

The next leg of the journey: How do we make *High Quality Care for All* a reality?

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"In [our region] we have had a surfeit of strategies over the last twenty years. The one thing they have had in common is that nothing happened."

Strategic Health Authority leader, speaking at NHS Confederation Conference, 19 June 2008

The final report of the Darzi review of the NHS, *High Quality Care for All*, sets out bold policy proposals to take the NHS to its next stage. The ten Strategic Health Authorities, in creating their local visions as part of the review, have led a monumental and far-sighted effort to describe their goals for better health outcomes and better care for their local populations. While this was, no doubt,

very hard work, experience has shown that successfully executing on visionary plans is even harder work. So, as we celebrate the journey thus far and move forward on the consultation and implementation process, we cannot but wonder: *Is the NHS adequately prepared for the next leg of the journey?*

Key points in this report

- 1 *High Quality Care for All* and the ten SHA region reports collectively set out a compelling vision of the future NHS and provide a foundation for transformational change.
- 2 History suggests that implementation processes are likely to be the weakest link in turning the *High Quality Care for All* proposals into reality. Implementation needs to be managed in ways that have never been done before in order to achieve results that have never been achieved before.
- 3 There is a need to reflect on what has worked in the past, in the NHS and other healthcare systems. An evidence-based implementation approach should be built. This means considering not just what actions are needed to reform the system but also how to embed and institutionalise the reforms and enhance the potential for breakthrough change.
- 4 In the context of the UK government's public service reform model, over the last few years, less emphasis has been placed in the NHS on building capacity and capability than on other approaches such as performance management and market-type incentives. Evidence from a range of sources suggests that many local NHS organisations and systems lack the change capacity and capability to deliver the reforms.
- 5 Capability building needs to be 'hard-wired' into the daily work of NHS staff. Initiatives such as the Productive Ward demonstrate just how much energy for change can be unleashed by encouraging front-line teams to question how they work and providing simple tools and skills development.
- 6 The skills and capabilities that already exist within the system should be built upon. Evidence suggests that bringing 'outside in' change capability (consultancies and external experts) can add momentum, new perspective and skill in the short-term. However, in the longer term it is 'inside out' change, the capability of the system to change itself that will create the sustainable improvements we seek.
- 7 Evidence from high-performing health systems indicates the need to invest significantly in leadership-level skills for large-scale change; to mobilise for improvement, strategically align goals, and create measures and implementation initiatives; to work explicitly with models and theories of large-scale change; and to balance short-term operational results with longer term transformation.
- 8 Evidence from these systems also highlights the value of using information on comparative performance to bring about improvements in care, with the focus being on clinical quality. Transparency of information on variations in clinical quality should be used as part of performance management and to inform the public about the standards of care being achieved by NHS organisations to enable the aims of *High Quality Care for All* to be taken forward.
- 9 Consideration should be given to how to frame the implementation of *High Quality Care for All* to gain wholesale staff and public engagement, not just in planning and prioritising but in the entire change implementation process. Whilst politicians and policy makers may seek a 'once-in-a-generation' big bang launch of major new directions, it will pay to be restrained with NHS staff, focussing on clarifying and integrating efforts.

In this paper, we offer our review of the outputs of the *Next Stage Review*; focusing not on the 'what' of the specific proposals, but the 'how' of executing and delivering the anticipated changes. We describe the recent evidence and experience in healthcare regarding execution of large-scale change, and provide critical recommendations of things to consider as we move on from the current milestone.

The regional reports from the *Next Stage Review*

The nine SHA regional reports on *Our NHS, Our Future*, together with the Healthcare for London *Report on the Consultation and Recommendations for Change*, collectively present a compelling case for change across the country. The documents are typically labelled as a 'strategic vision' or 'clinical vision' and each sets out ambitions for health and healthcare in the region over the next period. All the reports are characterised by a depth of strategic analysis, an integrated approach to health and healthcare improvement, significant clinical engagement in the development process and explicit ambitious goals for change. In fact, they represent a step-change in the ability of the NHS at its most senior level to set out a visionary case for change.

Overall, the regional reports are very strong on 'what' needs to change but much less strong on 'how' it will happen. Perhaps this is an unfair criticism since the guidance given to SHAs in developing the reports was to follow a traditional model of strategy development, with an initial 'vision' stage, followed by a consultation process. Yet if we examine world-class approaches to large-scale implementation of change, we consistently see two characteristics (Institute for Healthcare Improvement, 2007):

- implementation planning is an integrated part of strategy development and it is considered from the beginning of the vision setting process
- there is an explicit link made between the outcomes sought, the hypothesis on the factors ('drivers') that are most likely to deliver that outcome and the specific project or programme plan for delivering the improvements. This means that the specific actions that are recommended are built upon an explicit theory of change.

There is evidence of these characteristics in some of the regional plans. Examples include the North East Transformation System as an implementation vehicle in the North East SHA proposal and the comprehensive *Delivering Our Vision* strategy from North West SHA. However, it is hard to evaluate most of the proposals from an implementation perspective because there is insufficient evidence to make a judgement.

So what other sources of evidence should we draw on in designing an implementation strategy to deliver sustainable results?

Approaches to public service reform

A good starting point for our reflection is a quick review on approaches to public service reform to-date. We will return to them later in the report. Over the last eleven years, the Labour Government has pursued an active programme of public service reform with four main components (Figure 1). Experience in the last decade has highlighted the strengths and weaknesses of each component (Prime Minister's Strategy Unit, 2006).

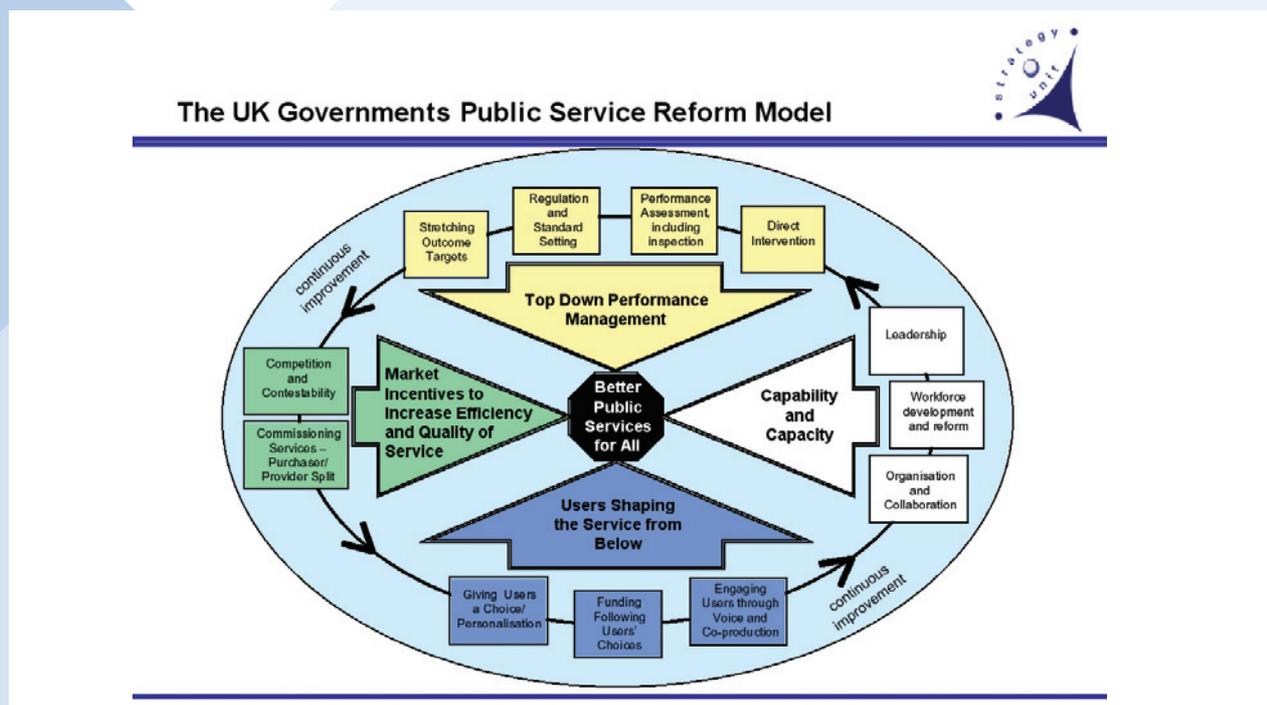


Figure 1
Source: The Prime Minister's Strategy Unit (2006) *The UK Government's approach to public service reform: A discussion paper*.

- **Centrally-driven performance management** has contributed to improvements in performance in a number of public services through the application of targets and other interventions, such as National Service Frameworks in the NHS. Whilst this approach has delivered results, it has well known limitations, including the stifling of innovation and creativity, limiting aspiration and ambition to the level of the standard or performance target, and increased bureaucracy.
- **Market incentives to increase efficiency and quality of service** have also played a part in performance improvement. By offering the users of public services a wider range of options from which to choose, and by requiring providers to compete for resources, competition and contestability have contributed to improvements in efficiency and quality, as in the reductions in waiting times. The limitations of this approach include its discouragement of the sharing of best practice, a risk that market forces become an alternative rather than an addition to building internal capability for improvement, and undermining of the public service ethos.
- **Users shaping services** is a third approach and is closely linked to the use of market-type incentives. As well as offering users more choice, this approach seeks to strengthen the collective voice of citizens, empower users by giving them control over budgets, and involve them as co-producers of services, as in the Expert Patient Programme. The limitations of this approach include the risk that equity may worsen as the articulate middle-classes profit at the expense of the poor, and the weakness of voice mechanisms in changing the behaviour of public services.
- **Strengthening capability and capacity of public service leadership and the workforce** has involved bringing in and developing talent, improving workforce development, pay and workforce reform (as in the new contracts for NHS staff), and using data on comparative performance to drive up standards. The limitations of this approach include the failure to use the opportunities offered by workforce reform to achieve performance improvements (eg the new contract for consultants in the NHS), and the uneven investment in leadership development and local improvement capability.

In practice, all four of these approaches have been used in various combinations in different public services. In the NHS, greatest reliance has been placed on top-down performance management, supplemented by market incentives and users shaping services from below. By comparison, less attention has been given to strengthening capability and capacity. *High Quality Care for All* signals a change in emphasis. Lord Darzi, in presenting his recommendations, has suggested that there will be no new nationally determined targets and no large-scale restructuring of the NHS system. However, much less has been said, either nationally or regionally, about the need

to build capacity and capability for large-scale change and improvement.

NHS capability for change

Evidence from a range of sources suggests that many NHS organisations fall short on the change capability required to deliver the proposals emerging from the *Next Stage Review*. For instance:

- the Office of Government Commerce study of change capability in the NHS (July 2006) scored the NHS at only two out of a possible five for seven out of nine categories assessed. The NHS got low scores in use of change management methods, staff development approaches and change leadership
- a study of NHS Trusts and PCTs by the University of Warwick (2006) looked for evidence of the kind of improvement approaches that have been used in industry for more than 50 years to improve operational efficiency and effectiveness. The researchers found strong evidence of such capacity and capability amongst high performing NHS organisations and in some of those with the greatest improvement challenges. However, they found very limited capability in evidence-based change management amongst the majority of NHS organisations that are in the middle of the performance curve
- a review by Ham et al (2007) showed a significant deficit in project management skills across the NHS, specifically in the management workforce. The report found that that this was hindering effective progress in delivering sustainable service improvement.

This evidence is backed up by recent experience by the NHS Institute for Innovation and Improvement which suggests that the biggest area of unmet need amongst local NHS organisations is in 'hands-on' improvement skills both for leaders and front-line teams, and how to align change capability with local strategic imperatives.

Our assessment is that in the next stage of NHS reform, there needs to be a much stronger focus on strengthening capability and capacity at all levels.

Moving from good to great in human service organisations like the NHS - to borrow the language of Jim Collins (2001) - involves understanding that many of the answers to the problems that exist lie within. This does not entail reverting to a system dominated by unaccountable professionals. Rather, it means engaging front-line staff much more fully than has been the case hitherto and supporting them through education and development to bring about improvement in care for patients and service users. In the process, there is a need to put more emphasis on measuring and comparing performance, and developing leadership skills and capabilities in the use of performance data, linked to incentives that can drive quality improvements.

In the next section of the paper, we set out some of the evidence from research into high performing organisations and provide case studies on large-scale change in healthcare. In order to make a timely contribution to the debate, we have not sought to carry out a full systemic review but to summarise some of the latest evidence.

In the final section of this paper, we develop these ideas further as an agenda for the NHS leaders considering the implementation of *High Quality Care for All*.

High performing healthcare organisations

The need to give priority to strengthening capability and capacity is reinforced by the findings of three recent global research studies into high performing healthcare organisations.

International comparison of healthcare systems

A two-year project led by Ross Baker at the University of Toronto (Baker et al, in press) examined the characteristics of five international systems and two Canadian systems. Based on fieldwork in each of these systems and analysis of their performance, Baker and colleagues identified the following common attributes of high performance:

- outstanding **leadership**
- quality and system design as a **core business strategy**
- significant investment in **building capability for improvement**
- **integration of services** across levels of care, sites and disciplines
- harnessing of **information technology** and meaningful measurement
- focus on **putting patients/clients first**
- **engaged physicians and workforce**
- **strategic alignment** of aims, measures and activities
- **incentives** and **accountability**.

Organising for quality

Further insights are offered by an international study conducted jointly by researchers from the RAND Corporation and University College London (UCL). Bate, Mendel and Robert (2008) selected for study nine healthcare systems in the United States and Europe. These were a variety of hospital and primary care organisations renowned for high performance and excellence in implementing and sustaining quality improvement. The research team identified six core challenges in the case study institutions:

- **structural:** organising, planning and co-ordinating quality efforts
- **political:** addressing and dealing with the politics of change surrounding any quality improvement effort

- **cultural:** giving quality a shared, collective meaning, value, and significance within the organisation
- **educational:** creating a learning process that supports improvement
- **emotional:** engaging and motivating people by linking quality improvement efforts to inner sentiments and deeper commitments and beliefs
- **physical and technological:** designing physical infrastructure and technological systems that support and sustain quality efforts.

A distinctive contribution of this study was to move beyond a list of the characteristics of high performing organisations to analyse the process for organising for quality and overcoming the above challenges. By comparing the different organisations that were selected as case studies, Bate and colleagues found that there were many routes to quality improvement. There is no one 'right' method or model. It was **the interaction of key factors in varying contexts** that helped to explain the journeys the organisations they studied had been on.

One of the implications that follow is that it is difficult for healthcare organisations as complex adaptive systems to copy or transfer experience from other organisations without understanding their own distinctive history and context (Plsek and Greenhalgh 2001). People and relationships are critically important in facilitating or inhibiting quality improvement, and a key task of leadership is to understand how to work with the people who work in healthcare organisations to tackle the challenges identified by Bate and colleagues. In the case study sites they followed, leaders did this in various ways, including through structural interventions (eg using communities of practice), cultural interventions (eg emphasising staff empowerment) and educational interventions (eg providing training in quality improvement methods).

World-class quality in healthcare

Anthony Staines (2007, see also Øvretveit and Sousa, 2008), a Swiss researcher, carried out an in-depth study of the healthcare organisations globally that have made the greatest improvements in clinical outcomes and quality. The good news, from a *Next Stage Review* implementation perspective, is that it is possible for healthcare organisations to make transformational improvements in clinical performance. However, even with significant resources and leadership effort, it takes a long time to create change across the board.

Amongst the 'world-class' organisations that Staines studied, it took a minimum of ten years of sustained effort to get measurable results across the whole system or organisation. Any healthcare system that pursues such a strategy has to reach a 'threshold', below which investment in improvement will not yield results. The threshold will only be reached when a number of 'infrastructure' elements, those that

create the conditions that lead to better outcomes, have been in place for a significant period of time. These elements include:

- building **leadership** will and commitment
- freeing up **resources** for clinical quality improvement
- **training** staff
- establishing **indicators** and **data collection systems**.

Staines notes that, in fact, performance may actually appear to deteriorate before it gets better. This typically happens because more efficient data collection systems are introduced which capture more data (and therefore illuminate more problems) before the real improvements kick in.

As Staines describes it 'initial investment in change goes into the balance sheet, not the operating results.' He identifies leadership tampering as a major barrier to reaching the investment threshold and achieving results. This means changing direction before the old direction had time to deliver. Equivalent examples of leadership tampering in the NHS include organisational restructuring and continuously introducing new policies and initiatives.

Case studies: Jönköping County Council and the Veterans Health Administration

Moving from systems level approaches to public service reform, through research on high performing healthcare organisations, the experience of two organisations that have been successful in programmes of improvement and transformations holds further lessons for change implementation in the NHS.

Jönköping County Council

In Sweden, Jönköping County Council is widely recognised as an organisation that has achieved and sustained a high-level of performance (Øvretveit and Staines, 2007). This is illustrated in its standing in the league tables that are used to compare performance across Sweden. In UK terms, Jönköping is an elected regional health authority serving a population of around one-third of a million and raising most of its resources through local taxes. Healthcare in Sweden is run on a devolved basis with the national government in Stockholm setting the legal framework and determining the entitlements for citizens, but the county councils have the main day-to-day responsibility for healthcare funding and delivery.

Referring back to the four approaches to public service reform described by the Prime Minister's Strategy Unit (Figure 1), Sweden has made little use of top-down performance management because such an approach is incompatible with that country's devolved system of healthcare. Market

incentives have also been absent because in Jönköping the controlling politicians have not favoured the use of competition and contestability as drivers of reform. Users shaping services from below have received greater attention, not least through the accountability of politicians to the public through the ballot box.

However, Jönköping has relied primarily on strengthening capability and capacity to achieve improvements in care. From an NHS perspective, notable features of Jönköping's approach include:

- **organisational stability:** in contrast to the NHS, Sweden has enjoyed a large measure of organisational stability, enabling leaders to focus their efforts on service and quality improvement, not distracted by structural changes
- **continuity of leadership:** the Chief Executive of Jönköping County Council has just retired after being in post for 19 years. Before that he was the Director of Finance. He therefore brought to the role the intimate knowledge of the business and the constancy of purpose that Collins (2001) identifies amongst characteristics of successful leaders
- **collective and distributed leadership:** Jönköping has given priority to the development of a leadership team to work with the Chief Executive, and to the development of leadership right through the organisation. This includes a strong emphasis on clinical leadership in the front-line improvement efforts ('microsystems') that are the focus of much of the quality improvement work in the county
- **investment in education and learning for improvement:** Jönköping has created its own in-house facility, Qulturum, which acts as a central focus for quality and culture and a centre of education and learning in quality improvement. It has made a very significant investment in building its own improvement expertise and cadre of experts in innovation and improvement. Much of the work that is done in Qulturum draws inspiration from links with international leaders in quality improvement such as Don Berwick and Paul Batalden
- **a vision of patient-centred care:** all of Jönköping's work is directed at improving care for patients and service users. This is symbolised by Esther, a fictitious 88-year old whose experience is used to enable clinical staff to map current care pathways and explore how they can be improved to better meet her needs.

In Jönköping, quality improvement is seen as a long-term, and at times a slow, journey that is not amenable to quick fixes. The emphasis is therefore placed on building momentum for change rather than speed, and recognising that sustainable change depends on building capability and capacity for improvement throughout the organisation.

Veterans Health Administration

The experience of Jönköping can be compared with that of the Veterans Health Administration (VA) in the United States. The VA was widely perceived to be an organisation in crisis in the early 1990s. Following the appointment of Ken Kizer as the new Chief Executive, the VA embarked on a major programme of transformation that led the Washington Monthly in 2005 to describe it as 'the country's best healthcare system'.

Research into the transformation of the VA (see, for example, Oliver, 2007) has identified the following factors as being important in its turnaround:

- the move away from a fragmented system centred on individual hospitals to a system based on 22 **regional service networks**
- the introduction of a **performance management approach** focused on key targets enabling the headquarters to hold the regional directors accountable for performance
- the development of a **culture of measurement and reporting** centred on key performance criteria facilitating comparisons between regional networks through increased transparency
- the emphasis within the performance management approach, and the culture of measurement and reporting, on **clinical quality** as well as other aspects of quality
- the use of **financial and non-financial incentives** to support performance management and quality improvement
- the use of **information technology**, including the electronic patient care record, to achieve closer integration of care and to support the use of measurement and reporting as drivers of improvement
- the **investment on health services research** (pre-dating the appointment of Ken Kizer) and the ability to lever the capacity for research in the organisation to support quality improvement and to make the results available through the scientific community (eg through articles in the New England Journal of Medicine on the progress made in the VA)
- the **strengthening of leadership** at all levels of the organisation, including the involvement of doctors and other clinicians in key leadership roles.

In moving away from a fragmented system centred on hospitals to a system of regional service networks, the VA was able to demonstrate the benefits of integrated care. These benefits include achieving good outcomes for patients with chronic diseases and reducing the use of hospital bed days by 50% in five years without adverse effects on the quality of care (Ashton et al, 2003).

Throughout the transformation, Kizer focused on quality as the overriding goal of his strategy. In using performance management, he emphasised the need to develop this collaboratively rather than to impose it top-down. This entailed working with regional directors and clinical leaders to agree the targets and measures that should be used in performance contracts. As in Sweden, the public reporting of performance data was seen as an important driver for quality improvement in the VA.

What are the implications for the implementation of *High Quality Care for All*?

The NHS is at a critical point in its journey. The reforms of the past ten years have clearly moved the service forward, and the national and regional plans under the *Next Stage Review* set ambitious goals for the future. The key question now is how we proceed from this point onward to execute on these plans.

The fundamental issue is that, as we discussed previously, the NHS is a complex adaptive system. This means that any major intervention changes not just aspects of the system, but the very nature of the system itself. This is made even more complex by the fact that the NHS is predominantly a human activity system, which introduces issues of politics and group or self-interest that are difficult to model or predict. Any large-scale strategy has to be cognisant of these realities. Drawing on the research evidence summarised above and the experience of high performing organisations, we believe that there are important implications for leaders at every level of the NHS system:

- 1 **The biggest challenge for leaders lies in building greater capacity and capability for change within NHS organisations and the public.** Research on large-scale change shows us that if services are to improve dramatically, it will be through the engaged improvement efforts of front-line clinical and managerial staff that do the work. While over the past ten years we have seen the development of the capacity and capability for small-scale, incremental change in pockets within the NHS, a significant investment of time, resources, and leadership effort will be required to create the capability for large-scale change across the whole of the NHS.
- 2 The experience of high performing organisations is that they have invested their own resources in building capability among staff and promoting 'inside out' change, for example, through Qulturum in Jönköping. **The evidence tells us that bringing 'outside in' change capability can add momentum, new perspectives and skills in the short-term. However, in the longer term, it is 'inside out' change, the capability of the system to change itself that will lead to sustainable improvements for every patient and local**

population. As a result of the reform process over the past ten years, the NHS has tremendous organisational memory on how to implement radical change, probably more than any other national healthcare system globally. We should treasure that and build on it.

3 **The evidence suggest that, on its own, wholesale formal training in quality improvement and change management techniques will not deliver the results we seek. Capability building needs to be 'hard-wired' into the day-to-day practice of our staff** (Keller and Aiken, 2008). Initiatives such as The Productive Ward demonstrate just how much energy can be unleashed by encouraging front-line teams to question how they work and providing simple tools and skills development to support them, on the job. Across the NHS, we need to find the mechanisms to tap into and mobilise the huge pool of latent individual and organisational energy for change, as has happened in the case study systems.

4 **Our research stresses the importance of planning and resourcing large-scale change implementation.** We need to calculate upfront how much extra time, effort, skills and systems will be required to execute the change and create the space and resources for it to happen. We cannot just assume that people will fit it in on top of existing busy jobs. Evidence suggests that if anyone's workload increases by more than ten per cent as a result of an implementation initiative, it is likely to run into problems (Sirkin et al, 2005). Dedicated resources need to be identified and set aside for key implementation and change management roles, including people taking on project management responsibilities (Ham et al, 2007).

5 **As the case study organisations demonstrate, change capability is not just about the micro-level ability to make improvements at the front-line of patient care (although this is critically important). We also need to invest significantly in leadership-level skills for large-scale change.** Specifically, leaders need to know how to mobilise individuals, teams and communities to the cause of change; how to strategically align goals, measures and implementation initiatives; how to work explicitly with models and theories of large-scale change; and how to balance short-term operational results with longer term transformation.

6 **The Jönköping and the VA experiences reveal just how powerful publishing and comparing variation in performance on key quality indicators can be as a lever for performance improvement.** The lesson from these high performing organisations is that transparency of information on variations in clinical quality should be used as part of performance management and to inform the public about the standards of care being achieved by NHS organisations to enable the aims of *High Quality Care for All* to be taken forward.

7 **We need to consider how we frame implementation of High Quality Care for All to gain wholesale staff and public engagement not just in planning and prioritising, but in the entire change implementation process.** Paradoxically, transformational change is more likely to succeed where it is framed as a continuation of the present, starting from the organisational legacy and what people are used to (Barrett and Fry, 2005). Whilst politicians and policy makers may push for a once-in-a-generation 'big bang' launch of major new directions, it will pay to be restrained with NHS staff, focussing on clarifying and integrating efforts.

8 While it may be hard to admit it, we need to acknowledge that front-line staff in the NHS are much more motivated by the needs of the members of the public that they encounter daily, than they are by the pronouncements of senior leaders that they see rarely. **Devoting resources to build even more capacity in members of the public to play constructive roles in driving improvement work might be the most rewarding investment the service will ever make** (Reinertsen et al, 2008).

9 While competition can, no doubt, drive up standards of performance, when it becomes a barrier to collaboration it may have gone too far. The private sector has much to teach us here about getting the right balance between competition and collaboration. For example, while firms in the automotive industry compete fiercely, they still find ways to share for the common good breakthroughs in areas such as safety and fuel efficiency. **Regional and national leaders should take responsibility for reflecting carefully on current efforts and actively working to strike a better balance between competition and collaboration.**

In the wake of the release of *High Quality Care for All*, we invite NHS leaders to consider carefully what they will do next using the nine points above as an initial challenge. We now have new goals for the future, but we have had new goals before, have we not? We have approaches for executing on new plans and goals, but these have never quite delivered fully on what was so enthusiastically envisioned at the initial release of the plans, have they? We have been at this point in the journey before, have we not?

The question now before the NHS leadership community as we contemplate how we will execute on the changes outlined in the national and regional plans is: What will we do this time round - simply more of the same, or something different?

The NHS Institute for Innovation and Improvement will be contributing more ideas on implementing large-scale change in the autumn of 2008.

References

- Ashton, C et al (2003) Hospital Use and Survival Among Veterans Affairs Beneficiaries. *New England Journal of Medicine* 349: 1637-46
- Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmachovish K, Born K. (In press) *High Performing Health Systems: Delivering Quality By Design*. Toronto: Longwoods Publishing.
- Barrett F and Fry R (2005) *Appreciative Inquiry*. Chagrin Falls: Taos Institute.
- Bate P, Mendel P, Robert G (2008) *Organising for quality: The improvement journeys of leading hospitals in Europe and the United States* Oxford: Radcliffe Publishing.
- Collins J (2001) *Good to great*. London; Random House.
- Ham C, Parker H, Singh D, Wade E (2007) *Getting the basics right*. NHS Institute for Innovation and Improvement (www.institute.nhs.uk)
- Institute for Healthcare Improvement (2007) *Execution of strategic improvement initiatives to produce system-level results*, IHI White Paper (www.ihl.org)
- Keller S, Aiken C (2008) *The inconvenient truth about change management. Why it isn't working and what to do about it*. McKinsey and Co.
- The Office of Government Commerce (2006) *Review of change capability in the NHS* (unpublished). (www.ogc.gov.uk)
- Oliver, A (2007) The Veterans Health Administration: An American Success Story? *The Milbank Quarterly* 85: 5-35
- Øvretveit J, Sousa P (2008) Successful hospital and system quality programmes: How did they do it, and is there evidence of improvement? *Quality and Safety Improvement Research: Methods and Research Practice* from the International Quality Improvement Research Network, Lisboa: Escola Nacional de Saúde Pública, v. 8.
- Øvretveit J, Staines A (2007) Sustained improvement? Findings from an independent case study of the Jönköping improvement program, *Quality Management in Health Care*, 16, No. 1, pp. 68-83.
- Plsek PE, Greenhalgh T (2001) The challenge of complexity in health care. *British Medical Journal*, 323:625-8.
- The Prime Minister's Strategy Unit (2006) *The UK Government's approach to public service reform: A discussion paper*. (www.cabinetoffice.gov.uk/strategy)
- Reinertsen JL, Bisognano M, Pugh MD (2008) Seven leadership leverage points for organization-level improvement in health care (second edition). IHI white paper (www.ihl.org)
- Staines A (2007) *La relation programme qualité / résultats patients* [Thèse de doctorat]. Lyon: IFROSS, Université Jean Moulin - Lyon 3; 2007.
- Sirkin H, Keenan P, Jackson A (2005) The Hard Side of Change Management *Harvard Business Review*, October, 83(10):108-118.
- Walley P, Rayment J, Cooke M (2006) *Clinical Systems Improvement in NHS Hospital Trusts and their PCTs: A Snapshot of current practice*. NHS Institute for Innovation & Improvement (www.institute.nhs.uk)

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