happen.

'Let's do this, together' they thought. They started by piloting their idea.

A small-scale (virtual) test of their idea

The group decided that a pilot study would give them an opportunity to test their hypothesis and find out whether the new model would really have the anticipated impact on quality, timeliness and efficiency of care in acute hospitals. One interviewee described the importance of this clinical and academic approach:

I realised that we had to have data to prove the worthiness of the project and what we want to achieve. From the clinical point of view I set the clinical processes, how we're going to see the patient and all these kinds of things. From the academic point of view, I set up the datasets, the questions and the process of collecting this data.

They worked with academic colleagues and built an evaluation model containing a range of parameters in the three key areas that they needed to see impact: quality, cost and activity. They included capability in this system to link these measures for financial modelling – for example, costs associated with length of stay, and thus cost reductions. They also included measures of staff and patient experience, which the group found invaluable. This approach helped to get others on board:



I think if you say: 'I'd like you to start working in a different way and change what we're doing', people say: 'My director doesn't want that, or the medical director's got concerns' or even 'The chief exec thinks this is probably a waste of time'. Whereas, if you're saying: 'This is a pilot, we'll evaluate it, we think we're going to be in a better place than we are now, we're not promising miracles but there are lots of reasons that we can articulate very well' [people are much more likely to get involved].

Piece by piece, from these experimental tests, the group created a model of care.

Creating a new service to pilot in practice

Interviewees recall starting from the beginning to create the new service:

We had to build everything from scratch, the IT system, the information governance, the protocols, the process, the academic part and the clinical part. Having a governance structure, a steering project group and a project board that I could go back and escalate things up to and say: 'Who are our contacts and our equivalents on the other side who we can just bring things up to?' really helped.

They outlined a number of factors that were valuable in their efforts to do this.

Defining ethos and brand

Despite being initially hesitant, the group heeded advice they were given about creating a defining ethos and brand – and they found this to be invaluable. One change leader explained:

I was very sceptical initially about the name of the service [RAID]. We had jokes about fly-killers and were a bit sceptical about that whole marketing side of things. But it was actually a very, very good idea, because what it meant was after that there was a very single identity to the service, and even though people might interpret it in different ways, there was much more of a sense of 'it does what it says on the tin'. When people talked about it in City and then across the other Birmingham sites and then nationally, people had a reasonable understanding of what was meant. Prior to that they hadn't, because when you talk about liaison psychiatry, it can mean different things. Having a clear name and a vision and a statement of some core principles seemed to make a big difference.



A learning approach

The group used an iterative process, built around constant questioning, rather than trying to shoehorn developments into what they initially thought correct:

We kept saying: 'What's the financial impact of this? What's the clinical impact? What's the quality impact? What's the patient experience? What's the relatives' experience?' We were trying to measure all of that in different ways.

Intelligent recruitment and development of the team

Interviewees said it was important to recruit the right staff at the right level:

We wanted staff who were passionate about the model, but also people who could grow into the role as well. We got senior medical staff who would be well-respected by their medical colleagues in the hospital, we got nursing staff who were very experienced – who'd either got liaison experience or would understand and buy into the model. We also recruited junior staff. We wanted to grow and sustain the model. We were thinking about future-proofing and 'growing our own'.

They highlight that in many cases, it was not about new recruitments but working with existing staff, which requires focus on motivation, development and encouragement. In some cases, though, this did not work and they had to accept loss too:

I had a group of clinicians, doctors and nurses with me, who believed in the value we wanted to bring. Some of them didn't to be honest. Those who didn't like the new way of working, we never sent them away. They just left us because the value of the new team and the pace of the new team didn't suit them. But the people who stuck, they were people who were committed.

Working across the organisation to bridge the gaps

Having built a team, they set to work across the organisation trying to bridge the many frontline gaps. To do this, the team had to use a range of skills and insights:



The home treatment team staff would often come in during the night to see people in A&E, but they weren't really familiar with A&E processes, and they didn't, through no one's fault, necessarily have good working relationships with A&E physicians or nurses. They wouldn't consider physical health, or quite understand how the hospital would work, so they would just look at it purely from their point of view – 'Is there a treatable mental illness at this point? Do I need to do something with them or not?' The model that we developed and the staff we brought in, we very much wanted those staff to align themselves and to embed themselves in the acute hospital and to be part of the system rather than to be outside of the system. So it was very much about being based within...

To build a service that responded to the needs and pressures of the acute hospital, they needed to learn to work alongside the staff in A&E or the wards, and this required dialogue. Interviewees said two components were essential for this. First, being open – really listening and together creating joined-up methods:

We had a sense of 'what's the noise that's coming from A&E or acute hospital clinicians or whoever', and tried to address those things jointly with them. For example, the A&E staff were worried that they would get to 3.5 hours of having seen somebody perhaps with a paracetamol overdose, and then they'd say, 'We'll now refer them to RAID and RAID will take an hour to see them, and then we'll have automatically breached [the four-hour target]'. So we said: 'Why don't we just get you to refer to RAID as soon as they come through the door?' Some of the liaison staff were resistive to that for various practical reasons. So we developed a model of a parallel process of assessment: the RAID team come alongside the acute hospital staff very early, right at the front door.

Second, being physically present:

We had people who were based outside for practical reasons in other hospital sites, in mental health, and we said, 'No, what we really need is people in the front door. We need an office in the A&E department. We need staff to be visible', you know? We need to be part of the environment, because we felt that that then lent itself (a) to a much quicker response but (b) also to the staff in the acute hospital accepting this new model and accepting this new team, and realising that the team was going to be there to work with them, and they weren't sort of outsiders who were just poking their nose in from time to time. We felt that physical location was really important.



Creating an IT solution to support collaborative working

The group realised that their idea would need support from IT to link the acute and mental health systems together and allow an integrated liaison service. They were delighted to find the IT team willing to support their project. Group members described their relief that such a key stakeholder was now on board:

I'm not sure whether it was the passion or the luck or getting the right people around. People in the IT team were enthusiastic about the idea of the project and the value of the project made them go the extra mile to help us.

The small group and the IT team found ways to unblock something that had proven a challenge: bringing together disparate datasets about the same patients.

Everybody around you would tell you, 'You can't share data with other trusts'. The problem is that a patient in liaison psychiatry is registered with the mental health trust and also with the acute trust. In the NHS those two trusts are two separate entities. So part of the data I need is in the mental health trust, the other part of the data is in the acute trust. And the initial perceived barriers: 'You can't share this data because of confidentiality!' But when you persevere, when you get the information governance leads for each trust and you sit down and talk about the protocols, there is a process to do a data-sharing agreement in a very simple way, and match the data and get it approved through the clinical governance and medical directors. There is always a process to do things. Sometimes the fear and the perceived danger can put people off.

Leadership that sets an example: showing that 'change starts with me'

The leaders of the team (the core team, sponsors and colleagues who were supporting the work) took the view that this project could only be successful if they were very visible and provided leadership from the front, on the wards, and developed their colleagues' skills by working alongside them. Tasks were shared out according to the needs of patients rather than by hierarchy or traditional roles. This served to break down barriers between physicians and psychiatrists, as well as between doctors, nurses and other members of the team. A leader noted:



What I preach I had to practice. People are not stupid – they look at your behaviour. If they think you are just making their jobs harder and you sit in your office relaxing, they will never do it for you. If people look at you and they see you working with them step-by-step and maybe slightly harder than anybody else, they believe in the message you give them. They believe it's genuine.

Keeping an eye on progress and using this to guide future direction

The group developed a means of measuring their progress and tailored their approach accordingly, continually striving to improve quality:

We compared ourselves with other organisations; we benchmarked around Core 24 standards; we compared ourselves with London hospitals. We've done that mainly to make our argument for funding, saying: 'We're giving you a good service, we're green in the majority, we're able to deliver what's expected, we're reducing breaches, we're seeing people in a timely fashion'.

The early informal feedback showed that medical and psychiatric teams were starting to work together, collaboratively, to look after their patients' needs. These visible 'quick wins' encouraged the team that they were on the right track:

One of the encouraging things I saw was really good collaboration between psychiatrists and physicians; cases of a physician and a psychiatrist standing together in A&E saying: 'I don't know whether this is organic or psychiatric so how do we manage it between us?' Before that, it would have been either/or. There would have been a lot of ping-pong between different departments.

Internal evaluations showed that the project reduced bed days and costs (Tadros *et al* 2013), which further strengthened their case. Its impacts were confirmed by an external evaluation (Parsonage and Fossey 2011), which also raised its profile:

I think once that happened there was an external badge that said 'this does make some difference'. I think that was when it started to gather traction.

A small group of professionals in a hospital setting had succeeded in transforming mental and physical health care for their patients. What happened subsequently? The RAID approach was rolled out to other Birmingham hospitals in 2011. It was



initially delivered by the same small team – the consultant, the nurse and the manager. They went across to the new sites and used their experience to make sure that the project was successful there too.

From pilot to business as usual

The next phase was to take RAID from a pilot project to become ‘business as usual’ across the other sites. The interviewees noted that it is one thing to start a new project and demonstrate impact, but quite another to ensure that it becomes part of the fabric of an organisation. They talked about the resistance they experienced when trying to roll out the model:

In terms of rolling out across the different trusts: I learned that you can handpick a team to get a pilot project going, but when you go and tell everybody else that it's business as usual in their area, it was a very different atmosphere then. There was a lot of resistance. You were dealing with four times as many staff across the other four hospitals. You weren't handpicking people to champion it, you hadn't got a pioneering consultant, or a real 'let's go out there and make a difference' manager. What you had was people saying: 'I've worked in liaison psychiatry for 20 years and this is how we do it and why should we change?'

And why the resistance? They cited a combination of factors:

Some of that was practical, some of it was probably bloody-mindedness, and I think some of it was anxiety as well. I think there definitely was a sense for some people that they were stepping outside of their comfort zones.

The team were fascinated that a range of fairly simple things proved effective in ensuring that people keep going, despite the competing priorities of their busy day jobs: ‘the 101 other things that we're expected to do with our time’. Some of these are recounted below by staff from the core team and in sites it was rolled out to:

- **Nurturing a sense of pride in the team, work and organisation**

I think staff in RAID are very proud of the service, and because of that, they want to keep going, they want to keep improving, they want to keep changing.



- **Use of data – to motivate and inspire, rather than demoralise or criticise**

I have used the data analysis to put more enthusiasm in the team. When we were working very hard to see every patient within an hour and worked 24 hours, 7 days a week, some members of the team were not sure why we were doing this. When they started having data in the short term, they could see the quality benefits and how much money we saved to the NHS. I remember one of the nurses stood up and said: 'We're doing a bloody good job!' From that point the enthusiasm was spread in the team. The problem we have in the NHS is how we give people the positive feedback loop of what a good job they're doing. If we don't have that, people lose sight of why they're working hard.

- **Career opportunities and interesting workloads**

It's highly attractive to nurses who want to take on enhanced roles. From the medical point of view, it's quite attractive too. It's not mental health day in, day out. They see different things. Their opinion is very valued, it's very much a consultative role, which they like, rather than seeing patients day after day, they get some very interesting work come through and it pushes your boundaries as a psychiatrist or as a psychiatric nurse about you're making a decision here, it's not clear-cut, it's very different. And that's attractive to people.

- **Understanding the importance of the work being done**

Staff need to understand what we are trying to achieve, what it will look like, what's the point doing it. Otherwise, it can seem like change for change's sake and I think we get a lot of that in the NHS where we just rename something and re-jiggle the staff resource a little bit. It needs to be more fundamental. What are the benefits for the patients and carers? What are the benefits for the system, the benefits for the service? Being really clear on what you're trying to achieve.

- **Training together**

Some staff were unsure about working beyond their 'comfort zone' and so to address this, the team initiated a successful training package. This proved particularly useful for staff who previously had a more limited range of experience in psychiatry but would now be assessing a wide range of conditions.



When we rolled out the model, we did a package of training for staff: training on drugs and alcohol, management of older adults with mental health issues, and we developed a training package for adults of working age or general psychiatry. We delivered that with our own clinical staff to all the staff who were coming into the area. I think that made some inroads into making people feel more comfortable.

But despite this, certain things made it harder for the team. Recognising and acting on these challenges early on helped to make it easier:

- **Keeping up interest**

One interviewee noted a loss of interest that could creep in over time by individuals, organisations or even the health and care system:

...the excitement, the gloss wears off, the day-to-day operational challenges come in. We saw that fairly early on and we started to chip away at it.

It is essential to keep moving on, but they noted that it can be hard. For example, it became necessary to disperse the core team to keep working on several fronts, but this was challenging as they had limited capacity to do that, given their own day jobs. They did what they could around this because of their dedication, but in the long term that is not tenable. It remains a quandary as to how best this should be done.

When we set up over at Heartlands Hospital, [the clinician and manager] went over and led there. It made an immediate difference. [The clinician] immediately aligned himself to various consultants and picked up from where he'd left off at City. The director had operational pressures, so [the manager] helped. But that's really difficult when you think about spread and scalability. As soon as you do that you're scrabbling around and can't clone [the clinician or manager]. It's difficult to work out how to do that and keep the energy of the team running.

- **Planning for longer-term capacity at the outset**

It's okay to say as a pitch at the beginning: 'We will be available 24/7, we will be an integrated service, we will see adults, older adults and drug and alcohol'. What we didn't do then, because we didn't know, was set expectations



around capacity. That was a real failing because now the level of activity is phenomenal compared to when we first started it. Particularly at some hospitals, the amount of patients coming in has been quite a problem, and we never factored that in. We never said: 'We expect this amount of work to be done, so as soon as we go to more than this work, we'll need another half-time consultant, or we'll need another two nurses or whatever'.

- **Uncertainty for managers due to short-term funding, with some staff also reluctant to join RAID**

The structure of funding proved particularly challenging. One service manager reported:

It's a difficult battle, because we're constantly having to renegotiate around the funding. We have a two-year contract, a three-year contract, that doesn't give stability around staffing. Staff come and say: 'If you're not going to keep me more than two years, I'm not sure I want to come to the job'. It's difficult to attract high-calibre staff if you don't have that stability in it.

Another major hurdle for RAID was the decision to divert funding for drug and alcohol services to local authorities, as this led to the appointment of another provider to take on this element. The impact was twofold: fragmentation of patient care and the risk of losing a large part of the budget. An interviewee explained the nature of funding and why it nearly destabilised the whole service:

We augmented bits of money from drugs and alcohol commissioning, mental health commissioning, older adult mental health commissioning, and put it all together to run a service: roughly £1 million a year for a 24/7 service. Suddenly we lost the money for two and a half nurses because that was the alcohol money. We had to think, who's going to put in those nurses? Do mental health step in and do that? Do we start saying it's not going to be a 24-hour service, it's now going to be a 20-hour service? Or do we have less nurses during the day?

- **Defining success**

The RAID team stuck to its objective to improve patient care, while also recognising that this approach was likely to yield other financial and



performance benefits. However, team members raised questions about what really constituted success:

The challenge was trying to work out who our master was and what we were trying to serve. Is it all just about trying to go back to the senior leadership team and demonstrating that we've saved so many bed days? There's no doubt that that was important, but [is that what success really is? Who decides?]

To continue to operate in this landscape, the psychiatry team had learnt the importance of being agile and adapting to its environment by constantly evolving and innovating. As well as expanding the service across sites, they extended to cover different services too. Currently, liaison psychiatry extends to the care of patients with cancer, stroke, liver disease and amputations, as well as connecting patients with acute and chronic medical problems to appropriate community psychiatric services. It also includes a street triage system and an emergency assessment suite:

We've created the psychiatric decision unit here on the back of the RAID service, which is about diverting people from A&E at an earlier point and getting them into a unit where they can have an ambulant assessment. We have 120 people through that every month that potentially have attended A&E or have rung 999. We have a street triage team, which is a combination of police, ambulance and mental health nurses. Rather than the patient going to A&E, that team will go out and see them, will make an assessment that it's mental health, not physical health, and they will take them to our psychiatric decision unit.

The team's quest to unlock untapped potential and expand their work continues.

Contemplating the future

There has been much interest in the future of RAID. The model is considered a success (Parsonage and Fossey 2011) and has been adopted at other sites across England. The Royal College of Psychiatrists became interested in creating new versions of RAID:

We called it RAID, but they came along and said, 'We could take this a bit further - RAID Lite, or a five-day RAID, or a RAID 24/7, or a RAID Comprehensive...'



Further local developments are currently under way, including RAIDPlus, which aims to address some of the concerns about the availability and capacity of beds for psychiatric patients in the NHS:

I'm sure you are aware in mental health we have a big problem with finding psychiatric beds and patients are moved out to areas as far as Newcastle and Plymouth from Birmingham.

RAIDPlus aims to help by using data to guide the day-to-day management of patients. The plan is for the newer version to comprise four elements, combined in a crisis care co-ordination centre:

- CADDI (capacity and demand dashboard information)
- predictive analysis
- technology for bed management tool
- platform for patients to have continuous contact with services.

An interviewee explained why they think this will help:

A digital solution to look at the demand on the team and compare that with the capacity that we've got at any different time... A time and motion study. It will be really helpful. When I was working clinically in [hospital], you were just dealing with the next patient through the door. It felt like you couldn't see the wood from the trees. I'm not saying this solves everything, but it will give us more understanding of what we're doing. We can say: 'We're really busy. Look at our workload. Look at the demands. Look at the capacity we've got. Let's try and make decisions around that.'

And still, interviewees said there is further untapped potential. Some felt that developments in liaison psychiatry in Birmingham have not done enough to address issues related to ethnicity, in the city or nationally.

I don't believe our organisation, the hierarchy, is representative of the population. The workforce is not representative of the population. It's a really important point.

Disproportionately there are certain members of the community that have very poor experiences nationally. This is what we know. People on section are more likely



to be black males than they are white middle-class females. Health outcomes are worse for particular BME [black and minority ethnic] groups. These are the things that we need to be looking at.

Some feel that there are many more opportunities to bring mental health to the forefront and gain parity with physical health – for example, in current efforts to integrate care (in sustainability and transformation plans (STPs) and integrated care systems).

Others have asked how the approach could be extended to bridge the gap between health and social care, as there remains considerable fragmentation. Moreover, interviewees expressed a feeling that the NHS appears reluctant to change – suggesting that perhaps staff are ready to change but the system is holding them back.

I was in an STP conference yesterday. I think humans are more ready than the infrastructure. Humans are moving towards accepting that we could work together, we could share resources and support each other for the benefit of the patient. But the infrastructure we have at the moment is still not ready. Even now, if one of our staff moved to the next door trust, they wouldn't accept the training they had; they would have to repeat everything. Bed management, how we share the beds together; because when we share the beds or we want to share beds, people set away talking about Payment by Results, about commissioning – 'who's paying for the bed', 'my money's different from your money'. So, humans are moving towards working together. Technology will help us. But the infrastructure is not ready yet.

This story demonstrates many things: the power of data, technology, and mental health to bridge gaps. So much has already been achieved just in one site. But it also shows that there is a lot more to do. The story of RAID in Birmingham forces us to revisit key areas and question how to unlock their potential. It begs us to consider, as a health and care system: have we yet embraced the power of parity, the value of diversity and the potential of technology to revolutionise health and care?



4 The Northumbria story

Northumbria Healthcare NHS Foundation Trust is a rare example of services across a large catchment area can change with the arrival of a ground-breaking new hospital in an entirely new location. It provides secondary care services to a population of half a million people, including in North Tyneside and Northumberland. In 2004/05, the trust started a 10-year programme to establish sustainable emergency care, which led to the opening of an innovative, purpose-built facility at Cramlington in June 2015, at a cost of £95 million. The Northumbria Specialist Emergency Care Hospital (NSECH) is staffed by A&E consultants 24 hours a day, 7 days a week, and by specialty consultants 7 days a week from 8.00am to 8.00pm. Before this, emergency services were delivered at three sites across Hexham, North Tyneside and Wansbeck, which were subsequently redesignated as urgent care centres. The programme intended to transform acute care and improve clinical care effectiveness by facilitating access to specialists, reducing reliance on junior doctors and implementing treatment more rapidly.

Twelve months after it opened, an internal review showed it had resulted in reduced length of stay, reduced readmissions, and improved mortality scores for patients. After the first year, external analysis showed that total A&E attendances had risen by 13.6 per cent, but patients were generally treated more quickly (O'Neill *et al* 2017). The Care Quality Commission (CQC) rated the trust and the NSECH as 'outstanding' in 2016 – one of only four organisations nationally to receive the highest accolade (Care Quality Commission 2016).

The Northumbria story is an epic tale of foresight, resilience and bravery. It challenges us to question more and takes us on a rather fascinating journey. In telling this story, we have pieced together interviews from 12 people who were nominated by Northumbria Healthcare NHS Foundation Trust as playing a key role in developing the work or experiencing its impact. This is the story of Northumbria, as viewed through their lens.



Forced partnerships, 'merger mania', a commitment: where it all began

Northumbria's story starts in the 1990s. An interviewee set the scene:

Cast your mind to the geography of the north east of England. See the stretch of land that lies from the River Tyne up to the Scottish border and from the east coast into the middle of the Pennines? Everything here that isn't the city of Newcastle is us.

Covering 2,500 square miles and half a million people, a diverse population; an urban population in the old industrial corridor by the River Tyne, and a very dispersed rural population across much of the rest. Three very different hospital groups served the population, each with their own quirks. One day in 1998 they were told 'Right, you're going to form one trust'. An interviewee remembered it well:

The time of 'merger mania', as I called it, when small trusts were being told: 'You've got to come together'. So three institutions that had completely different ways of working, serving completely different populations, were suddenly told: 'You've got to come together and make a go of it'.

Perhaps it was no surprise that those words created a sense of instability, pressurised thinking and emotional confusion as staff tried to deliver this instruction:

We spent two years having rows about whether one hospital was going to score over the other. All of the usual human behaviours where people are thrust together and have spent years preserving their own little entity, they're suddenly told that means nothing, 'You're going to be a new entity now and you've got to make a go of it'.

Amid this turbulent 1990s environment, a far-sighted chief executive officer saw potential problems ahead. She decided to bolster internal capabilities to provide quality care and made a commitment to have a clinically led trust. Over the course of her 16 years in post, she worked tirelessly to deliver on her promise and laid a very solid foundation for change. One of her successors recalled:

She wanted clinical teams working out how they could improve clinical services across the whole patch, rather than thinking, 'this is my little hospital'. She trained clinical leaders - I was one - and we developed an in-house training programme to train people in the way the NHS works, the way money works and, most importantly,



change management. So she created a whole cohort of people who understood that change was necessary, but also understood a sensible way to go about it.

The chief executive initiated a range of initiatives and had a reputation for backing clinicians. She involved service users, inspired many others and set higher aspirations for the trust. The impact of her work was to create a positive culture. At least three generations of local leaders were nurtured as a result. Years later, she reflected on her work in a King's Fund report on system leadership (Timmins 2015):

We gave clinicians space to think and to change the recipe book for the service which they owned. I've seen some magic. People trust each other to take risks to make things even better.

The investment of the chief executive's time, energy and support underpinned the story that unfolded. Her work shows that development of leadership skills across a local system does not mean creating more passive viewers and acquiescent circumstances; quite the reverse. The success of her efforts was in generating a strengthened positive force for change.

Skills turning into action: speaking up to address concerns

The new cadre of skilled clinicians could see trajectories in their hospital and across the country that could negatively impact on care – inefficiency, inequality, waste, untapped opportunity, and an increasingly thinly stretched workforce, with one site losing its trainees in this time. One change leader recalled:

We knew fine well we were struggling. We were running three full-time emergency departments and acute medical units. Most of us worked across at least one of them, often two. Maintaining patient safety and quality was just not going to work.

These clinicians had a choice: continue struggling to cope with what they could see was a sub-optimal situation, or do something to change that situation. Rather than remain silent, likely to have been prompted by their leadership development, these clinical leaders chose the latter and spoke up to raise their concerns. Their voice carried far across their organisations, spread by a positive culture that valued quality, openness and trust, and over time created both a realisation that change was necessary and further impetus to act.



Management that listens, enables and champions others

By 2005 a new chief executive was in post, someone who knew the area well having been in the Northumbria system since 1990. He was determined to stay true to the local organisational culture, and not only listened but actively sought out further clinical opinion about what he heard:

For a long time the plan was to choose a hot site and a cold site, which we knew was going to be operationally and politically very difficult. When I became sole chief exec in 2005 it was pretty clear that the hot/cold site thing wasn't going to work. I came up with the idea of talking to clinical staff about what the alternatives would be and trying to isolate things that we definitely needed to consolidate and the things where there was a choice. We had a very well-established clinical leadership model where people were very engaged and usually just had really great ideas. Every time a clinical director or other senior clinician was having a one-to-one, we'd just revert to the white board and scribble stuff around. So that's how it was formulated.

A clinician recalled how much he and his colleagues valued this approach:

We spent about four months just drawing pathways, colouring in, this needs to be next to that, this needs to be above that. And it was all built around patient flows. So the building itself is putting bricks and mortar around a way of working, rather than shoehorn a way of working in to a rigid box.

Another clinician recalled this 'sponsorship' and how much it meant to feel valued and supported, heard and understood, particularly at moments when self-doubt crept in:

[The CEO] always said to me: 'Forget the age thing, it's about whether you have the appetite and the skillset'. It took me a while to get my head around that because medicine is intrinsically hierarchical.

Discussions and a decision

Through this positive approach, the group started with a blank sheet of paper and no particular model. Through their soft 'knock about', drawing and debate, they identified a range of options: building one large new hospital for all services;



developing hot/cold (non-elective/elective) sites; closing some services at night; but all were considered unfeasible. After further debate, they reached agreement on a preferred option – a compromise, but nonetheless what they collectively deemed best:

Many of us would have loved to have been able to put everything on a single site, but for a whole variety of reasons – not least cost – that was going to be impossible to deliver. So, the next best thing was to consolidate the acute services.

We spent months arguing about which hospital was going to be ‘the hospital’. Out of that grew the idea that actually none of them were going to be ‘the hospital’. They were all in the wrong place. They were all landlocked and couldn’t be developed. Out of that came ‘the Cramlington General concept’, which was: we needed to break out of our existing plant, pick somewhere special that was accessible for our population and do something different in terms of providing emergency care.

This held potential to improve patient care: care quality was at risk of deteriorating if no action was taken; emerging evidence showed potential patient and clinical benefits from the new model, and it offered much opportunity to improve efficiency and flow. For example, avoiding the need for admission for people who needed investigation only, or opportunity to provide more appropriate care by rebuilding pathways: ‘If you’re sick – come to us (NSECH); in all other situations – we’ll try to come to you (other sites)’. A number of additional factors contributed. Three interviewees explain:

Our model was a bit fragile in places and I don’t like being reactive.

There was a clear appetite to really step up our game. I’m quite ambitious and competitive. We were keen to find a new way of delivering a new standard.

We knew that unless we were better, services would end up elsewhere.

While the group had agreed on their preferred option, they were mindful of the consequences of this decision for staff and local people. Unwilling to be arrogant in assuming the right to make such a choice or to think that they knew best, hospital leaders chose to invest their time and energies to embark on a much



more arduous journey. They instigated a process of far-reaching engagement over a two-year period to consult on what was best, generating conversations that others may neglect.

Engaging with the public

The group consulted with as many people as possible, conducting more than 80 public engagement meetings, with clinical teams sometimes travelling to three different venues in one night. They used a range of engagement methods including websites and TV interviews, and sought input from existing user groups as well. Change leaders recalled the scale of the consultation:

The biggest engagement event that the NHS in England has ever seen! It was absolutely both fascinating and bizarre. We did a whole series of them in a variety of venues. I remember going to one somewhere in the north of Northumberland where we actually had to evict the sheep from the village hall that we were using.

An enormous effort to have conversations, measure what people were saying, what their concerns were and satisfaction. And visibly try to address concerns.

Interviewees recalled the rich learning generated through this process; their surprise at the public support, how much the public wanted to be involved, it being a genuine process of dialogue rather than one-off events:

We learned stuff all the time as we engaged and spoke more to the public.

The public got it very quickly. We got a 78 per cent return saying, 'Yes, this is right, please do it', 20 per cent saying, 'Yes, please do it, but could you do it a bit closer to where I live' and 2 per cent saying, 'You've all gone mad, just leave it as it is!'

If somebody raised an issue, we tested it to see if it was an issue that needed to be solved, then go back to people and say 'Thanks, we've taken that on board'.

I learnt a lot about how to put together an argument, stand up in public and influence change.



The process generated much interest but it was not necessarily an easy time. The public demanded more and more say in something they cared deeply about. Maybe this was a marker of successful engagement: the ability to mobilise and generate a robust dialogue or spark more interest.

As the process evolved, so did mindsets. More than an exercise, it became a means of forging a new relationship with the public, challenging assumptions and surfacing fears, developing narratives and using enquiry to generate richer dialogue. It reiterated for some the notion of 'serving' the public; working for and feeling accountable to people who use the service. Others reflected that despite this, plans had changed very little. The communications approach has been described as 'industrialised' and proponents say that there was an 'almost religious belief that if you have the right conversations and listen, you'll be all right'. The effort that went into the public engagement was extraordinary, but some question whether it was more an exercise in informing and reassuring the public, rather than consulting on the best course of action for the region's emergency services.

In contrast to the public engagement, the group were less prepared for challenges that came from other parts of the system. But with resilience, tact and empathy, they faced this and realised the importance of bringing along these partners as well. Slowly, they chipped away and it paid off, bringing them powerful allies – people who could help to overcome important barriers, sometimes with relative ease.

Political engagement

One powerful force encountered by the group was rather unexpected: politicians, both in local government and in Westminster. Politicians had the power to obstruct progress if they wanted to maintain the status quo. Perhaps a force in the health sector that is less well-understood – and vice versa – there was surprise when the emerging plans drew political pushback. Some in the group felt fearful about the growing clinical situation, and what they deemed imminent clinical risk – a threat to people's lives. Unable or unwilling to see this political world, 'stop blocking us', they thought:

The real barrier to change was local politicians. For some, it was a chance to get on the front of the paper: 'Once again the NHS has done down the people of whichever town. This is a disgrace, why aren't they building it where we are?'



But what they found was that politicians could also be tremendous allies; it was a matter of engaging them effectively as well. With patience, they began a dialogue to understand each other's views, each other's priorities, frustrations and passions. Politicians and the health care professionals involved all had views that were justifiable and, mindful of this, worked through their own plans. Interestingly, the group found that politicians could be likened to their local clinicians. They both operated on a mandate based on the people that they served, and they were willing to listen if it meant improvements for their constituencies or populations. And knowing this, the language changed. Efforts were made to persuade politicians of the clinical benefits of moving.

We put together a package to sell to our politicians and spent years doing the same presentation over and over again before we persuaded our MPs that actually, instead of thumping a table and saying: 'How are you going to keep our local hospital open?', if they thumped a table and said: 'How are you going to get my constituents access to the best possible care that you can provide?' it would result in a better answer.

As such, they forged good relationships with local MPs and a better sense of dialogue.

We knew all the MPs really well, and we spent a lot of time with them and other stakeholders just keeping the relationship going. We had a political chairman who had been a leader of a council, the vice chair was leader of the other council, et cetera. So there's a strong muscle about how you work with political colleagues.

But it was not going to be easy for some who could potentially lose out. To their surprise, critical support came from the MP with the furthest constituency – the one whose constituents could have been most affected:

We knew it was going to be tricky for the ones who effectively lost their main A&E. They were able to say 'I'd rather it stayed here but I understand that to deliver this standard it needs to be done in this way'. To be honest, all of the MPs were fantastic at that. The guy that really helped in all that was the MP in Berwick, who was the furthest away and actually managed to get everybody on board 'Really, it's going to move 6 miles, you're complaining? All of my people travel an hour'. They got the point and agreed: 'We should trust them and let them get on with it'.



They had gained permission to give their plan a go. This act of open-mindedness and willingness to support helped them to overcome this seemingly insurmountable challenge, creating a vital opportunity to deliver transformational change.

Commissioner involvement

At that time, clinical commissioning groups (CCGs) were just being created as a result of the Health and Social Care Act 2012, so another interesting and notable dynamic fed into the situation. CCGs are GP-led commissioning units responsible for local hospital funding. Criticism at the time included the hurried nature of the reforms, which meant that people found themselves working in CCGs with limited commissioning experience or skills. Those in hospitals – having been used to entirely different structures – found it hard to accept the changes too. Three interviewees reflected on the pressures and limitations at the time:

It was the first year of CCGs, when it was set up. We were all finding our feet. So there was probably a bit of a lack of experience in how hard to push things, lack of focus. Northumbria [hospital teams] didn't really see what the CCGs could add and weren't particularly co-operative. And certainly, they have a reputation – as a lot of successful trusts do – in not particularly enjoying external scrutiny and criticism. I can't pretend that it was an easy and open discussion.

I remember having meetings and asking about patient flow, apparently causing irritation, not really getting a clear answer. I remember asking about the numbers of patients, the other hospitals and how that had all been worked out, and there was a kind of: 'Of course we have' response. Maybe we should have delved a bit deeper.

A lot of this was mooted before the financial crash. I think if this was mooted now, it wouldn't get off the ground. I suspect there would be a lot more overt challenge about what the true costs of the building would be. A lot of the real hard financial times for the NHS have hit subsequently.

Interviewees expressed differing views at this stage. Some argued that these conversations held the key to the quality of the entire future project and that better relationships may have helped. Some sympathised with local leaders on both 'sides' who had to grapple with the demands of the major 2012 reforms – plunged into



new and unfamiliar situations, much responsibility and pressure, lack of time for familiarity and formation of relationships, while both were trying to cope with the major changes and just do their best.

Ongoing clinical and managerial support

As we have seen earlier in this story, Northumbria already had an ethos of clinical and managerial joined-up working. But as with the public and politicians, the process of engaging with staff needed to be continued. Credible clinicians were often felt to be most capable of engaging other clinicians:

I think it's fair to say the organisation feels quite strongly that to be a credible clinical leader you need to be credible clinically...

But doing that was not always easy. For example, workload pressures often meant that clinicians were juggling two roles. One interviewee explained what being a 'credible clinical leader' involved:

You have to work a normal clinical job and, clearly, do that well. I am full-time compared to my colleagues, which clearly creates a time pressure, but without that I genuinely believe I would not have the credibility that I have from a senior leadership perspective, and I think that's absolutely vital.

Engaging with other clinicians did not always prove easy either. Clinical leaders described 'pockets of resistance' that they encountered or even, in one case, a 'brutal' experience of trying to lead change in a clinical environment:

There were people who, quite frankly, at times were just out to destroy the whole process and to make it as difficult as possible. You know, there were grievance processes within all of this. It all got very nasty at times.

Almost universally, the clinical leaders we spoke to said that it was possible to overcome this resistance using a few fairly simple strategies: resilience, use of data, senior backing, and a determination to keep marching towards quality provision:

I stuck to my guns in terms of what I genuinely believed and increasingly felt I had an expanding cohort of people who believed it was the right direction of travel



clinically for our patients. We had pretty hard metrics on things like mortality, which showed significant discrepancies between the units. I mean, you just can't hide from that.

Often, just a conversation helped and was sometimes an opportunity to 'let off steam':

It was just being completely open with them and saying, 'I need you to tell me honestly what you're thinking'. That helped an awful lot with relationships.

And sometimes senior support was needed to overcome challenges too:

I knew I had senior backing: the medical director, chief executive, the business unit and executive director level. From a personal protection sort of sanity perspective, I categorically used them at times as a sounding board and benefited hugely from them saying: 'You're doing the right thing, just keep your head down and keep on going'. Occasionally I had to wheel them out for physical and moral support for the really crunchy meetings where it was a case of: 'We are going to do this because we've debated it long enough now and it's the right thing to do'. Having people like that in the room just consolidates that discussion and the decision.

Through a combination of approaches, the group managed to convince more and more clinicians. The more people they brought along with them, the more enthusiastic they became. But not everyone was won over. There were also 'huge fallouts' and ultimately some people left the organisation, unable to accept the scale of change proposed; change leaders had to accept that this, too, is part of the transformational change process.

Another key factor was the good working relationships that existed between managers and clinicians. Managers stress the importance of this more joined-up approach and how helpful it was for them to understand the clinical agenda: 'As an organisation, we've always paired our managers with clinicians really well'.

They understood that ensuring quality needed an assets-based approach by managers: recognising that clinicians had rich insights that were invaluable for supplementing their own managerial skills. But this, too, required managers knowing when to listen rather than just dismissing concerns out of hand:



There were two or three people from our clinical strategy group that I would pick up the phone and ask: 'Is this something that we need to be worried about?' Sometimes it was background noise. Sometimes one of them would say: 'Do you know what? That actually is an issue that we need to look at.'

Sometimes, the person that you might perceive to be the least engaged, or the most negative about a change, is the person that really brings the wicked problems to the fore, because everybody else is so enthusiastic about everything that you miss it. The temptation is just to shut them off, and just say: 'Oh god, it's such and such having a whinge in the background'. But, quite often, there is something in there if you think: 'Do you know what? I need to just take 10 minutes to listen to what you're saying, so I properly understand it. Then, we can get to the nub of, is it a personal thing, or actually have you genuinely got something there?'

Moreover, the team at Northumbria found that the reverse can also be true. They found that empowering staff was an absolute necessity, and one which requires time, quality approaches and an understanding of human behaviour. Without this, they found, individuals are unlikely to become engaged, representing an invisible force that can block transformational change:

What happens is that people come late, they leave halfway through, they miss one meeting. All of a sudden, without really noticing, you've got a process where it seems to be going along quite fine, but actually you're not getting true engagement. You can imagine two scenarios in two different trusts, different ends of the country: exactly the same processes, you would end up one of them regarded as an overwhelming success and one of them regarded as a complete failure. You would look at the two processes and think: 'Why? We had a bit of engagement' and really, the difference will be the quality of that input.

Interviewees reflected on this critical point; invisible forces are often overlooked.

Building the hospital from 'a stick of rock'

So with permissions from numerous stakeholders, the building works began. Change leaders and participants described the excitement associated with building a new hospital:



It's not often, to be fair, in one's life that one gets such an opportunity.

Building something like the Cramlington Hospital is a discreet, tangible thing... a physical new building is a great mobiliser for change.

The process of creating the hospital was helped by a range of factors. There were many consultants already working between sites, and a strong and experienced managerial team. Some teams (eg, acute medicine) had already separated on-call activity from specialty activity so the step to the new site did not seem so dramatic. Clinical and management staff had already 'cut their teeth' on rationalisation programmes and new building projects. So there was a wealth of local experience and expert skills:

I've worked for the health service for 14 years and every year we have a big project to do, which is over and above your day job. The difference with this one was it affected everybody – the whole trust. Everybody needed to know about it and to be on board with it. We'd never done anything like it before, nor had anybody else, and we were starting from a blank canvas. We populated the canvas over time, which guided us to the way that we ended up doing things.

The existing culture in the trust was found to be incredibly helpful as well. Interviewees proudly described the co-operative, 'can-do' attitude that prevailed:

A lot of that comes from the vision of the leaders and people who have been prepared to say yes and try something out, learn from mistakes, and not point the finger or blaming when something didn't go quite as well as anticipated.

It is like a stick of rock – through any part of the organisation and in cross-sectional terms you invariably see clinician paired up with manager. That is a vital harmony and facilitates the sort of change dialogue and operational dialogue that needs to go on in an agile and reactive organisation, and one that innovates.

There's lots of assurance processes, making sure things were on track. But the philosophy here is: develop a reasonable framework, give people a reasonable ask, then trust them and hold them to account. It's just the fundamental belief really.



But there were challenges too:

It wasn't so much that we were building a new building, we were unpicking clinical pathways. We were separating out the emergency strands of work to go into the new hospital, while maintaining the elective work on our general hospital site. We had to make sure – because we were moving a piece of work, staff, or particular equipment – that it was available still where it was needed somewhere else.

Some techniques used were well-established, but others were invented as they went along. Risk was a big part of the challenge due to its public nature:

I suppose my feelings were, it's a really positive thing to do, it's exciting, but real trepidation, this is a massive project. As we were kicking it off, I think Terminal 5 had just come on stream at Heathrow and got a massive bad publicity. The thing that really stuck in my mind was: 'If we mess this up, front page of The Sun'. That's what we were sort of playing for, really, so you had to get it right.

The sense that other parts of the NHS were watching to see if it was a success before proceeding also felt frightening. The organisation's strong culture and ethos enabled them to continue on:

We come from a culture here where to try and to fail is not necessarily a bad thing. I accept trying and failing on a grand scale is not a good thing, but learning from mistakes is not something that would be frowned upon.

In this way, they continued to work together to keep venturing forwards, while working with architects on the new building, running three hospitals and striving to seamlessly continue providing the best possible care. After 10 years – a decade of hard work – the new hospital opened in Cramlington on 15 June 2015.

It is a tribute to the monumental efforts of its staff to work together, forge new relationships, find ways to overcome barriers, and carry on despite all the challenges they faced. So what were the insights from its first three years?



Year 1: a soaring high, very positive results

Delivering such a major project is an achievement in itself – the impressive Cramlington building attests to that through its very physical presence. In terms of quality care provision, the hospital had achieved the following results by the end of year 1.

- One of only a handful of trusts nationally to meet the four-hour standard for patients to be seen during the whole of 2015/16.
- 14 per cent reduction in emergency hospital admissions, with almost 7,500 fewer people being admitted, resulting in a £6 million saving for the local health economy.
- Senior clinical decision-making from emergency medicine consultants on site 24/7 and almost 80,000 radiology examinations performed, resulting in much quicker diagnosis and treatment for seriously ill or injured patients.
- Improvements in clinical outcomes – for example, in cardiology, where very early indications show that the number of people now surviving heart attacks has dramatically increased since the centralisation of specialist expertise.
- Consultants in a range of specialties, including consultant cardiologists, now work 7 days a week and do twice daily ward rounds on weekends (as on weekdays).
- 9 out of 10 patients using the emergency department rated care as good, very good or excellent, and 97 per cent of inpatients would recommend their care to friends and family.

The team were celebrated for achieving successful transformational change. Maybe inevitably this proved somewhat difficult to maintain, as their experience during year 2 testifies.

Year 2: the rollercoaster ride takes another bend

Interviewees recalled a range of problems that bubbled up over the months that followed, which raised questions in people's minds.



- **Within 10 weeks, they reached 10-year anticipated activity levels**

We'd future-proofed it for what we thought was going to be 10 years, but in actual fact, we effectively delivered those numbers within 10 weeks, and we've sustained those levels. We've been filled to the gunnels almost since day one.

Like the rest of the country, the hospital experienced increased activity. However, the scale and speed of the increase puzzled many. The new model of care was encouraging patients to attend A&E, rather than seeing their GP or attending urgent care. Interviewees have been asking: what contributed to this unexpected demand?

One interviewee wondered if it was their enthusiastic efforts to promote the new service:

Almost every bus in the region had posters on. It just draws your eye to the fact that there's something new going on. I think there was an over concern that people with serious life-threatening illnesses would turn up at what was the old site. I think the message probably was an overkill and has backfired a little bit.

Some suggested another contributory factor was the availability of more tests. A GP explained that the ease of getting tests quickly may have been an incentive for patients to go to A&E but also says that these tests may not be needed at that time. A bystander highlighted another issue related to the tests:

A bit of clinical risk aversion has crept in. One observation is that if you've got diagnostics, you also get people doing diagnostics because they're there, even if they don't necessarily need to be done in the A&E.

Interviewees suggested that doctors may have been ordering more investigations because it was possible to do so in the new system, maybe easier than previously. Was it a sign of improved or unnecessary practice? Was it a sign of fear of medical risk?

- **Estimates of staffing requirements**

Another well-publicised issue was the staffing pressures that occurred. One interviewee described why they think this may have happened:



Staffing based on averages, I was gobsmacked with. If you put everything in thinking there's seven days a week, so we need a seventh of the workforce every day, you're going to run into problems. A lot of the rotas were done on averages. But there's variation: for example, most primary care and secondary care within a margin of tolerance know Mondays are going to be busier. You can see that from the papers now. You've got to flex the workforce to match the demand.

Interviewees questioned what it was that contributed: a lack of time or skills, an oversight, or maybe a lack of centralised support?

- **Reduced post-opening governance**

Some staff compared post-opening to the pre-opening decision-making processes that existed:

Pre-opening: anything to do with the new hospital came to us for decision. We had a clinical strategy group. It wasn't one person's decision. Post-opening: there wasn't that, so... 'Who do you go to for this?' 'Who has the final say?' I think that's where it got lost... Everybody owned it, but it needed that central person. It needed one person to say: 'You're now running it, this is yours, you need to make sure it runs and it's your decisions of how, this is what we expect.'

Questions also surfaced about whose responsibility it was to quality check. One interviewee noted a leadership transition that may not have helped:

I think that the trust has been through a difficult time over the last two years. NSECH opened; there was then a significant change of leadership. I think the two coinciding has not helped, given that almost opening is the start of the journey. You've got one journey to open it, you've got the second journey of making it a really functional unit. Opening is great, but the hard work almost starts then, and I think that the changes at that point possibly have made it harder.

Others questioned whether the commissioners, as part of handing over monies, should have checked the plans for operating the new hospital by sustaining a process of helpful dialogue. Some suggest it is the unchartered nature of new projects of this type that makes it difficult to allocate overall responsibility; others say it is a system failure to connect or share lessons from those who opened hospitals before.



- **A little staff frustration**

Many people like the building and say it is a big improvement. However, there has also been some negativity from staff and the public about the design of the building:

The design's probably not as good as it could have been. Traditionally in A&E you've got this sense of cohesiveness because you're centred and you see people. The layout doesn't help from that point of view. The junior doctors are saying this place is a nightmare of a rabbit warren. Some of the circular bits mean that people pass as ships in the night among teams. No canteen means that nobody's got a place to eat. There's a lot to be able to say at those coffee breaks. Those are the times that people bond. I think some of that team ethos is gone.

Some say the physical shortcomings from the staff perspective may be due to the focus on patients' perspectives during the design stage. Other staff interviewed were very clear that they had been involved, helping to shape plans with the architects, right from the start. Some suggest that the impact of the physical design could have been reduced by providing more organisational development support to bring the two teams together after opening – a fascinating conundrum that remains relatively unexplored.

A passion to keep striving forward

Despite all the years of hard work and achievement, it seems that this last bend in the team's journey has taken its toll. Interviewees explained why they had tried so hard: a sense of duty to the people they care for, a sense of wanting to do their very best, not willing to provide anything less. External forces served to complicate matters: pressure to meet targets, to demonstrate value, leading to a sense of pushing hard against the tide. After 10 years of juggling, trying hard to secure improvements, it can be extremely demoralising to face intractable problems or to think it has not worked as anticipated. But they have not been halted in their tracks; fuelled by the resilience they built up in the early days, a robust organisational culture, and 'a stick of rock', they are determined to see through all problems they encounter, and have maintained their passion to continue striving for transformational change.



One interviewee [a bystander] left us with this reflection:

The NHS is exceptionally risk averse at the moment. People aren't allowed to fail. There's been focus on NSECH for lots of good reasons and there's some really good work going on. But, the ability to say, 'You know what, this isn't working' - I think there hasn't been that bravery, and I think part of that is because actually nobody wants to know. They just want success stories. There's almost this narrative around 'things have got to be a success, and we're not going to talk about the warts and all of things not working'.

The Northumbria story highlights the need for each of us to really question what we mean by successful transformational change in health and care. Instead of searching for a fixed endpoint of success or failure, it signals that both are important parts of a transformative journey. It highlights the role of setbacks in achieving success. But it also shows the nature of work in the health and care sector in dealing with individuals' lives, and so it begs a question about our willingness to fail in such an important area. If we are willing, what level of failure can be tolerated? If not, how possible is 'success'?



5 The Buurtzorg story

The story of Buurtzorg (Dutch for ‘neighbourhood care’) is a well-loved one. It is about a pioneering health care organisation established 12 years ago with a ‘nurse-led model of holistic care that has revolutionised community care in the Netherlands’ (see [Buurtzorg undated a](#)). Its outcomes include reductions in the overall cost of care, fewer hospital admissions, and high levels of satisfaction for patients, families and staff ([Gray et al 2015](#)).

The model is now being implemented in many countries, by 950 teams, employing more than 10,000 nurses and nursing assistants, and providing care for more than 65,000 people worldwide. In England, Buurtzorg is developing the model with NHS and social care commissioners at pilot sites in London, Kent and Suffolk.

Buurtzorg’s biggest supporters, however, are its clients, who praise its transformational nature. They want its story to be shared so that others can be supported to receive an equally high standard of care, as this service user told us:

I had an accident and was paralysed, wheelchair condemned. I needed a lot of care. I chose Buurtzorg because they put the client in a central place in their way of taking care of people. It was really important for me that I could start my work again, that I could enjoy my work again. Buurtzorg was a wonderful experience. That sounds a bit ridiculous but it’s really true. I met beautiful people with love for their profession. It was tailor-made for me. Magnificent.

In describing how the Buurtzorg story unfolded, and how it is different from our UK examples, we have pieced together interviews from eight people who were nominated as having played a key role in the work or who have experienced its impact. This is the story of Buurtzorg as viewed through their lens.

Happy memories and declining trends

The story begins in the Netherlands some 30 years ago, at a time when many district nurses felt that care was good quality and based around what mattered most to patients. They worked in villages and cities in small, autonomous teams. They felt able to spend time understanding patients’ needs and worked together to make a positive difference to people’s lives – the reason they had entered the nursing profession in the first place.



Over time, however, national health care policies changed, with a growing perception among those working in health care that managers had gained more power. The changes seemed to bring more bureaucracy and less autonomy for those delivering care. District nurses were not able to spend the time needed to understand what would work best for patients in their care. Managers started to demand more focus on nurses demonstrating performance against targets, but those targets were not always seen to be based on patients' needs or staff insights. Quite often, the targets created more work, taking away from the act of caregiving and potentially reducing quality. One interviewee noted:

Because of the policies of the national government and health insurance, we saw the way in which organisations dealt with health care change rapidly in 15 years. It got much more production-driven, task-oriented, care became fragmented and quality went down, costs went up.

The more this system became management-driven, the more administrative tasks were created, the more community health nursing time became eroded and the volume of paperwork went up, and the more dissatisfied staff became. One said:

From the perspective of the patients, from the perspective of the nurses, but also from an economical perspective, we were doing the wrong things.

Many nurses were not happy with the changes. Some complained, but felt their views fell on deaf ears. Others felt unhappy but did not know how to do anything about it – they felt powerless in the face of the 'system'. One interviewee recalled their frustration:

There were a lot of unhappy nurses in the teams and they were complaining to me, and I was complaining to my manager and my manager was complaining to his [but nothing was changing]. This was in a lot of organisations in the Netherlands.

One nurse in particular felt unable to see this unfolding without doing something positive. In the mid-2000s, this nurse was working as the managing director of a homecare company. With more than 20 years' experience in district nursing prior to that, he had seen the decline and was worried about the impact on patients and staff if the situation continued.



This nurse could remember better times in the country but had also seen the power of successful improvement initiatives when he worked in the Ukraine developing primary health care. Reflecting on his wealth of experience, it gave him an idea. Instead of watching as the situation got worse, was it possible to go back to basic community nursing principles and build a system that worked better for patients and staff alike? He recounted:

There were many reasons for me to say: 'Let's try to design another concept which is much more inspirational for the nurses and gives high quality and saves costs by bringing better solutions'. I know what the needs for patients are as a nurse; as a director I had been involved in different projects so I knew how the system works, and I think I'm idealistic. I call it an 'idealistic idea': how we can improve things and have the desire to improve it. If you see things not working, you try to do it better.

But why this idea for a self-regulating community nursing model? Where did it come from? He explained that it came from his combined experiences:

When I started to work as a community health nurse in the 80s, we were quite self-regulating. My idea was, the structures and management systems are damaging the professional work of nurses and doctors. I had this very strong opinion about self-supporting professionals. My idea was that nurses can organise the work themselves very well. We don't need support from management roles. I was convinced because of my own experience as I worked for eight, nine years myself in a similar way.

Still, why only nurses and not doctors and other clinical professionals too? He explained:

If you look at the dynamic and the daily routine of nursing and home care in neighbourhoods, you see that a 24-hour service can be delivered by nurses. It is not very effective to have all the other disciplines in the immediate team. Instead, you create virtual teams around the patient, depending on their needs – for example, the physician, the physiotherapist, the pharmacist. They're all in the network of these nurses, but they are not part of the physical team, they're more virtual teams.

Still only a concept in his mind, quite some way from turning it into reality, and with questions about whether it could work and how to make it happen, he chose to act.



Choices, friends and a further refined idea

To pursue his idea, the nurse took a bold decision. He resigned from his job as managing director, despite the element of financial risk, and instead took up work as an independent consultant so that he could begin to drive the changes he wanted to see. This gave him more flexibility and enabled him to network with other organisations who were interested in the concept. It also bought him some time to refine his idea. He talked it over with a few friends, including a former nursing colleague and an IT expert who had experience of building data systems. They all proved to be invaluable allies in those early days and later on too. It was important that the friends represented a rich diversity of experience and perspectives, as this enabled a broad base and solid foundation on which to strengthen and develop his idea. One friend, with IT expertise, described the early stages:

It started at my kitchen table together. We had ideas of the model and I was thinking about the organisational aspects and the IT system. I didn't have much to do with the actual health care, so not caregiving – that's not my background. I've got a background in public administration and IT. Together with [the change leader], who was especially focusing on good nursing and good health care, we are this team.

This small group of friends developed the nurse's initial thinking into a more detailed plan. They wanted to create a small but scalable model, building on the concept of self-managed teams of community nurses working together to provide high-quality care to groups of people at neighbourhood level. The friends could see how the concept made better sense for staff and patients, and could work well. They believed in the benefit of ensuring that district nurses could spend most of their time doing what they were needed to do (and were good at doing), and knew it was important to reduce their administrative work. The idea of channelling administrative work to a small group of support staff made a great deal of sense. In fact, it later became a fundamental principle about how the small group wanted to approach their work: humanity over bureaucracy. Their own life experiences led each person to relate to the idea in a different way. One friend, a musician, said:

Somehow the idea [the change leader] had about smaller teams and self-organised teams really made me think of my own experiences. I was playing in a band for 25 years and we played a lot at weddings. When he explained how a team should work,



it reminded me of working in a band without management and having different roles within this team. So what he explained to me as a Buurtzorg team, I thought: 'Why isn't it just like playing in a band? Have fun, do your work, do your job, make customers happy, solve problems. Why should it be so complex and bureaucratic?'

But despite wanting to believe this kind of change was possible, they still had some doubts as to whether years of declining quality could really be reversed:

To me [the concept] made sense because as I was a community nurse like [the change leader] was in the 80s, I had seen how good it could be and also the changes during the years. So, when he told about his ideas, I said, 'Well, that would be great but it almost seems too good to be true'. I was a little bit sceptical... firstly because, 'would it be possible?' I think that was a little bit my attitude, my reaction on it.

But despite these doubts, the friends recalled being prepared to support turning the idea into a reality because they believed in the change leader and trusted his judgement. They also knew that he believed in them. One friend recounted the factors that contributed to them wanting and feeling able to support the change leader to turn his idea into reality:

[The change leader] is a clever man. He has a real intrinsic drive to improve the lives of people. We all do have, but he was able to combine his ideas and frustration, and use that to come up with this new idea. It might also be his background – he studied economics as well. And being a visionary. He was able to have in his network the right people beside him to come up with this new idea and build this model.

So, a group of friends, committed to putting an idea into practice... but how could they make it happen?

Small-scale, flexible beginnings

In 2006, the change leader and a small group of district nurses set up their own social enterprise in the town of Almelo and called it Buurtzorg ('neighbourhood care'). The model was designed around the simple premise of a small team of self-managing nurses looking after people in their own homes. They decided to create a 'small but scalable' unit. When providing care, nurses would build good



relationships with their 'clients' and the network of carers around them. They would act as 'health coaches' – that is, emphasising how clients self-manage and strengthen their quality of life to prevent or minimise further illness. The nurses also worked closely with other professionals to ensure that care was co-ordinated around the client.

Initially, some of the friends (with others from their professional networks) worked at Buurtzorg on a voluntary basis, holding down other jobs and helping in evenings and weekends. Over time, as they began to see early successes of taking a different approach, they became more vested in its development and confident about its potential. For some it took up to a year, but they attribute much of their long-term dedication to this early phase, when they learnt to take small risks in a protected environment, with plenty of support:

To start with, I was a little bit sceptic. I was attracted to organise the financial administration for starting a company and it was ok because my other job was still a full-time job and I was keeping on doing that. My manager said: 'It's ok that you work for Buurtzorg in the evening hours', so that was no problem. That organisation had a total revenue of €80 million and I was responsible for financial reporting on that revenue, and at that time Buurtzorg had a total revenue of €500,000 or something [so it would have felt too risky to leave my job to join Buurtzorg then]. From December 2007 till 2009, I read a lot of good stories about Buurtzorg and the concept of self-steering. During that period I got more and more convinced that it was a very good concept, and when I was asked in June 2009 to work full-time for Buurtzorg, I was already totally convinced about the good model of Buurtzorg.

Clinical leadership: forging new ways in an old system

A key element of the model is that nurses were trusted to 'self-govern' and to use their expertise to work with clients. The small teams were deliberately designed so that nurses could support each other and not rely on a manager, co-ordinator or others. However, even for experienced district nurses, this cultural change – of breaking away from hierarchy and bureaucracy – took some time, requiring reassurance and support from colleagues to be confident to break out of an entrenched way of working. One nurse described the daunting yet exciting challenge of being trusted to find her role as a self-managing nurse:



It was excitement and a journey that it felt like we were doing all together, and seeing how it would go. In the first year I thought: 'Is this really going to be sustainable? Can this work?' At some points, I don't remember when, but I had to see and admit that it actually worked, which sometimes still surprises me.

The change leader played an important role in supporting the people around him to find their own solutions, introducing the concept of coaching to reduce the need for external management. He spotted talent among other nurses and nurtured this. He also worked to ensure clear and consistent messaging across the organisation in an approachable manner. A service user noted the importance of this approach:

The [change leader] is very, very, very consistent in his way of thinking and his way of talking to the organisation. He never makes the fault of being top-down and telling people what to do. He always gives them their own responsibility: 'What would you do if you are responsible? Make your own decision. Be involved in the things you are doing'. It's the quality of [the change leader] that he is so consistent.

They decided to show that a new way was possible, rather than simply fight the old system:

The old system was really about control and very unproductive. The incentive was so different. [When we started] Buurtzorg, we said: 'We have this institute, we have to deal with it because that's how it is for now in the Netherlands. We don't want to fight this system. We want to show good examples of how we can change this system. We want to show the institute, the government, that it can be done in a different way'.

The coach's story

To support the more positive approach to working that Buurtzorg took, the change leader and his team placed a strong focus on accessing coaching support to enable staff to feel in control of their work and be 'the best that they could be'. They created a team of clinically experienced coaches to mentor teams. The nurse who built up this part of the Buurtzorg model described her own story and her evolution while in post:



When I came to work as a coach I didn't completely understand what that role would look like. It was a sort of trusting and thinking: 'Why not give it a try?' I grew bit by bit in the role. I was a manager before so I had to adapt to this whole new way of working, I was used to thinking I know best so I have to decide. So it was really adopting and learning step-by-step through the first years. By listening to the people, listening to the teams that I was coaching, seeing the results, listening to the clients, understanding the organisation, it worked. I began feeling confident and getting the trust. It just took time to realise that there could be another reality.

And what helped her to find the right approach? A number of things:

The [change leader] was important, especially in the first period, in the first years because I had to understand the idea. You can't just get a paper and read it and then understand it. It's a sort of process that you have to go through and learn before it really gets into your... Well, almost into your DNA.

Also important was working together with the teams, because they understood how it should work. They would quite often say 'Hey, you go too far as a coach' and 'Now this is up to us'.

I talked a lot with other people outside of Buurtzorg; my family, my friends, my former colleagues, also a board member and his colleague... Those people were very important for me to reflect with and listen to their ideas. I shared the 21 years in the other organisation with them and my step towards working for Buurtzorg, also my questions saying this could really happen.

There was a book which was well-known in Holland because of its model of organising and structuring an organisation. I looked at that and related to it too.

We have this methodology within Buurtzorg – the solution-driven method of interaction. This external organisation guided and trained the whole organisation on this methodology. So they also were important for practical training.

She found two other nurses who were also coaches and they supported each other as a network of peers.



The main coach described the approach thus:

I focus on asking, 'How can I support you as a team? What do you need as support?' This can be different in every team. 'What can I do for you?' My goal is to guide them in this process. It's not up to me to make a decision. Sometimes it's quite simple things and sometimes it's really complicated. But it's always about supporting and guiding them and advising them. For that, you have to be able to listen to teams, develop these skills. Those skills are really important. The [can tell] if you have those competencies or if you're not really interested in them or if you want to steer [them]... they immediately react [to you]... or you hear it after you leave. But they immediately react on it. They help you as a coach in staying a coach and not stepping into this pitfall of becoming a manager.

A nurse working in a Buurtzorg team noted the value of coaching:

It's not always sunshine. Sometimes there are issues when working together with colleagues and then a coach can be helpful to have a helicopter view. As a team, you're really involved and sometimes stuck, you can't see clear anymore. You can ask the coach to be, like, kind of a mediator to help in the process. The coach will never say: 'You have to do this' but they will help you with the process, find your solution.

The coach says part of her journey has been learning. She shares insights about two challenges she encountered as part of the coaching role. The biggest challenge was not to jump in too quickly to make decisions or provide solutions (which she says will mean you lose them) but instead to guide and support the teams to come up with their own solutions. The second challenge is what to do when teams struggle, experience conflict or split up – something which, although rare, does happen. In this case, she involves the change leader, who is the only one with a formal management position within the model.

Finally, she highlights, it is critical that there is a strong relationship between those working to support clinical teams and for them together to create enabling conditions:

I always say my clients are the teams, as a coach. We are all there to support them. We: the coach, the back office and [the change leader] support them. There's a constant, quite organic collaboration between me, the back office and [the change leader]. And there's a formal collaboration structure for this too.



Enabling conditions for quality

The central 'back office' consists of 45 support staff or administrators, supporting the whole of Buurtzorg's provision. One interviewee said:

What is not needed to be done or can be taken away from teams will be done in the back office. The back office is not controlling. There are really smart IT systems. The back office will pick out if they see something really strange all of a sudden appears. Then the back office will contact the team where it happens. Often also the coach... And they say: 'This is what we see, are you aware as a team and as a coach? Can we help you? How can we support? Is it just incidental or has this become a structural issue? Do you need any help for that?'... Once every two months, all the coaches together, meet with the programme leader and the director of the back office.

Those who came from health care teams describe how novel it was to work in Buurtzorg, with its flat hierarchy, emphasis on 'keeping things simple', and the back office function being simply to facilitate district nurses' work and keep administrative requests to a minimum. This more symbiotic and enabling relationship was highly praised and valued by staff:

I felt quite, like, liberated. In my other work I was busy with generating a lot of management information but I really doubted whether it was useful. In Buurtzorg, I did things which helped the organisation and the pleasure in working increases.

Creating a clinically useful IT platform

Another important part of the Buurtzorg model was its use of IT to support quality clinical practice. The initial plan had been to procure an off-the-shelf IT system but the team found that was not possible, so they had to create one themselves. The IT expert who had been involved from the start helped to build a bespoke system that better suited the work of Buurtzorg nurses. He described why he got involved, revealing insights into the product he created:

I had done a lot of IT projects in health care. None of these projects had to do with nurses and caregivers. It was always about management and controlling and human resource management and financial management and all these kinds of



things. I have been doing that for 10–15 years. And that bothered me a lot. So I had fun doing this project around Buurtzorg because it was really about the nurses and nursing and the way they were working.

Like the Buurtzorg model itself, they decided to start the IT component in a small but scalable form. The IT expert described how they worked with the clinical teams to design the facility, constantly checking on their own decisions and asking themselves whether they were making those decisions in service of the staff or in an attempt to control and manage the organisation. He says starting small minimised the risks. He stressed that the mantra of their IT approach was to keep things simple:

In our design we were really focusing on keeping things simple [for the frontline staff]. When a new rule came up or a new demand from insurance companies, we kept asking: ‘Why do we need it, is it really helping the nurses?’ When it is not helping the nurses: ‘How can we change it so that it will help them?’ We were always smart on that. Sometimes we convinced them that it wasn’t really helpful to ask and we came up with better options, which were fitting more to the nurses. A lot of the requests come from asking things that are not really helpful for the nurses but only help management or other stakeholders. When you grow, one of the biggest risks is to translate all these questions from the stakeholders into more complicated IT. So we did a good job in keeping things simple and avoiding complexity.

The IT expert found that his ‘clients’ – the nurses – were very interested in what he was developing, which to him indicated a measure of success:

I was amazed about the attraction from nurses and the way they were very eager to use new IT systems. I knew from earlier implementations of IT systems that it could be a hard job to convince nurses to use a new system, but it all happened in a very smooth way. They learnt together and said: ‘It’s a nice system, you don’t need to help us anymore, we know how to use it and we tell other nurses too.’

Once tested at that small scale, he explained, they could then expand by adding on similar units, which he likened to an organism growing:

It was like a cell-dividing system. When the team grew bigger, we just split it into a new cell and another team started as a new cell – a cell-splitting organisation.



Political interest and support

As news of Buurtzorg's successes began to spread, it sparked the interest of the Dutch health minister. She knew of the change leader's reputation; he was reliable and much liked too. More importantly, the Buurtzorg idea spoke to a number of her priorities and issues that she was grappling with. The minister asked her deputy to find out more, and after meeting a delegation from Buurtzorg, the deputy was impressed. After seeking input from others in the field, the approach made a lot of sense to the Minister of Health and her colleagues:

At first we couldn't believe it. It was almost like a new washing detergent! But we started to talk with people who worked at [Buurtzorg] and other places. And we talked to patients who had health care from other health care providers before Buurtzorg. There were investigations; research was done to see the difference between what Buurtzorg was doing, what other health care providers were doing. And we saw it was more what patients needed. It was more how the nurses wanted to work. It was cheaper. The claims were true.

A change sponsor who was working in the Ministry of Health at the time reflected on what appeals so much about Buurtzorg:

We had the same vision. We talked about how to realise that vision. The Buurtzorg way of working: no hierarchy in the organisation. The nurses work in small teams in which they have lots of room to organise themselves. Not only room but also the responsibility. The bureaucracy is taken away from them. There is really good technology in place which helps them organise their work. And they deliver really high-quality health care because they really listen to the patients.

With that, Buurtzorg gained key political support, which helped in its growth over subsequent years. The Ministry of Health was receptive to the idea and early measures of success in terms of patient and staff satisfaction only bolstered this support. One of the Buurtzorg team noted the importance of conversations in generating and sustaining interest:

We just talked to everybody in the system. We invited the Minister of Health to see, we talked to the health insurers, every now and again we said: 'Come and see this' or 'We want your opinion about that.' 'If you think it is a good thing, please support us.'



We worked closely with all the stakeholders in the system and with the Minister. We got a lot of free publicity, newspapers, television programmes... a lot of attention... It was always told by the nurses, so the nurses became the communicators that were on the television, and the credibility of what we were doing was very high. Everybody believed that what we were doing was really good.

Through their efforts to ask for help in this way – positivity, reaching out, demonstrating benefits to staff and local people – they found they often got support and much more besides: opportunities, publicity, keys to unlock ‘doors’ that would have been much harder to open otherwise. Eventually, and backed by evidence of improvements, the Dutch health ministry would hold up Buurtzorg as the example of patient-centred community health care that other providers should aspire to. They designed a development programme for community health care providers and sought input from the change leader and others at Buurtzorg to showcase the ‘better’ way:

There were lots of health care providers who wanted to do better but did not know how. So we made a programme in which we collected a better way of delivering health care, which was already tested in reality, like Buurtzorg. Health care providers who wanted to adopt that way of working, we would help do that. We would do that by providing knowledge and people who could guide them in the process.

Quality, growth and client leadership

Having started as a team of four district nurses in 2006, Buurtzorg then grew rapidly. Interviewees recalled this well:

I think we had our first curve early. It was growing fast. I think after half a year, a year... But the third and fourth year there were hundreds of new nurses each month. It was really hard work but there was a lot of positive energy.

When a new team came we knew what to do. We had a good procedure. It was hard work, but not so complex or stressful, because the basic set-up was very good.



Despite this rapid growth and hard work, the founders never lost sight of quality provision. Clients (service users) continued to report the excellent quality of care provided by Buurtzorg:

It was very important that I could rely on the same faces every day. They are like family to me. When you have received care for one hour and a half every day, every morning you can't only speak about your physical condition or your illness, you also speak about your relationships, or about your friendships, your hobbies, the sports you used to do – all the things in life. It was a nice professional help, but also very personal involving in my life real assistance. That was wonderful and it still is.

As Buurtzorg's staff and client base grew, so did the involvement of clients in the planning and oversight of care at a whole-model level. They formed a client 'council' and members developed strong professional relationships with staff. A client described his role:

We advise in the headlines of care, dementia, or the hospital, for example. I talk to insurance companies and to the minister, the secretary of the country, in The Hague, and all kinds of important people. There's complete trust and complete transparency in all those things. I'm never told to be telling something. I can make my own decisions. I have organised afternoons where clients gather to talk about Buurtzorg. These are five, six times a year, and every time there are 70, 80 clients from Buurtzorg. We talk to each other, how we can improve things or how we experience things. I communicate with [the change leader] and his project managers.

Growth within and beyond the Netherlands

Twelve years since it began, and with 950 teams across the Netherlands, Buurtzorg still has fewer than 50 back-office support staff. Despite this growth, the small but scalable unit concept remains – with new teams still coming on board through a bottom-up approach:

When you want to start a new team, it's always the initiative of some nurses. It's never that Buurtzorg says we want to put the team in Amsterdam and here and here. But really from bottom-up, the initiative of the nurses, who would say:



'I think Buurtzorg might work in my village. Can we start a team?' and then we have a conversation with the coaches and with [the change leader]. Together we decide, 'ok, this might be a good initiative', and that is how teams start.

Buurtzorg teams have retained the original ethos of belief in each other, selecting the best people for the job and enabling them to flourish. However, scale has presented one challenge: matching demand to the funds available at different times. In the Netherlands, insurance companies pay for health care. Occasionally, this method puts Buurtzorg in a difficult financial position – for example, if they need to carry out a higher volume of work than has been contracted. Even then, they insist on providing quality care, as one interviewee explained:

There is a volume package deal for the year ahead, and that's very difficult for a growing organisation like Buurtzorg because during the year we normally reach this volume at the end of September, so we have three months more to go. In the end, it will be paid by insurance companies, but we have three months of overruns, which are not paid for. So there's a huge financial risk. The way of working of Buurtzorg is very efficient, so that's a starting point. The business model is well thought over and well worked out. We keep discussing this with the insurance companies. We try to convince them to pay in advance – sometimes it works, and sometimes it doesn't. But we refuse to not treat patients. So from time to time, we have losses, from time to time, there's profits. We use the profits as kind of a reserve for times worse.

Independent evaluations of the model demonstrate positive outcomes for clients and staff: fewer hospital admissions; shorter length of hospital stay; overheads are lower than the national average for health care providers; higher workforce productivity and reduced rates of sickness absence (Gray *et al* 2015). Buurtzorg has the highest client satisfaction rates compared to other providers in the Netherlands (Gray *et al* 2015); and it has won the 'Employer of the Year' national award several times (see Buurtzorg undated b).

The Buurtzorg model has also expanded into areas such as mental health, children and families, and the team has supported other Dutch international care organisations to adopt the model. It has generated interest in other countries as well, including the UK (Royal College of Nursing 2015). However, success has pulled the original 'kitchen table' group in directions they had not anticipated. The nurse



recruited in the early days as the coach now uses similar principles to co-ordinate the organisation's international activities. The change leader travels across the world promoting the Buurtzorg model and encouraging others to 'keep it simple' and do it themselves. So, reflecting on his Buurtzorg journey, what advice does the change leader have for others wishing to follow a similar path to transformational change?

We were very lucky that we had these friends with all the different skills. I think we are a group of innovators together. We're very disciplined in how we worked up until now. So be realistic, try to do something, but prepare yourselves very well.

To end our story, we will start where it all began – with the 'client' whose views we gave at the start of this section. He is the one, after all, who despite his ill health and being wheelchair-bound, travels hundreds of miles in his attempts to optimise care for others. After a long and thoughtful pause during his interview, he offered a message to all those working to transform health and care in the UK:

When you are open-minded, and you are willing to make a real change, you should look to the beginning of Buurtzorg. When you do that, you can change everything. You have to start small and without management and grow from your success. It was like... we call it a 'stain of ink'. It will grow across the whole country and benefit so many. But to do this, it is very important for quality that you choose the best people, not people who want the comfort of the easiness. You have to go for really motivated professional people. That's very important. Quality, not quantity, and growing fast but not faster than you can guarantee that quality.

And with this clear message, we end our quartet of transformational change stories.



6 Conclusions

These four powerful stories highlight two key points. First, across the health and care system, there are impressive groups of people who work tirelessly together and, as a result, achieve great things. These stories are a tribute to their determination, bravery, and resilience – their dedication to improving people’s lives. Their role in making health and care improvements should not be underestimated.

These stories also highlight key questions for health and care leaders. Do we understand and learn from the experiences of those who are trying to transform health and care? Do we understand the potential that remains untapped? Do we recognise that achieving transformational change involves hard choices about our level of ambition and the level of risk we are prepared to take? Are we ready to embrace this fully across the health and care system? The stories challenge us to look carefully into the machinery – for example, at existing structures and the power dynamics that may compromise efforts – suggesting that until we do, we may never move beyond incremental change to achieve fundamental transformation of health and care.

In this section, we reflect on what the stories tell us about dilemmas currently faced in the health and care system. They represent some thoughts to support those leading health and care transformation efforts but are not a comprehensive list. Their purpose is to spark conversation, bring together efforts and energies, and thus create a greater force for transformational change across health and care. What follows is merely a starting point.

Transforming our approach to transformational change

Widening our definition

In health and care, the concept of transformational change is complicated by the human interactions involved, where risks and benefits have potential to impact on people’s lives. Examples of health and care improvements are numerous, but according to the definition these are often incremental changes rather than transformational change *per se* (Alderwick *et al* 2016). This calls into question the definition and what it really means to transform health and care.



The nature of transformational change

The four stories show that transformation is multi-layered, messy, fluid and emergent (Plsek 2016; Timmins 2015). It is not merely about changing how a service operates across health and care organisations, but requires a fundamental rethink to find new and better solutions. It requires a shift in the power balance within relationships, in mindsets and in ways of working, at every level of a system. Our stories imply the need for a better understanding about this and acceptance that achieving transformational change requires a new approach.

An organic approach centred around a core purpose

Bromley by Bow started with a small act supported by a vision: to improve local people's lives. The model and plans grew organically over time, but the core focus remained the same throughout. Success was measured by depth of understanding of local needs, their approach to listening, their use of an assets-based approach, staff and community measures of success. It is not easy to approach change without using road maps, frameworks and project plans, or to be comfortable with chaos and uncertainty. Yet it was key to their success. Our stories suggest that transformational change requires being open to this way of working and thinking. This resonates with Don Berwick's advice to favour 'curiosity and invitation' rather than 'command and control' approaches (Naylor and Charles 2018). It also resonates with swarm theory, which builds on insights from nature about the role and impact of social behaviours (Miller 2007). There are many change models, studies of human behaviour and leadership resources that can support more collaborative and distributed leadership and ways of working (for example, The King's Fund 2018a, b).

The time, skills and learning focus needed for transformation

In the face of unprecedented financial and service pressures, transformational change is urgently needed (Murray *et al* 2018). But our stories show that it can take many years, sometimes decades, to achieve. Work being done in Dorset, Frimley, Greater Manchester, and other integrated care systems across the country (Ham 2017) reiterates the importance of the time needed to build local relationships and establish quality efforts towards local transformation. This tension between the time needed for transformation and the sense of urgency places great importance on two things: learning and leadership. It calls for a stronger focus on how we learn as a health and care system, understanding and



connecting efforts (locally, nationally, internationally and from other sectors as well), and building from this rather than starting afresh. Our stories also stress that approaches and lived experience should be the main focus rather than models or form. This requires time for local stakeholders to create an ongoing process of learning. Finally, the stories stress the need for time and support to build skills, relationships and confidence to achieve transformational change. They show that success depends on a form of leadership that can operate skilfully in this landscape and unlock the transformative power of people working together to improve health and care (West *et al* 2014), combining clinical and managerial experience and bringing disparate groups together.

Challenges to face

Overcoming inertia – creating a receptive context

Our stories show that staff working in health and care are very motivated by a vision of safe care, better ways to deliver quality, or simply ‘improving a day at work’. But they also show that many people do not feel able to act as the change leaders in our stories did, to do things differently. Staff described a sense of wanting to act but feeling unable to, thus contributing to inertia and preserving the status quo. Our advisory group quoted Martin Luther King Junior to sum this up: ‘We are confronted with the fierce urgency of now’ and yet so few large-scale transformations have happened in health and care to date. This warrants further study to understand and address the underlying barriers.

The concept of power

‘Power’ was important in transformational change and played out in different ways in each of the four stories. We described barriers within the system that could be disempowering (Lewis and Fernando 2017). There were also good examples of empowerment. In Northumbria, managers and clinicians shared power in designing emergency care; in Birmingham, power came in the form of the data, background research and ongoing evaluation to create a compelling case for continued funding; while in Buurtzorg, coaching approaches were powerful in helping nurses to break away from reliance on management and to develop their own solutions. The power of good experiences of care also meant that clients were prepared to go to great lengths to promote the model of care. In Bromley by Bow, there was a strong clash around power between the health care and



community sectors, as well as a push from the local community for change. This was exemplified by members of the local community who rallied around to support their friend when services failed to do so.

'Old power' and 'new power'

Power dynamics were important in the stories. For example, 'old power' (held by a few, closely guarded and inaccessible) versus 'new power' (enabling people at a grassroots level exercising agency) (Heimans and Timms 2014). Our stories include examples where old power collided with new power, but other cases show that old power can also enable new power. For example, in Millom (Cumbria), the local community clashed with the NHS when there was a threat of closing a hospital in the area. Health service leaders realised they needed to allow the community to co-design a new model of care based on the use of technology with a more successful result (NHS North West Leadership Academy 2016). There were also examples of shifts from old to new power in the stories, but these were limited; some power clashes were still impacting services and relationships many years on, showing how hard it is to shift deeply ingrained mindsets.

Maintaining dual focus

Our stories highlight another pressing question: how to work effectively within current constraints as well as championing fundamentally different structures to support transformation for the future. Our interviewees suggested that a dual focus is needed given the current system needs and constraints; and that it is possible to change the system by thinking: 'how to feed the beast and do things in a radically different way as well?' Buurtzorg staff described creating a new system in the context of the old, over time demonstrating its possibility and shifting the whole landscape. Longer term, however, there is a need for a wider health and care debate about how best to propagate these efforts within a learning and supportive system that can be open to and deliver transformational change.

Difficult choices

To work in these radically different ways requires some very difficult choices. There are tensions between radical innovation and needing to protect people from harm; between pace of change and the time it takes to fully engage the people



who need to be involved. There is also tension between providing frontline care in acute settings where an individual's life is affected 'now', compared to having a longer-term focus; an opportunity to prevent ill health may be of greater magnitude and affect many more lives, also happening 'now' but in less visible ways. Hence, there are questions about the scale of transformation: How far could and should it go? Is there an end point for transformation? Indeed, what does 'success' look like? Our stories imply that the answer lies with local communities, patients and frontline staff (Turle 2017; Doughty 2016; Seale 2016; Ham 2014). If that is the case, there may be a need to fundamentally reconsider who is leading and driving transformational change.

Opportunities and untapped potential

Change sparks

Across the four stories, transformations were prompted, or 'sparked', by change leaders seeing and acting on needs in the local landscape. In Northumbria, the delivery of care across three separate hospitals was challenging their desire to provide quality care. In Birmingham, separation of physical and mental health care meant that patients going to the emergency department were not always receiving timely support for mental health problems. In Bromley by Bow, it was felt there was a lack of social inclusion and holistic support for local people. And before Buurtzorg, increasing bureaucracy meant that community nursing was overly complicated and not always based on what mattered most to patients. In all of these cases, the human motivation of wanting to make a difference was a very powerful, and perhaps the strongest, driver of what subsequently happened. The role of change leaders' previous and diverse experiences, access to broad networks of experts, and having the skills to understand academic resources helped to nurture the sparks into ideas and create movement behind the change. The advisory group remarked that while change sparks are potentially abundant, 'the system doesn't feel very sparky' and could do more to help people to nurture the spark. We are left asking: How can the system build a more receptive context for transformation and nurture these change sparks?

The power of communities

Possibly the most impressive power evident in our stories came from the community and the power of people to deliver great change: communities driving health and care innovations, providing ideas that shaped completely new primary



care models, reshaping plans for hospital provision, sparking career choices that transformed a whole city, overseeing care provision through citizen councils, and travelling great distances to support others to receive quality care. Our advisory group provided examples of similar experiences and suggested a need to rethink the relationship with communities and service users (Doughty 2016; Seale 2016), including looking again at the role of health and care organisations (Foot *et al* 2014). It is possible that communities are the ones with real power to transform health and care.

However, during interviews we were struck that we did not hear their voices and perspectives more. Each site provided us with people in the other roles, but we had only a small number of patient representatives put forward for interview. We identified two possible reasons. First, the possibility that transformational programmes are being driven by managers and senior professionals rather than service users or those caring for them. Second, an issue with terminology. The concepts of ‘systems working’ and ‘transformational change’ may be less engaging for service users and communities (McCannon 2017). This challenges health and care leaders to rethink approaches and ensure that quality insights are driving transformation efforts.

The potential of technology

These stories suggest that much transformation potential lies in technology, but for it to be effective it needs to be used to make it easier for staff to provide quality care, using positive approaches, and by keeping it simple. Buurtzorg created IT solutions with frontline staff and service users and focused on creating systems that would enable clinical teams to do their job of caring for clients well. In Birmingham, RAID staff talked about using data to motivate and energise teams to maintain quality efforts. The literature on high-performing health care systems shows how often change begins by using data to expose a need or issues or what is no longer acceptable (see *The King’s Fund* 2015). This is supported by work such as the Getting It Right First Time programme, where data enabled improvement conversations (Getting It Right First Time *undated*). Northumbria and Bromley by Bow go further to describe types of information that are not as readily collected but are powerful tools for transformation: stories, experiences, recounts, enquiry, and dialogue.



The need for transformational leadership

Collaborative leadership and sponsorship

The need for collective leadership, shared values, and learning approaches has been described within the stories and is echoed in The King's Fund's work on systems leadership (Timmins 2015): being comfortable with chaos, holding the space in the middle, creating bridges, understanding that one size does not fit all. We called for 'no more heroes' in the past (The King's Fund 2011; West *et al* 2014), and change leaders in the stories also stressed the importance of a collaborative effort in making these stories possible. They show the need for individuals with skills to kick-start and drive through transformation in a way that is inspiring, approachable and supportive; also described by Timmins (2016) and West *et al* (2017). In our four stories, change leaders played a facilitating role and engaged others in delivering the transformation. The change leader and change participant roles were at times interchangeable, suggesting that it is important for them to work closely and support each other to implement change. In Buurtzorg and Northumbria, the change leader supported others by sometimes taking on a coaching role. Our stories also show the importance of 'sponsorship' by forward-thinking commissioners, politicians, managers and those willing to work around system constraints to enable the testing of these new ways of working; unsung heroes some would say.

Cultivating team approaches

In Buurtzorg, nursing teams self-regulated their work, making collective decisions, drawing on coaching support when needed. At Bromley by Bow, there was an induction programme designed to introduce new health care staff to a different working relationship with colleagues in the community centre. The stories show the importance of considering how teams can be supported to sustain the energy needed to work towards transformational change. Understanding the need to keep staff motivated, staff in Birmingham described the importance of a positive feedback loop and celebrating success together. This is about maintaining a focus on team members' motivation, which in turn is drawn from doing things that can improve the quality of care for service users and can be a source of personal joy and fulfilment (Collins 2015). Our work on collective leadership shows the importance of developing an organisational culture to support effective team working (West *et al* 2014).



Hearing the unspoken, seeing the invisible

Bromley by Bow also demonstrates the importance of keeping an open mind: being aware of our experiences and biases, our own perspective, and remaining open and curious, despite this. McGregor's work (1960) on 'Theory X' and 'Theory Y' of human motivation may explain some different and silently conflicting approaches, showing that underlying assumptions that staff dislike work (X) or take pride in their work (Y) can lead to very different styles (for example, authoritative compared to participative). All our stories also show the invisible nature of key forces. For example, the effects of physical spaces or physical presence on feeling valued and healthy, the impacts of job titles to empower or disempower self-care and self-management or the less visible needs in the community such as prevention of ill health. We have seen, through all the stories, the need to look for these proactively with an open mind and an enquiring approach. Our stories show that such forces can be both invisible and impassable, terminating change efforts or steering them towards later difficulties unless surfaced early and dealt with skilfully.

Creating supportive and enabling ways

Our stories demonstrate the power of staff and communities to drive transformation efforts. But the 'ask' to transform health and care requires thought about how best to enable staff and communities to do this. Buurtzorg created their model around enabling frontline staff: a core administrative office removing any unnecessary work and 'keeping it simple'; a coaching approach to unlock solutions from the front line; manageable units; and a mantra that frontline staff know best. Birmingham used a similar approach. Northumbria and Bromley by Bow show that community-led is often best.

This requires enabling conditions. In Buurtzorg, some individuals took nearly a year to be won over, but this investment resulted in a model that stood the test of time. Advisory group members describe similar potential in our workforce, but also 'exhaustion' with staff pulled in different directions, unsure where or how to start or support transformation. Our stories show the importance of giving people time and space to think through the purpose of transformation; to understand the current struggles and worries they face; to offer support instead of demanding change with no time to prepare or engage. Change can feel risky and people can be afraid of what they might lose. It is important to recognise the emotional burden of change



and prevent staff from becoming burnt out and demoralised ([Timmins 2016](#)) – offering ‘lifeboats’ in the form of support to help them deal with this.

More fundamentally our stories show that there is a need to reconsider the structures that impact on their work (the ‘machinery’) – funding, training, regulation, organisational cultures, and wider factors influencing the health and care system – and consider ways to make it easier for staff and communities to transform health and care ([Dougall 2017](#); [Ham and Murray 2015](#)).

A collective focus on transformational change

The insights presented in this report are likely to be key considerations for those wishing to create transformational change in health and care. They require our collective focus to address the areas highlighted; to bring about a new understanding and approaches, create effective ways to deal with the barriers, to unlock the tremendous potentials, optimise the machinery and foster the collaborative leadership that can bring about health and care transformation.



7 Reflections from Advisory Group members

I applaud the approach that Durka and colleagues have taken in telling the four stories. It feels radically different to other publications on transformation, yet it chimes with my experience as a change practitioner. In the world these stories paint, change doesn't start at the top of the system with senior leaders; it starts at the fringes with activists. Even in the Northumbria case study, where the story begins with a foresighted CEO, she cedes power to a network of distributed leaders. The change leaders build a spectrum of allies holding both formal and informal power; they don't rely solely on positional power. Transformation isn't a change programme in a defined timescale; it is a state of permanent revolution. Formal leaders could do well to learn from the activist leaders in these stories. It means changing how we think change happens; building power (the ability to achieve our goals) in different ways, creating an environment where people feel valued and safe to challenge the status quo, and maintaining energy for the long haul. I hope this publication sparks a transformation in how we go about large-scale change.

Helen Bevan, Chief Transformation Officer, NHS Horizons

Transformational change requires a shift in accepted practice, a willingness to adapt and, in many cases, a cultural change. None of this can be achieved without strong and generous leadership that prioritises high-quality, patient-centred care. If leaders are able to maintain a laser-like focus on mission while enabling their staff and listening to beneficiaries, they will undoubtedly succeed.

Vicky Browning, Chief Executive, Association of Chief Executives of Voluntary Organisations (ACEVO)

Meeting the challenges for our NHS now and in the future seems, at times, quite insurmountable. Increasing demand, complexity, resource constraints and lack of staff feature heavily. And yet, there are those who seem able to fight through the seeming chaos, define reality and build a shared vision. Most importantly, they then – with dogged determination, discipline and collaborative values



- navigate a path to success despite all the bear-traps. This excellent report brings the experiences of four groups who exhibited all those traits and more in order to transform and produce success. Powerful lessons for us all and highly recommended reading!

Dr Taj Hassan, President, Royal College of Emergency Medicine

This is a great read that should inspire others to work for real change for the better. These leaders have focused on improving lives and seeing whole pictures and making improvements that work on the ground. Currently, there is such pressure for action and for success as seen from the top of the tree, that anyone who wants to listen to people and work through communities is likely to be marginalised. Unless we get very strong muscle requiring mandatory partnership and evaluation from patients and voluntary sector partners, and mandatory investment to develop and support this role as active partners, transformational change that is simply imposed from above will fail. A systems inspection regime that requires this co-production might help, but we need carrots as well as sticks. Could we also create a network to join up, support and develop those who want to work with communities, and an award system in every footprint that recognises and rewards genuine co-production with local people and communities?

Nicola Kingston, Patient and Public Voice representative

I found the four case studies fascinating and plan to use them with my STP [sustainability and transformation plan] colleagues to support shared reflection on the change process that we are seeking to lead. Perhaps what struck me most was the disconnect between the long-term, organic and deep-rooted change described in each story and the top-down, often short-term process that seems to be baked into the NHS. Fundamentally, we all want the same thing - the best possible outcomes, great quality of care and all achieved with the best value for money. But it can be remarkably difficult to decide, with our staff and the public we serve, what 'success' really would look like - and whether it would be the same as those national targets or, in some cases, different.

Rt Hon Patricia Hewitt, Chair, Norfolk and Waveney Sustainability and Transformation Partnership

It is a delight to see a study that focused on the 'real life' messy nature of transformational change in health and care systems. We all have a tendency to focus on structure not function, and on governance not relationships and trust. We all also overestimate what can be achieved in a few months and



underestimate what can be achieved over a year. When I speak to leaders in health and care, they don't need support with leadership theory, they want to hear from people who have gone before them. They want to hear about the ups and downs of transformational change, what worked best, how barriers were overcome, what people wished they had done differently with the benefit of hindsight. This study will really help them.

Dr Vin Diwakar, Regional Medical Director, NHS England (London Region)

This is genuinely new. Much of the writing on transformation focuses on concepts or approaches. Many of the guides flag up that transformation is never going to be a tidy, linear process. The great value of this report is to illustrate, through powerful examples, just what transformation really feels like for those involved. So, the setbacks and side-steps are as much part of these stories as the successes. In avoiding easy answers and simplistic conclusions, the report is a salutary guide to those embarking on large-scale change; reassurance for those in the middle of it; and a refutation of the myth that calling something a transformation is the same as actually making it happen.

Debbie Sorkin, National Director of Systems Leadership, The Leadership Centre

It's been a pleasure reading the report and I have personally learnt a lot. I have recognised the importance of a change spark and shift of old power to new power. My own observations around some of the transformational change I have witnessed focus on leadership for 'population health care', including the need for leaders to offer greater focus on the need to steward precious care resources, much like seeing water as a precious commodity in a desert. I also wanted to emphasise the greater focus on creating a culture of 'team-based' care, which addresses the need to really focus on creating great teams versus 'pseudo-teams', which remain pervasive in the system.

Dr Nav Chana, Chairman, National Association of Primary Care

What a great handbook for current and future leaders on the reality and complexity of genuine transformation; that it takes time, that it's about people and their relationships with each other; that it takes patient and reflective leaders; that these leaders don't always sit within our organisations but sit within communities, knowing that if challenges exist within these communities then the solutions must also lie there. These are authentic stories for change presented as they were told; they are given enough space to breathe and come alive rather than being



reduced to a few quotes to validate the evidence of transformation tools. It's this collaboration between the evidence, the tools for transformation and the first-hand account of stories that makes this [publication] so refreshing.

Samira Ben Omar, Head of System Change, North West London Collaboration of Clinical Commissioning Groups

There is no 'one size fits all' approach to manage the complex challenges we currently face in health and social care. These case studies are tools in our armoury, and demonstrate the importance of adaptive leadership, ruthless determination and patient-centric design, if we are to have a fighting chance for sustainable health care. We need to learn from these cases, and allow them to be the 'spark, that will light the fire' for transformational change ['quote' from Star Wars: The Last Jedi, 2017].

Dr Junaid Bajwa, GP, Clinical Associate, NHS England New Models of Care programme



References

Ackerman L (1997). 'Development, transition or transformation: the question of change in organisations' in Van Eynde DF, Hoy JC, Van Eynde DC (eds), *Organization development classics: the practice and theory of change – the best of the OD practitioner*. San Francisco: Jossey-Bass.

Albury D, Beresford T, Dew S, Horton T, Illingworth J, Langford K (2018). *Against the odds: successfully scaling innovation in the NHS*. London: Innovation Unit and the Health Foundation. Available at: www.health.org.uk/publication/against-odds-successfully-scaling-innovation-nhs (accessed on 21 March 2018).

Alderwick H, Dunn P, McKenna H, Walsh N, Ham C (2016). *Sustainability and transformation plans in the NHS: how are they being developed in practice?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/stps-in-the-nhs (accessed on 20 March 2018).

Anandaciva S (2018). 'A&E performance reaches a new low'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2018/01/ae-performance-reaches-new-low (accessed on 12 January 2018).

Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmacovich K, Born K (2008). *High performing healthcare systems: delivering quality by design*. Toronto: Longwoods Publishing.

Becker L, Saunders RJ, Hardy R, Pilling S (2016). *The RAID model of liaison psychiatry: report on the evaluation of four pilot services in east London*. London: UCL Partners Academic Health Science Partnership.

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) (undated). 'Rapid, assessment, interface and discharge'. BSMHFT website. Available at: www.bsmhft.nhs.uk/our-services/urgent-care/rapid-assessment-interface-and-discharge/ (accessed on 21 March 2018).

Bromley by Bow Centre (undated). 'Our mission & model'. Bromley by Bow Centre website. Available at: www.bbhc.org.uk/our-mission-and-model (accessed on 22 March 2018).

Buck D (2018). 'Housing: a home for STPs looking to influence the wider determinants of health'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2018/03/housing-stps-wider-determinants-health (accessed on 19 April 2018).

Buurtzorg (undated a). 'Buurtzorg T'. Buurtzorg website. Available at: www.buurtzorg.com/innovation/buurtzorg-te/ (accessed on 26 March 2018).

Buurtzorg (undated b). 'Our organisation'. The Buurtzorg website. Available at: www.buurtzorg.com/about-us/our-organisation/ (accessed on 27 April 2018).



Care Quality Commission (2016). *Northumbria Healthcare NHS Foundation Trust: quality report*. London: Care Quality Commission. Available at: www.cqc.org.uk/provider/RTF (accessed on 7 March 2018).

Charles A, Ham C, Baird B, Alderwick H, Bennett L (2018). *Reimagining community services: making the most of our assets*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/community-services-assets (accessed on 7 March 2018).

Collins B (2015). *Staff engagement: six building blocks for harnessing the creativity and enthusiasm of NHS staff*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/staff-engagement (accessed on 2 March 2018).

Dahlgren G, Whitehead M (1991). *Policies and strategies to promote social equity in health*. Sweden: Institute for Futures Studies.

Dougall D (2017). 'Clinical leadership: moving from good will to good practice'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2017/10/clinical-leadership-moving-good-will-good-practice (accessed on 2 March 2018).

Doughty M (2016). 'Building collaborative partnerships with patients and communities'. Interview, The King's Fund, 24 February. Available at: www.kingsfund.org.uk/publications/leading-collaboratively-patients-communities-interview (accessed on 2 March 2018).

Duffy B (2018). 'Public expectations of the NHS'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2018/02/public-expectations-nhs (accessed on 12 February 2018).

Foot C, Gilbert H, Dunn P, Jabbar J, Seale B, Goodrich J, Buck D, Taylor J (2014). *People in control of their own health and care*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/people-control-their-own-health-and-care (accessed on 2 March 2018).

Getting It Right First Time (undated). GIRFT website. Available at: <http://gettingitrightfirsttime.co.uk/> (accessed on 27 March 2018).

Gilbert H, Peck E, Baird B, Edwards N, Naylor C (2014). *Service transformation: lessons from mental health*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/service-transformation (accessed on 2 March 2018).

Gray BH, Sarnak DO, Burgers JO (2015). *Home care by self-governing nursing teams: the Netherlands' Buurtzorg model*. New York: The Commonwealth Fund. Available at: www.commonwealthfund.org/publications/case-studies/2015/may/home-care-nursing-teams-netherlands (accessed on 7 March 2018).



Ham C (2018). 'Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/making-sense-integrated-care-systems (accessed on 7 March 2018).

Ham C (2017). 'Whole-system transformation requires whole-system engagement'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2017/10/whole-system-transformation-needs-whole-system-engagement (accessed on 27 March 2018).

Ham C (2014). *Reforming the NHS from within: beyond hierarchy, inspection and markets*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/reforming-nhs-within (accessed on 2 March 2018).

Ham C, Murray R (2015). 'Collective leadership will keep forward view ambitions on track'. HSJ, 18 February. Available at: www.hsj.co.uk/comment/collective-leadership-will-keep-forward-view-ambitions-on-track/5082228.article?blocktitle=Comment&contentID=12603#.VOSPxS7Ebxz (accessed on 21 March 2018).

Ham C, Berwick D, Dixon J (2016). *Improving quality in the English NHS*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/quality-improvement (accessed on 3 March 2018).

Ham C, Dixon A, Brooke B (2012). *Transforming the delivery of health and social care: the case for fundamental change*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/transforming-delivery-health-and-social-care (accessed on 7 March 2018).

Ham C, Alderwick H, Dunn P, McKenna H (2017). *Delivering sustainability and transformation plans: from ambitious proposals to credible plans*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans (accessed on 3 March 2018).

Heimans J, Timms H (2014). 'Understanding "new power"'. Harvard Business Review, December. Available at: <https://hbr.org/2014/12/understanding-new-power> (accessed on 7 March 2018).

Hulks S, Walsh N, Powell M, Ham C, Alderwick A (2017). *Leading across the health and care system: lessons from experience*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/leading-across-health-and-care-system (accessed on 7 March 2018).

Lewis M, Fernando J (2017). 'Transforming the NHS through second-order change'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/articles/transforming-nhs-through-second-order-change (accessed on 2 March 2018).



McCannon J (2017). *How can we accelerate the focus on spread and scale in population health?* Speech at The King's Fund Annual Conference, 29 November. The King's Fund website. Available at: www.kingsfund.org.uk/audio-video/joe-mccannon-accelerate-spread-scale-population-health (accessed on 27 March 2018).

McGregor D (1960). *The human side of enterprise*. New York: McGraw Hill.

Miller P (2007). 'The genius of swarms'. The National Geographic website. Available at: <http://ngm.nationalgeographic.com/2007/07/swarms/miller-text> (accessed on 4 April 2018).

Murray R, Jabbal J, Maguire D, Ward D (2018). *Quarterly monitoring report 24*. The King's Fund website. Available at: <http://qmr.kingsfund.org.uk/2017/24/overview> (accessed on 7 March 2018).

Naylor C, Charles A (eds) (2018). *Developing new models of care in PACS vanguards: a new national approach to large-scale change*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/developing-new-models-care-pacs-vanguards (accessed on 20 April 2018).

NHS England, Care Quality Commission, Health Education England, Monitor, NHS Trust Development Authority, Public Health England (2014). *NHS five year forward view* [online]. London: NHS England. Available at: www.england.nhs.uk/publication/nhs-five-year-forward-view/ (accessed on 7 March 2018).

NHS North West Leadership Academy (2016). *Learning from the Millom experience – an NHS NWLA systems leadership grant success story*. Cumbria Learning and Improvement Collaborative. Available at: www.thecllc.org.uk/news/249-learning-from-the-millom-experience (accessed on 7 March 2018).

O'Neill S, Wolters A, Steventon A (2017). *Briefing: the impact of redesigning urgent and emergency care in Northumberland*. London: The Health Foundation Improvement Analytics Unit. Available at: www.health.org.uk/publication/impact-redesigning-urgent-emergency-care-northumberland (accessed on 7 March 2018).

Parsonage M, Fossey M (2011). *Economic evaluation of a liaison psychiatry service*. London: Centre for Mental Health. Available at: www.centreformentalhealth.org.uk/evaluation-liaison-psychiatry (accessed on 7 March 2018).

Pettigrew A, Ferlie E, McKee L (1992). *Shaping strategic change: making change in large organizations. The case of the National Health Service*. London: Sage.

Plsek P (2016). 'Large-scale change'. Blog. Advancing Quality Alliance (AQuA) website. Available at: www.aquanw.nhs.uk/resources/large-scale-change-paul-plsek/21239 (accessed on 26 March 2018).



Royal College of Nursing (2015). *The Buurtzorg Nederland (home care provider) model: observations for the United Kingdom*. London: Royal College of Nursing. Available at: www.rcn.org.uk/about-us/policy-briefings/br-0215 (accessed on 7 March 2018).

Seale B (2016). *Patients as partners: building collaborative relationships among professionals, patients, carers and communities*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/patients-partners (accessed on 2 March 2018).

Tadros G, Salama RA, Kingston P, Mustafa N, Johnson E, Pannell R, Hashmi M (2013). 'Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model'. *The Psychiatrist*, vol 37, no 1, pp 4–10.

The King's Fund (2018a). 'Organisational development: helping your organisation be fit for purpose, fit for the future'. The King's Fund website. Available at: www.kingsfund.org.uk/consultancy-support/organisational-development (accessed on 21 March 2018).

The King's Fund (2018b). 'Programmes to support you at all stages of your leadership journey'. The King's Fund website. Available at: www.kingsfund.org.uk/courses (accessed on 4 April 2018).

The King's Fund (2015). 'Learning from high-performing health care organisations'. Conference, The King's Fund, 21 April. Available at: www.kingsfund.org.uk/events/learning-high-performing-health-care-organisations (accessed on 21 March 2018).

The King's Fund (2011). *The future of leadership and management in the NHS: no more heroes*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/future-leadership-and-management-nhs (accessed on 7 March 2018).

Timmins N (2016). *The chief executive's tale: views from the front line of the NHS*. London: NHS Providers and The King's Fund. Available at: www.kingsfund.org.uk/publications/nhs-chief-executive-interviews (accessed on 2 March 2018).

Timmins N (2015). *The practice of system leadership: being comfortable with chaos*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/practice-system-leadership (accessed on 3 March 2018).

Turle S (2017). 'How to involve patients in quality improvement'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/embedding-culture-quality-improvement/patient-involvement (accessed on 3 March 2018).

Walsh N (2017). 'Supporting leaders to deliver transformational change'. Article. The King's Fund website. Available at: www.kingsfund.org.uk/publications/articles/supporting-leaders-deliver-transformational-change (accessed on 7 March 2018).



West M, Collins B, Eckert R, Chowla R (2017). *Caring to change: how compassionate leadership can stimulate innovation in health care*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/caring-change (accessed on 2 March 2018).

West M, Steward K, Eckert R, Pasmore B (2014). *Developing collective leadership for health care*. London: The King's Fund and Centre for Creative Leadership. Available at: www.kingsfund.org.uk/publications/developing-collective-leadership-health-care (accessed on 2 March 2018).

World Health Organization (2018). 'Constitution of WHO: principles'. WHO website. Available at: www.who.int/about/mission/en (accessed on 21 March 2018).



About the authors

Durka Dougall is a senior consultant in the Leadership and Organisational Development team and a consultant in public health medicine. She has more than 20 years' experience working as a doctor, commissioner, manager and systems improvement specialist. Durka is programme director for a range of STP development initiatives, jointly runs the Integrated Care System and Integrating Physical and Mental Health Networks, is working on a project on the vision for a population health system, and leads this project on transformational change. Durka has worked with NHS England, Public Health England, Health Education England, UCL Medical School and British Medical Association.

Before joining the Fund, Durka worked as Head of Transformation and Population Health Improvement for the NHS supporting 13 health and care organisations to improve services. Durka was awarded Masters in healthcare leadership with distinction, a Masters and Fellowship in public health, and was named NHS Emerging Leader of the Year by the London Leadership Academy in 2014.

Matthew Lewis joined The King's Fund as a part-time visiting fellow in August 2016. He has been a consultant in general medicine and gastroenterology at Sandwell and West Birmingham Hospitals since 2002 and has more than 10 years' experience in clinical management, most recently working as Group Director for Medicine and Emergency Care. He carried out his clinical training in Manchester and North West England. Matthew has a Masters in medical leadership from Warwick University. Sandwell and West Birmingham is currently focusing on streamlining clinical processes, modernising working practices and addressing financial challenges – issues that Matthew has been exploring with The King's Fund and which are relevant to the wider NHS.



Shilpa Ross is a senior researcher in the Policy team and works on a range of health and social care research programmes. Her recent projects include quality improvement in mental health and the future of HIV services in England.

Before joining The King's Fund in 2009, Shilpa's research focused on the resettlement of offenders and substance misuse treatment. She has extensive experience in qualitative research with practitioners, service users and policy-makers. Shilpa holds a BSc in psychology and criminology.



Acknowledgements

We would like to express our gratitude to all the change leaders, sponsors, participants, recipients and bystanders that took part in this project. Although we cannot name you all here, we are grateful to you for telling us your stories and hope that we have done justice to your experiences within this publication. We are grateful to site leads for your help to co-ordinate interviews and for taking the time to verify the content of this report.

We would also like to thank the members of our advisory group who reviewed our findings and offered their own reflections on transformational change. We are fortunate to have had the guidance from a diverse range of experts in health and care: Vicky Browning, Vin Diwakar, Taj Hassan, Samira Ben Omar, Patricia Hewitt, Nicola Kingston, Nav Chana, Junaid Bajwa, John Herring, Helen Bevan, Debbie Sorkin, and Becky Malby.

Finally, we would like to thank colleagues at The King's Fund for their support. Particular thanks are given to Chris Ham and Marcus Powell for their invaluable guidance and support, and to Rachele Rossini for her dedicated project management input. We would also like to thank Julia Fernando, Lisa Oxlade, Lynsey Hawker, Katie Mantell, Laura Bennett, Nicola Walsh, Patricia Boyle, Mary Jean Pritchard, Jeff Steer, Siva Anandaciva, Jo Maybin, Chris Naylor and Ruth Robertson for their advice and contributions to this work.



Published by

The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2568
Fax: 020 7307 2801

Email:
publications@kingsfund.org.uk

www.kingsfund.org.uk

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First published 2018
by The King's Fund

Charity registration number:
1126980

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ISBN: 978 1 909029 80 4

A catalogue record for this
publication is available from
the British Library

Edited by Kathryn O'Neill

Typeset by
Pinnacle Graphic Design Ltd

Printed in the UK by
The King's Fund

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The King's Fund has been calling for transformational change to respond to the growing pressures and demands in the health and care system. But what are the experiences of those driving and participating in the process of transformational change?

The stories of transformation initiatives at The Bromley by Bow Centre, Birmingham and Solihull NHS Mental Health Trust, Northumbria Healthcare NHS Foundation Trust and Buurtzorg Nederland that are included in *Transformational change in health and care* illustrate that transformation is multi-layered, messy, fluid and emergent. It is not just about changing how a service operates, but also about shifting mindsets, changing relationships and re-distributing power.

Two key messages emerged from these stories:

- there are groups who work tirelessly to achieve great things – the stories are a tribute to their determination, bravery and resilience
- there are key considerations for health and care leaders working to achieve transformational change.

The authors conclude that transformational change in health and care requires our collective focus to address the following areas: to strengthen understanding and approaches, to create effective ways of dealing with the barriers, to unlock the tremendous human potential of staff and communities, to optimise the environment to ensure it supports them, and to foster the collaborative leadership that can bring about transformation.

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London W1G 0AN
Tel: 020 7307 2568

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