

# The Development and Implementation of NHS Treatment Centres as an Organisational Innovation

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***Report for the National Co-ordinating Centre for  
NHS Service Delivery and Organisation  
R&D (NCCSDO)***

***December, 2006***

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## **Executive summary**

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### About this report

This three-year study examined the 'journeys' of eight National Health Service (NHS) treatment centres (TCs) as organisational innovations. In order to do this we:

- 1 conducted a technical evaluation (incorporating mathematical modelling) both of the concept and actual impact of TCs as an innovative way of delivering health care within the NHS
- 2 studied – using qualitative methods – the organisational and social factors associated with the development of TCs in order to demonstrate how these impact upon the implementation process and its outcome.

This report is based on data we collected through over 200 interviews with key stakeholders within the TCs, their host trusts and their local health economies; observations of meetings, of TC practices and general interactions; and documentary analysis of business plans, trust governance documents and marketing materials. Our synthesis of these data, together with the mathematical modelling exercises, was used to develop a series of key findings of relevance to policymakers, service planners, practitioners and those interested more generally in the diffusion of innovation and change management.

The cultures of our eight sample sites that chose to open TCs were all very different. We found a range of management styles, aspirations, interactions and drivers within the TCs. However, the one factor which united them was the sense that this particular organisational innovation was timely and necessary; alongside this we found a 'can do' mentality and the presence of some core 'champions' who were keen to implement this new organisational form. The milieu of the nascent TCs – their local health economy including the host trust, the primary care trusts (PCTs), the strategic health authority (SHA), neighbouring trusts, and their own internal staff – also showed a wide range of relationships that appeared to run along a continuum from hostility and conflict with most of the major stakeholders, through to much more harmonious and constructive partnerships with the major players, with examples of most points somewhere in between these extremes.

The local organisations that took up the challenge of establishing a TC did so for a wide variety of reasons. In addition to the generally favourable policy environment, local motivations to open a TC were often rooted in local history and context (for example pressure to find new capacity to treat patients on their own or other hospitals' waiting lists, a stalled plan to relocate surgical services or open a day-surgery unit, the need to find a use for an underused hospital building, the chance to engineer changes in local professional influence, and so on), which conspired to drive each local initiative forward. While to some extent these motivating factors were unique to each of our sites, some common features emerged.

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Firstly, the people. The decision to apply for TC funding inevitably resulted from the resolution of a number of often conflicting views (which we have referred to as contests of meaning). These were clearly influenced by key players who were themselves subject to pressures from the internal and external milieus of their organisations. For example there may have been – and usually were – idealists who saw the TC as a specific opportunity to transform patient care. But there were nearly always sceptics who saw it as yet another fad, opportunists who wanted to secure funding to develop a new service that was – in their view – much needed, and pragmatists who wanted to do whatever seemed most likely to improve services with minimum fuss. Even where there was consensus among those with the power to make the final decision, there were always discrepancies about their underlying motivations, rationales and intended outcomes, resulting in evolving and constantly negotiated clusters of decisions that gradually emerged as something approaching (at least) some of their initial visions of a TC.

Secondly, a unifying thread in the various reasons why these sites developed TCs is the sense that they wanted to bring about change – to ‘improve quality’, to ‘improve quantity’ or to ‘improve kudos’. In improving quality sites determined to transform the elective care environment (for example new buildings, infrastructure and clinical and administrative practices). This included fundamental reform of traditional clinical practices and transformations in skill-mix. In improving quantity the case studies were hoping to increase capacity, throughput and activity, and in this they were tightly coupled to a performance agenda set down by the Department of Health which was concerned with reducing waiting times and increasing activity. In improving kudos for the organisation the sites were hoping their TC would make their organisation more competitive (or at the very least prevent them falling behind and becoming uncompetitive). Some sites also used ties with external stakeholders (SHAs, the NHS Modernisation Agency or the Department of Health) as a way for the TC to improve the profile of the wider trust (or of key personnel within it).

Thirdly, all our sites experienced a variety of problems related to imprecise planning, financial setbacks and (usually) overcapacity, and all experienced some degree of evanescence of some of the original motivators for change, such as the principle of nurse-led care or other shifts in professional roles. For a variety of reasons, almost none of the TCs was able to plan and predict with any consistency or precision even such basic parameters as the numbers and types of patients they would treat. The way that the TC fared once it had opened depended partly on the changing state of the local health economy which was shifting constantly in the maelstrom of central initiatives and the very varied local responses to them. These included a programme of independent (private) sector TCs as part of a wider governmental push towards involvement of the private sector in the delivery of care, presaged in *The NHS Plan* (Department of Health, 2000a); the introduction of Payment by Results (Department of Health, 2002a), a new system for reimbursement; and the simultaneous introduction of the Patient Choice initiative (Department of Health, 2003a) and the Choose and Book programme (Department of Health, 2004a). Many of these had not only indirect but direct impacts on the ways the new TCs functioned (for example the financial incentives – or disincentives – for local trusts to send them patients). The outcome for each site depended on how the managers of the TCs were able to

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respond to this rapidly changing environment, which in turn depended on the relationships they had with key stakeholders in their local health economies. In this respect the TC managers and those of their host trust were, by their responses, enacting the environment with which they subsequently had to cope (for example, by the kinds of competitive or collaborative relationships they established with key local stakeholders).

Despite the turmoil, however, there was often perceived to be a positive impact on patient flows – such as increased throughput and a decrease in waiting lists – and significant innovations in the processes of care. These included preoperative assessment done by nurses via a questionnaire, a nurse-led clinical pathway about which patients were fully informed before arriving at hospital, well-honed individual care pathways with key milestones (based albeit sometimes controversially on models from the United States [US]), case managers in charge of discharge planning, PCTs providing planned intermediate care, and considerable redesign of the workforce and the physical environment in order to accomplish these new ways of working. But often the eventual changes were relatively superficial ('first order' rather than 'second order' transformation). By the end of the three-year study, three of the eight sample sites remained (partially) identified with the NHS-run programme, one had closed, one had been bought out by a private health care provider and three were at some stage of becoming linked with the independent sector. Only one of these appeared to have weathered the storm by emerging as a stand-alone NHS TC which closely mimicked the original exemplar of the policy model of what an NHS TC should be.

Finally, while we have shown that it is possible mathematically to model ways to optimise patient flows and bed capacity, the planning capacity of NHS management in the frenetic environment in which TCs were being developed meant that such considerations appeared much less relevant than perhaps they ought to have been. It was possible through our mathematical modelling to show, for example, that there were some circumstances under which the introduction of a TC might be predicted to offer little if any benefit to the local health economy, and indeed that serious problems of overcapacity might result (as in the event it did do, in just the kinds of sites that the model predicted). Yet despite the apparent strength of such logical argument, the local political and clinical context, motivations and environments would have made it impossible for such a finding to carry any weight in the complex evolution of plans, negotiations and implementation that occurred in all eight case study sites.

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## Practical implications of the research

### ***For policymakers***

- 1 Top-down, target-led central innovations will inevitably be recrafted at the local level to suit local needs and build on existing initiatives; they need therefore to retain appropriate flexibility (headroom) if they are to be crafted while still successfully fulfilling their core objectives.

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- 2 Policymakers should try to facilitate local innovation using 'design principles' that acknowledge the likelihood that rational planning of innovations will be limited in both its feasibility and its applicability in the 'volatile environment' of NHS management.
- 3 There should be more rigorous evaluation of innovative policies while they are on the drawing board, and where this reveals strong evidence – for example from modelling techniques – that problems will arise from the widespread implementation of an innovation, caution should be exercised.
- 4 Assessments of the likely impact of new policies on those that are already working their way through the system should be undertaken before a new policy is introduced nationally.
- 5 Even where an organisational innovation has all the attributes of likely success (for example it is widely acknowledged to have high relative advantage; it is apparently compatible with the values, norms and perceived needs of those who are expected to adopt it; and it has the potential to be adapted to a range of local requirements) there is no guarantee that it will work. It is also necessary to explore very carefully the potential interaction between the innovation, its intended adopters and its context when assessing the likelihood of successful implementation.
- 6 Specific training may be required among managers at all levels of the NHS, as successful implementation of organisation-wide innovations require a high level of both strategic and front-line change management skills, which are often in short supply.
- 7 Where an organisation's existing knowledge and skills base are insufficient, then the use of external change agents to support implementation may be required but is unlikely to succeed unless there is a common language and values system, and shared meanings between the policymakers, the facilitators and the front-line innovators.

## ***For change leaders and management practitioners***

Service innovation is a social and organisational process, which means that the *management* of innovation is predominantly an issue of managing the social and organisational factors associated with that process. We have identified 74 such factors from our research on TCs. We have detailed these at the end of this report in the form of 'design principles' for managing innovation in service delivery and organisation. These 74 principles are categorised in Section 10 under seven headings:

- 1 dealing with complexity, non-linearity and unpredictability
- 2 creating 'enabling' structures and systems
- 3 navigating the politics of innovation and securing stakeholder engagement
- 4 building the innovation network
- 5 creating a learning process
- 6 changing behaviour and culture

- 7 leadership.

### **Implications for future research**

- 1 Research is needed on the appropriate balance between centrally-generated innovations and those that are generated locally and disseminated laterally. The intended shift in the policy environment from the former to the latter will provide an interesting natural experiment.
- 2 Work is needed to help develop and evaluate the concept and use of 'design principles' in facilitating successful innovation. For example, within the new NHS policy context it might be possible to work with SHAs (perhaps using an action research or formative evaluation design) to explore the place of design principles for organisational innovation at the local level.
- 3 The nature and place of 'positive organisational scholarship' – a management paradigm which focuses on positive aspects and identifies opportunities (Camerson *et al*, 2003) – should be explored as a means of fostering a more receptive environment for organisational innovation.
- 4 We need to understand more about how middle managers such as the managers of the TCs and front-line NHS staff in general – given their central role in innovation – make sense of and therefore contribute to change outcomes in different change contexts. Relatedly, more work is needed to understand how the inevitable contests of meaning in multi-level and multidisciplinary organisations can be more successfully reconciled.
- 5 What are the sources of evidence that decision-makers draw upon when making the decision to innovate, and how are these played out in the negotiations and debates that precede the decision and subsequently shape its journey? In particular, how do political and power relations and organisational roles impact on this process?
- 6 A study is needed to explore the barriers and opportunities for change based on the findings of theoretical planning exercises and operational research studies. In particular what might better facilitate the influence of such evidence on service delivery and organisation within the NHS? Relatedly, a study is needed that explores the ways in which modellers and operational researchers might dispel the 'Cassandra complex' that currently affects much of their work.
- 7 A highly relevant methodological question is how researchers can best handle the problem of studying an organisational entity that is subject to a range of – sometimes incompatible and/ or shifting -meanings held by key players.

**Disclaimer**

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health

**Addendum**

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact [sdo@southampton.ac.uk](mailto:sdo@southampton.ac.uk)