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Doing transformational change in the English NHS in the context of "big bang" redisorganisation

Findings from the North East transformation system

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Abstract

Purpose – The purpose of this paper is to examine a bold and ambitious scheme known as the North East transformation system (NETS). The principal aim of the NETS is the achievement of a step-change in the quality of health services delivered to people living in the North East region of England. The paper charts the origins of the NETS and its early journey before describing what happened to it when the UK coalition government published its proposals for unexpected major structural change in the NHS. This had a profound impact on the leadership and direction of the NETS and resulted in it taking a different direction from that intended.

Design/methodology/approach – The research design took the form of a mixed methods, longitudinal 3.5-year study aimed at exploring transformational change in terms of content, context, process and outcomes. The sample of study sites comprised 14 NHS trusts in the North East region chosen to provide geographical coverage of the area and to reflect the scale, scope and variety of the bodies that formed part of the NETS programme. The qualitative component of the research, which the paper draws upon, included 68 semi-structured interviews, observational studies and focus groups. Data analysis made use of both deductive and inductive frameworks. The deductive framework adopted was Pettigrew *et al.*'s "receptive contexts for change" and four of the eight factors stood out as especially important and form the basis of the paper.

Findings – The fate of the NETS was shaped and influenced by the eight factors comprising the Pettigrew *et al.* receptive contexts for change framework but four factors in particular stood out as

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being especially significant: environmental pressure, quality and coherence of policy, key people leading change, supportive organisational culture. Perhaps the most significant lesson from the NETS is that achieving whole systems change is particularly vulnerable to the vicissitudes of politics especially where that system, like the UK NHS, is itself subject to those very same pressures. Yet, despite having an enormous influence on health policy, the political context is frequently avoided in research or not regarded as instrumental in determining the outcomes in respect of transformational change.

Research limitations/implications – The chief limitation is the credibility and authenticity of the interviews captured at particular points in time. These formed the datebase for subsequent analysis. The authors sought to guard against possible bias by supplementing interviews with observational studies and focus groups as well as running two dissemination events at which emerging findings from the study were subjected to independent external scrutiny and comment. These events provided a form of validation for the key study findings.

Practical implications – The research findings demonstrate the importance of context for the likely outcome and success of complex transformational change initiatives. These require time to become embedded and demonstrate results especially when focused on changing culture and behaviour. But, in practice, allowing sufficient time during which the organisation may remain sufficiently stable to allow the change intervention to run its course and become embedded and sustainable is highly problematic. The consequence is that bold and ambitious efforts like the NETS are not given the space and stability to prove themselves. Too often, politics and external environmental pressures intrude in ways that may prove dysfunctional and negative.

Social implications – Unless a different approach to transformational change and its leadership and management is adopted, then changing the NHS to enable it to appear more responsive to changing health care needs and expectations will remain a cause for concern. Ultimately the public will be the losers if the NHS remains insensitive to changing needs and expectations. The patient experience was at the centre of the NETS programme.

Originality/value – The study is original insofar as no other has sought to evaluate the NETS independently and over a reasonable time period. The research design, based on a mixed-methods approach, is unusual in evaluations of this nature. The study's conclusions are not so original but their value lies in largely confirming and reinforcing the findings from other studies. It perhaps goes further in stressing the impact of politics on health policy and the negative consequences of constant organisational change on attempts to achieve deep change in the way the NHS is organised and led.

Keywords Change management, Leadership, Politics, Quality improvement, Public sector reform, Health services

Paper type Research paper

Introduction

Securing transformational change in health systems is viewed as a top priority if they are going to be sustainable financially and able to provide care of high quality that is free at the point of use. Health systems are faced with mounting pressures arising from epidemiological and demographic changes, especially in respect of an aging population requiring integrated health and social care and lifestyle-related illnesses affecting all age groups, as well as from new developments in technology, treatments and other interventions. Given these pressures, it is argued that health systems, even those which are functioning effectively when judged according to existing standards, need to be able to undertake large-scale transformational change if they are to survive (Lukas *et al.*, 2007). This means being ever vigilant about removing waste and improving quality and patient safety (McIntosh and Cookson, 2012).

This paper examines a bold and ambitious scheme known as the North East transformation system (NETS) which has as its principal aim the achievement of a step-change in the quality of health services delivered to, and experienced by, a population of 2.6 million people living in the North East region of England. The NETS was conceived as an experiment in the adoption of large-system transformational change (Best *et al.*, 2012). While the NHS in the North East performs well, the health of

the population within the region ranks among the poorest in the country. The NETS sought to address this paradox by instigating a programme of change aimed at transforming the way services were provided with a view to improving their efficiency and effectiveness. The chosen method was derived from the Virginia Mason Production System, based on the Toyota Production System (TPS), as applied to the Virginia Mason Medical Center (VMMC) in Seattle which was one of the first hospitals to apply Lean to a health care facility.

The research design took the form of a longitudinal, 3.5-year study. The sample of study sites comprised 14 NHS trusts in the North East region. These were chosen to provide geographical coverage of the area and to reflect the scale, scope and variety of the NHS bodies that formed part of the NETS programme. A mixed-methods approach was adopted that explored transformational change in terms of content, context, process and outcomes.

The qualitative component of the research, upon which this paper draws, included 68 semi-structured interviews, observational studies and focus groups. Data analysis made use of both deductive and inductive frameworks. The principal deductive framework adopted was Pettigrew *et al.*'s (1992) "receptive contexts for change". It comprised eight factors (see Figure 1) and although all of them had a bearing on the issues considered in this paper, the four shaded ones were especially significant. In order of priority they are: environmental pressure, quality and coherence of policy, key people leading change, and the existence of a supportive organisational culture. Together these four factors frame the discussion which follows later in the paper and which points to the seminal influence of context and politics on what transpired. Although the evidence base

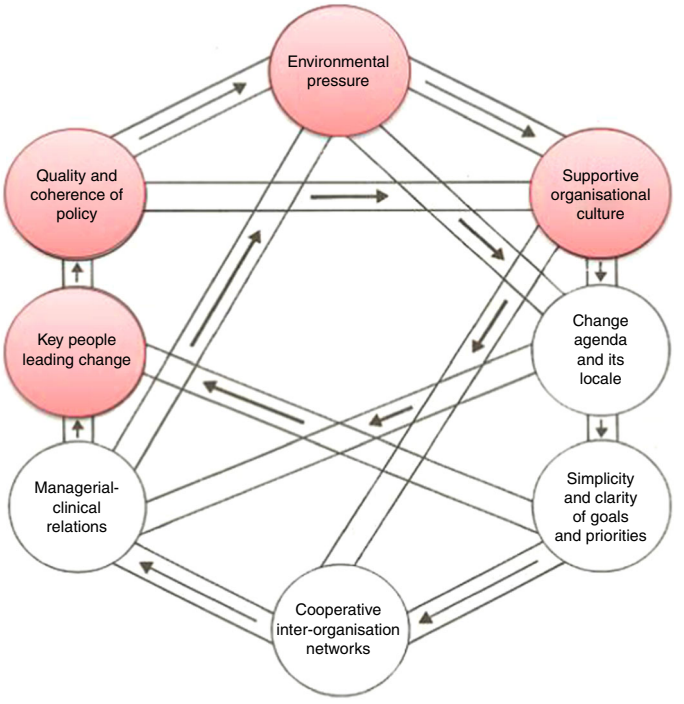

Figure 1.
Receptive contexts for change

concerning what needs to happen for transformational change to succeed is certainly "good enough", the major impediment to sustaining transformational change efforts is the seeming absence of political will to allow these initiatives sufficient time to succeed.

But before considering such matters, we first need to describe the NETS programme in more detail and to consider the nature of the impact upon it of the "big bang" NHS changes triggered by the UK coalition government following its election in May 2010.

NETS: origins and early years

Like many innovations, the NETS was borne out of a combination of multiple factors and influences, some planned and others occurring more by happenstance. Central to the project were two key factors: a determination to improve the quality of care and move services from being mediocre to good to being second to none; and the existence of a strong regional identity which would potentially allow an ambitious change programme to occur with sufficient resources and on a scale that might enhance the chances of success. As noted above, a paradox with the NHS in the North East is that although services are generally considered among the best in the country, exceeding targets and winning awards, the region has some of the highest and deep-seated health inequalities in the UK. Ensuring that services tackle such failings lies at the core of the NETS.

The NETS is the only example of its kind anywhere in the UK. Other NHS regions across England have for many years encouraged and supported not dissimilar change initiatives but these have been confined to particular hospitals or health care facilities. What is unique and bold about the NETS is its region-wide focus and attempt to transform people's experiences of a whole health system rather than its individual parts acting in isolation from each other. Given the current policy focus on integrated care, it could be argued that the NETS anticipated such a development through seeking improved collaboration in respect of care pathways and issues requiring joined-up working between health services and local government.

The implementation of the NETS began in mid-2007 and was led by a project team based at NHS North East. The team was established to promote the NETS and provide a link with the US consultants engaged in delivering elements of the initiative, notably Amicus and the VMMC in Seattle. The team also hosted meetings and acted as a repository for information about Lean. The enthusiasm and commitment demonstrated by the NETS champions, evident both in the team based in the health authority and in the local pathfinder/early adopter sites, were vital elements in establishing and making real the so-called three-legged stool – vision, compact and method – in NHS organisations across the region.

Vision

The vision as articulated by NHS North East was to be a leader in excellence in health improvement and health care services. To achieve this, the health authority adopted a zero tolerance approach, also referred to as the seven no's: no barriers to health and well-being; no avoidable deaths, injury or illness; no avoidable suffering or pain; no helplessness; no unnecessary waiting or delays; no waste; and no inequality. The vision set out the fundamental objectives and direction of the NHS in the region (NHS North East, 2008). It was shared with other public bodies, embedded in local strategy documents, promoted by the NETS champions, and cascaded down to all levels of the workforce.

Compact

As noted, a long-standing tension within the NHS has been the often difficult relationship between doctors and managers where tribalism has been the hallmark

rather than a more collaborative approach (Degeling *et al.*, 1998, 2001; Hunter, 2002; Gawande, 2011). To address this issue, and central to thinking about the NETS and its likelihood of success, the development of a "compact" between clinicians and managers was regarded as a priority. Its purpose was to shape and make real the psychological contract between clinicians and the institutions in which they worked to facilitate transformational change (Edwards *et al.*, 2002). To this end, the compact included a clear statement of responsibilities, rewards and sanctions that are aligned to the vision. Each pathfinder trust was empowered to develop its own compact to meet local objectives, needs and desired clinical outcomes (Hunter *et al.*, 2008).

Method

Lean thinking and tools derived from the TPS were the third leg of the NETS. There is a great deal of experience of applying Lean methods to the NHS and other parts of the public sector but nowhere on the scale envisaged by the NETS. The VMMC pioneered the application of the TPS to health care (Bohmer and Ferlins, 2005) and reported significant improvements in process and performance in regard to patient safety (Furman and Caplan, 2007). NHS North East anticipated that adopting the TPS method would enhance patient safety; increase capacity without increasing resources by making better use of existing resources; make full use of the potential skills and strengths of all the members of the team; increase patient satisfaction; increase staff satisfaction; shorten the patient pathway from first point of contact to completion of treatment; stimulate continuous improvement as a formative process for greatest health gain; and encourage a new culture of clinical care (Hunter *et al.*, 2008).

At the centre of the vision, compact, method triangle was the patient, and meeting their needs more effectively was integral to all that NETS sought to achieve. Of course, describing the three-legged stool and its aspirations to improve the functioning of the health system is one thing. Being confident that implementation would follow is another entirely. So, although a vision existed and was shared, it was less certain how widely it was supported. Also, while the compact was regarded as a critical feature of the NETS, there was less confidence that all were agreed on what "Team North East" was or meant or what it required to make it succeed. And, finally, when it came to the method, although there was widespread agreement that not everyone had to sign up to the VMPS as the chosen tool, it was also accepted that a common language and method was needed for the full potential of the TPS to be realised. It was regarded as the DNA of all the improvement work. But many of the senior managers in NHS organisations within the region argued that the evidence base for the VMPS and the benefits to outcomes had yet to be realised. In any case, some were already engaged with using some other method and were disinclined to change course and adopt the VMPS. A majority favoured a more flexible approach whereby a basket of tools was available upon which individual organisations could draw as they deemed appropriate for their circumstances. In terms of the other two legs of the stool – the vision and compact, they were broadly supportive.

Although the NETS was well underway before the introduction of the quality innovation productivity prevention (QIPP) challenge at the time of the economic downturn in 2009, it became a key driver for raising the profile of the NETS and injecting new energy into it. The NETS was viewed as the region's platform for realising QIPP with its focus on reducing waste and variation while at the same time improving quality and safety. But there was a view that greater convergence was required to provide the necessary leadership and discipline. QIPP was the means by which this could be enabled to happen in order to encourage learning and sharing across the region. A minority of

organisations and managers did not favour convergence in any form regardless of the motive and preferred diversity. As long as organisations were doing something, they argued, they need not be doing the same thing when it came to Lean methods.

In the event, the proposals to refresh and re-energise the NETS never materialised because the arrival of the coalition government in May 2010 and its move quickly to publish plans for a major reorganisation of the NHS put paid to them (Walshe, 2010, 2012; Hunter, 2011, 2013; Klein, 2013). As soon as it became evident that NHS North East had no future, the discussion became one of how to salvage what was already in place concerning the NETS rather than with how to strengthen and develop it further. In place of a focus on convergence, the emphasis was on maintaining a looser coordination centred on a slim resource located in one of the hospital trusts which had been an early advocate of the NETS approach involving the VMPS method.

Bringing about transformational change in health systems is regarded as particularly challenging in the most propitious of circumstances given the complexities involved and the multiple and diverse stakeholders to be engaged. When it is being undertaken simultaneously with a massive structural upheaval of the kind imposed on the English NHS by the coalition government shortly after assuming power in May 2010, which has left little of the prevailing infrastructure intact or stable, then the difficulties and challenges are of a different order. This is the situation that faced the NETS and it resulted in a prolonged period of uncertainly from the time of the announcement of the changes in July 2010 to their implementation commencing in April 2013 which also marked the demise of the strategic health authority, NHS North East.

Evaluating the NETS

The evaluation of the NETS commenced in 2009 and ended in June 2013 (Hunter *et al.*, 2014). It employed the receptive contexts for change framework devised by Pettigrew *et al.* (1992) for their study of strategic change in the NHS – see Figure 1. Eight interrelated and interacting factors make up the framework: the quality and coherence of policy; the availability of key people leading change; long-term environmental pressure; a supportive organisational culture; effective managerial-clinical relations; cooperative inter-organisational networks; simplicity and clarity of goals and priorities; and the fit between a change agenda and its locale.

For the purpose of this discussion, it is the first four factors which are of critical importance in shaping events (shaded in Figure 1). Receptive contexts for change are dynamic not static concepts and often change over time. Indeed, this is what happened in respect of the NETS and its development. The launch of the NETS and its early progress were underpinned by a receptive context for change comprising all eight factors although the four mentioned above were of particular importance. When the external policy context changed, commencing in mid-2010 with the publication of the coalition government's white paper setting out its proposals for significant structural change in the NHS, it quite quickly became one of non-receptivity (Department of Health, 2010). This is not to suggest that elements of what the NETS stood for, or had achieved, were no longer valid or at risk of disappearing altogether – as we will show, in some of our study sites the NETS has survived. But it is also the case that the system features that gave birth to the NETS and allowed it to aspire to the goals it set itself were put under serious threat from, and ultimately dismantled by, the policy and organisational changes announced in the white paper.

Taking the four key factors from the Pettigrew *et al.* (1992) framework that frame the discussion presented in this paper in order of significance, environmental pressure

has proved to be the most critical and potentially disruptive. In particular, there are the resource pressures arising from the collapse of the financial sector in 2008 and the government's determination to tackle the deficit and usher in deep public spending cuts. The NHS, although protected to a degree, is not wholly exempt from these and is required to save £20 billion by 2014 with further savings to follow thereafter. Determined to tackle the deficit through its austerity measures aimed at reducing public spending, the government has taken the opportunity to reduce the size of the public sector in order to encourage private alternatives (Taylor-Gooby and Stoker, 2011). Through such means it believes that health care services will become more efficient and result in improved quality. Choice and competition are the watchwords of the reform agenda rather than collaboration (Hudson, 2010; Reynolds *et al.*, 2012).

Coupled with the economic downturn and an abrupt end to the additional resources the NHS had enjoyed year-on-year between 2002 and 2008, is the changing policy context triggered by the coalition government's determination to simplify the NHS and devolve responsibility for decision making to front-line GPs. In such a context, so the theory goes, there is to be a much reduced role for the centre and therefore no need for an intermediate tier. The changes therefore led to the demise of NHS North East although NHS England has a subnational level comprising four regions with the North East being subsumed within the North region. Despite the wish to simplify the NHS structure, in reality things have not quite worked out as intended. There is both a more complex structure in place and localism has become a largely rhetorical concept in the face of continued top-down micro-management from government.

The second key factor is the quality and coherence of policy. The proposals for reorganising the NHS were criticised from many quarters for their alleged incoherence and perception that the problem for which they were deemed to be the solution was never clearly articulated or argued (Walshe, 2010; Timmins, 2012). Indeed, the NHS had been improving under the previous labour government and was gaining in popularity with the public (Dixon *et al.*, 2012). International comparisons also show it to have been improving and punching well above its weight compared with other health systems (Davis *et al.*, 2007). The case for reform, especially on the scale envisaged, had, according to its critics, simply not been made. This aroused suspicions that the real aim was an ideological one, namely, under cover of reducing the deficit, to dismantle the NHS as a public service and to replace it with a diverse range of services run by a mix of private and public providers (Leys and Player, 2012). But perhaps the most incoherent aspect of the policy was the fact it had been conceived at all since, in opposition, the Conservative party, and Prime Minister David Cameron in particular, had been unequivocal in stating that there would be no more top-down reform of the NHS since structural reform on such a scale was not seen to work and was disruptive and costly (Timmins, 2012).

The third factor refers to the key people leading change. The NETS would not have been conceived or happened if a handful of key people in NHS North East had not had the vision and commitment to see it happen (Erskine *et al.*, 2013). These individuals largely remained together over a period of years to provide continuity and consistency of purpose. But the changes announced in 2010 soon put paid to that and those same individuals at NHS North East were no longer co-located or in the same posts. More than anything, their departure hastened the demise of the NETS as originally conceived and led.

Finally, and linked to the third factor, is the existence of a supportive organisational culture. As is evident from the work on the compact (see previous section), the NETS is

nothing if not an attempt to change the culture of the NHS and the way staff operate and work together. A key component is the nature of the relationship between clinicians and managers which has always been a vexed and somewhat fractious one in the history of the NHS. It is generally acknowledged that the NHS comprises a complex set of cultures and trying to shape these in order to improve quality of care has been at the heart of the NETS initiative.

Although considerable uncertainty about whether or not the proposed changes would actually succeed in passing into legislation continued throughout most of 2011, it became clear that the government was determined to get its way (Hunter, 2011, 2013). In March 2012, the Health and Social Care Act was passed. At this stage in the journey it was inevitable that the original purpose of the NETS would need to be revisited.

NETS meets "big bang" change

The NHS in England (the NHS in Wales, Scotland and Northern Ireland has proved to be more stable and resilient) has been restructured regularly since 1974 with successive waves of change following each other with increasing rapidity. It should therefore come as no surprise that a new incoming government elected in May 2010 would quickly overturn its alleged distaste for massive "big bang" upheaval and impose possibly the biggest bang ever to affect the NHS (Hunter, 2011). Whatever the merits and/or demerits of the changes, and these continue to be hotly debated, it is fair to say that they took those working in the NHS completely by surprise. No one was expecting, or had been prepared for, what appeared in two white papers published in July (this one dealt with the NHS changes) and December (this one focused on the public health changes) 2010, respectively.

In terms of the impact of the changes on the NETS, these were quite profound insofar as they resulted in the loss of the region-wide body, NHS North East which had nurtured and nudged and generally overseen the entire initiative from its inception up until the time when the health authority's abolition was signalled. There then followed the departure or relocation of key NHS managers many of whom were redeployed to other posts elsewhere, often some distance away. The resulting loss of leadership and corporate memory meant that the original idea for a coalition of the willing gave way to a more modest entity hosted by a hospital trust that was itself one of the early pioneers of the NETS.

When major change is embarked upon in the NHS, the claims and counter-claims invariably result in the service being trapped between two irreconcilable tensions. On the one hand, it is often asserted that for the NHS to change, "disruptive innovation" is called for. It may be painful and may result in losses but overall, it is claimed, the gains far outweigh these. On the other hand, it is claimed that the NHS is too eager to change the organisational structure while leaving many of the issues to which such change is ostensibly addressed virtually untouched. This is because structural change can leave culture intact and if it is culture that is the target of change then a quite different approach is required. The architects of the NETS were acutely aware of this distinction and did not regard structural change in itself as having any relevance to what was required, namely, a wholesale rethink of the way the work was done. In short, changing the culture was the goal and for this to succeed, it was acknowledged that it would entail embarking on a long journey without an end in sight. It was also accepted that it would take several years to enable the changes to take effect and become embedded. Although large-scale transformational change is indeed viewed as a

never-ending journey, such a way of thinking did not sit easily in a public service like the NHS which demanded quick, visible and tangible results and which itself was undergoing almost continuous structural change. And so it proved. The NETS is not an island and it was unable to survive as originally designed, when subject to a politically led change initiative driven by central government.

Paradoxically, the NETS became a victim of the very change strategy it was seeking to supplant with a quite different approach based on changing the culture. This involved creating the momentum for change from the bottom up rather than being imposed from the top as had happened too often in the NHS hitherto. Even so, for some organisations and leaders locally, the centre was not central government in London but the health authority, NHS North East, located in Newcastle. Having the health authority drive and lead the NETS had many supporters but also some detractors who wanted to pursue a more diverse, locally led approach in which they had the freedom to do what they felt was right for their organisations and communities.

For the NETS to succeed on its own terms, the NHS was required to freeze in order to allow changes in culture and behaviour to take root. But with the NHS unexpectedly subjected to a major reconfiguration of its structures and systems, this virtually put paid to the ambition and original conception of the NETS as a region-wide venture that would provide a new and different way of realising deep change across an entire health community. Moreover, whereas the NETS ethos is one of encouraging cooperation and working together, the government's changes are about marketisation and putting services out to tender to allow private sector providers to compete alongside public sector ones. But as markets and competition are about fragmentation as organisations compete for resources (Currie *et al.*, 2008), such behaviour goes against what the NETS is seeking to achieve.

As the changes and the enormity of their implications became clear, different sites in our study adopted different stratagems either as coping mechanisms or because they had no alternative. In a community services trust work ceased altogether because of a merger with an acute hospital trust which sought to impose its approach to transformational change. This did not involve signing up to the full NETS package in terms of the VMPS and being a member of the coalition, although broadly similar aims were pursued. In some other sites work on the NETS either stalled or slowed down through insufficient resources or their diversion to other priorities. Finally, in two or three of our study sites, not all of them NETS champions, work proceeded more or less as planned in order to embed change and retain a focus on improving services.

The quotes which follow from the semi-structured interviews conducted for the study illustrate some of these issues. Our initial wave of interviews were conducted prior to the implementation of the 2010 reforms, although with the financial squeeze on public services, including the NHS, already beginning there was a recognition that money was going to get tight. The second wave of interviews took place when the coalition government's changes were beginning to take shape and impact on the work and consciousness of those leading the NETS in the region.

The importance of commitment and consistency of purpose at a time of major change is well articulated in the following excerpt:

> [T]he most important thing is to have that organisational commitment and the leadership and the consistency of purpose really to just keep going at it and be prepared for it to take time. It's quite difficult in circumstances where, you know, people are coming along and saying you have to reduce your budget by 25% over the next four years or something.

When asked specifically about the impact of the impending restructuring, this same interviewee went on:

> I do have anxieties about how the approach will survive and/or thrive in the region because the [Strategic Health Authority] has played an important part in keeping this together and keeping it going. I think inevitably that will fall away a bit without the SHA. Because even though many of the organisers are currently saying we need to keep this going, I think once it comes to a situation where there are individual pressures on each, different priorities will mean that people don't have quite as much to put into it (Medical Director, Mental Health Trust).

But the need to ensure survival was not always successful as the following excerpt shows:

> We're going through incredible change. We were striving to become a community foundation trust […] and hoping to be one of the first in the country. Now we're unable to do that for reasons completely outside of our control, so it's another change. We were planning on becoming an organisation in our own right where we would be in complete control and in charge of what we were striving to achieve. A huge risk to that is whichever organisation we end up being part of, what's their view on Lean and our philosophy and way of working? (Quality Improvement Lead, Former Community Services Trust).

Those wedded to the NETS approach as derived from VMMC's with the VMPS were convinced it was the right approach and should be maintained. The following excerpt gives a sense of this dedication and belief in what the chief executive had been exposed to:

> I found the visit to Virginia Mason absolutely inspirational […] What it did was it showed me what a hospital can become with the consistent application of this methodology and entwining it with their leadership and management development strategy and their OD strategy. So it's like a rope. Each of the threads is strong but actually when you interweave it, it becomes even stronger (CEO, Mental Health Trust).

But as has already been mentioned, change of this nature takes time and embedding it cannot be rushed if it is to prove sustainable. The point is eloquently expressed in this excerpt:

> I think it's slow embedding. It's not been wham bam we are now displaying these behaviours. It's a slow embedding of the process. [It's] the same with the quality system. [A] lot of staff have been through improvement activity […] [and] they become quite passionate converts. [I]t's about displaying the behaviours but is a sustained journey. Initially the Trust committed to 10 years. I don't think we could do it rapidly. It's not something you embed as an organisation in rapid or a fixed time (KPO Lead, Mental Health Trust).

As mentioned earlier, the choice of Lean method was an issue for the field sites not all of which wished to adopt the VMPS. The following excerpts reveal the different views with the first subscribing to a loose-tight approach while the second adheres to a purist approach:

> We were signed up to NETS […] and whilst we have got a commitment to do Lean management techniques and make savings and efficiencies wherever we can, we just weren't using the VMPS (Director of Corporate Development, Acute Hospitals Trust).

> I know we will keep pure to the model [VMPS] and I want to keep pure to the model because there must be a reason why Toyota despite their blip has been the most successful car company in the world […] and the totality of the approach isn't applying Lean techniques in an ad hoc way, it's the way it's linked with their people management approach (CEO, Mental Health Trust).

And finally the excerpt below demonstrates a determination to keep to the plan set out prior to the NHS changes:

> [NETS] is sustainable in our trust […] we did initially commit to a 10 year journey. Despite the NHS reforms that direction of travel hasn't changed (KPO Lead, Mental Health Trust).

In the Table I we link the above interview excerpts to each of the four key factors from the Pettigrew *et al.* framework (see Figure 1). As is clear, these particular issues and concerns were raised and reinforced repeatedly by our interviewees, including others not cited here.

Whether any of the organisations which adopted the NETS approach can sustain their commitment to it matters in terms of their own investment in transformational change. But of course, the NETS was about much more than simply its adoption by individual NHS organisations. Its original purpose was about whole system change across an entire region and in that respect the NETS has been unable to prove itself. Further, given the nature of the changes taking effect within the NHS it seems unlikely that an opportunity to test fully such an approach will ever again present itself. However, although the story of the NETS may not have an unequivocally happy ending, it does provide important lessons for ensuring that complex change initiatives do not easily get abandoned or derailed when structures change and/or disappear and people, who perform as "product champions", move on.

Lessons to be drawn from the NETS story

There are four important lessons to emerge from the experience of the NETS. These may apply equally to any major system-wide transformation initiative that is confronted by major structural change of a type which alters the entire landscape and context in which the project has been conceived and prosecuted.

First, given that at least three, and possibly four, of our 14 sites remained committed to the NETS programme while other sites adopted some of its features but had not bought into the whole package, in particular the VMPS method, it may be that the precise choice of method is less important than to what purpose it is put and the fact that there exists genuine commitment to improvement. This refers to the loose-tight tension noted earlier whereby being permissive about means may be perfectly legitimate as long as the purposes and goals are tight in terms of their clarity and measurability in order to demonstrate improvement.

Second, allowing a degree of flexibility over means while being tight about ends may be optimal when the whole system is undergoing major change, and embedding that change, as we have seen, takes time. Those sites that decided to remain outside the NETS "club" of early pathfinders and subsequent joiners may have insulated themselves from the loss of momentum that followed the announcement of the 2010

Table I.
Four key factors from Pettigrew *et al.* framework

Pettigrew *et al.* context	Interviewee
Environmental pressure	Medical Director, Mental Health Trust; Quality Improvement Lead, Former Community Services Trust
Quality and coherence of policy	KPO Lead, Mental Health Trust; CEO Mental Health Trust
Key people leading change	Medical Director, Mental Health Trust; CEO, Mental Health Trust
Supportive organisational culture	Medical Director, Mental Health Trust; Quality Improvement Lead, Former Community Services Trust; KPO Lead, Mental Health Trust

NHS changes. After all, they were not dependent on the NETS "family" having retained their independence to decide on what particular mix of improvement methods worked best for them. However, at least two of the study sites which were strong advocates of the NETS project were also able to maintain momentum largely because they had been among the earliest adopters of the three-legged stool and had begun to embed its principles and ethos throughout the organisation. It was this steadfast approach, combined with committed leadership, which provided continuity.

Third, at a time of significant upheaval affecting virtually the whole health system, a top-down led approach to change which in effect the NETS was in many respects carries particular risks if it cannot be maintained and if key elements and individuals are removed and/or relocated. In such a context, and to minimise any risk of a change initiative collapsing entirely or of being overly reliant on an heroic individual, engaging individuals at all levels in the change effort by adopting a distributed or shared model of leadership may optimise the chances of the change initiative being maintained especially in complex settings (Bennett *et al.*, 2003; Western, 2008). Shared/distributed leadership is perhaps most effective where the tasks are interdependent, complex and require creativity (Hartley and Benington, 2010). Fulop and Mark (2013) refer to the importance of "relational leadership as a process of social engagement and co-construction" and a means of coping with the seeming irrationality and messiness of major changes and reorganisations that are driven for political reasons. These facets of complex systems are all features of the NETS where situations arise that require what Heifetz (1994) calls adaptive leadership. The issues and challenges confronting the NETS require front-line staff to come together to find solutions to problems directly affecting them in order to do their work more effectively. Possibly the ideal combination for an initiative like NETS is the existence of both individual leadership and shared leadership. The former style is needed to get the organisation aligned with the NETS vision, compact and method but the latter style is essential to ensure that these elements are embedded and sustained.

Finally, and linked to the last learning point, it is vital that change is embedded in the actual work and is located with those charged with doing it (Seddon, 2008). It cannot occur somewhere else and then be imposed on the work situation. The analogy here is with NHS North East which was the key driver for the NETS and which provided strategic leadership for the entire process. However, once it became clear that the health authority was not going to survive it resulted in the whole NETS approach becoming less region-wide and more focused on a few enthusiasts and their respective organisations.

Therefore, while it may be possible to sustain some elements of transformational change when a whole system is undergoing significant turbulence, it is unlikely that the region-wide ambition of what the NETS sought to do can be protected and assured.

Conclusions

From this review of lessons, a number of critical factors stand out in respect of maintaining a commitment to the NETS or, indeed, to any other similar large-scale transformational change process. None of these is especially novel or unexpected but it is their combination that is especially important since no single factor operating in isolation will be sufficient to maintain progress. We employed the Pettigrew *et al.* receptive contexts for change framework to guide both data collection and analysis. In the context of this paper and its focus on the impact of the 2013 NHS changes on the NETS programme, four components of the receptive contexts for change framework were especially significant in accounting for what happened. While a supportive

organisational culture and key people leading change proved to be pre-requisites for effective change, neither were likely to occur or prove sustainable if the other two factors – environmental pressure and quality and coherence of policy – were not aligned and pulling in different directions. If the general environment is unstable and policy is subjected to frequent shifts of direction for primarily political or ideological reasons, and uninformed by robust evidence, then preserving and sustaining successful change initiatives becomes especially challenging and unpredictable.

Implementing transformational change is always a complex and difficult business (Best *et al.*, 2012). It has been estimated that the success of any major transformational change initiative is likely to result largely from a mix of politics and context. Ovretveit (2012) has issued what he terms a "transferability warning" whereby transformational change is more likely to be implemented where the following conditions apply: there is strong evidence (accounting for 20 per cent of success); there is implementation competence (30 per cent); and the context, including financial and regulatory issues (50 per cent), remains favourable. If these three elements are aligned then the precise change intervention is far more likely to succeed. But, as he acknowledges, achieving such alignment is rare and more likely the ultimate fate of a particular change will be at the mercy of political pressures and contextual factors over which there is probably no control or even influence.

Paradoxically, the harder aspects of method, including the choice of Lean tools, are easier to implement. Much more difficult, and often beyond the influence or control of local stakeholders, are the political and cultural factors that shape and determine so much of what happens, or does not happen, in complex health systems. Perhaps the most significant lesson from the NETS is that achieving whole system change is particularly vulnerable to the vicissitudes of politics especially where that system, like the UK NHS, is itself subject to those very same pressures. All of which bears out Navarro's observation that despite having an enormous influence on health policy, the political context is frequently avoided in academic research (Navarro, 2011). Yet, it was a Prussian pathologist turned anthropologist turned parliamentarian, Rudolf Virchow (1821-1902), who famously wrote: "Medicine is a social science, and politics nothing else but medicine on a large scale". The play of politics at a national level sealed the fate of the NETS and has largely determined what it has evolved into rather than what it might have become (Virchow, R. Quoted in Miller, 1973).

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