Improving the effectiveness of complex national service change programmes in health care

Report of findings from consultation interviews

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Executive summary

Introduction

National programmes are a set of activities run by national bodies which aim to secure large-scale improvement or service change in public services or policy. This project aims to fill a gap in the current evidence and support available to programme leaders about how to design and deliver these programmes, specifically in health care. The intention is to co-design a practical framework for staff working in health and care organisations drawing on existing guidance and tacit knowledge from people with practical experience from national programmes.

This report collates insights from interviews with 17 people who have experience in senior roles delivering complex national health care programmes. They have been used to inform the draft framework that will be tested with a wider group of stakeholders.

This project is funded by the Health Foundation. It is a collaboration between THIS Institute (The Healthcare Improvement Studies Institute), Ipsos, and the Health Foundation.

Context for national programmes in health care

Exploring why programmes happen nationally, and how the health care sector differs from other fields of public policy, are necessary first steps.

Programmes tend to happen nationally when they: require a centralised skillset, legislation or national policy levers to make a change; standardise practice at a national level; benefit from economies of scale; require the level of resources that prompt HM Treasury approval; and, more subjectively, focus on issues of political sensitivity and priority.

The specific characteristics of the health care sector that influence the design and delivery of national programmes include:

- The political resonance of health care services among voters which influences priority-setting and the level of scrutiny on health care programmes;
- The diffused power structures and influence of different health care organisations and their regional authorities, patient and professional groups, unions, regulatory regimes, and commercial organisations;
- An institutional structure that has (over the last decade) been designed to have more independence from Government;
- A diversity of professional hierarchies; and
- The level of public spending the health care sector absorbs.

What does good look like when designing complex national programmes?

The experiences and learning from interviewees have been distilled into five themes that inform what to factor into national programme design.

1. **National programmes in health care are delivered in a politicised environment.** Interviewees emphasised the centrality of politics to national programmes and its essential (if challenging to navigate) influence on decision-making, priority setting and expectations.

"Essentially it was like misdirection and a magic trick. I'm keeping the people here who want a billion pounds of savings [updated with progress] And over here, I've got my entire team spending their time trying to work out how can they actually make this work."

This means that leaders of national programmes have to: articulate a vision all can get behind; consider how to pitch potential solutions that speak to politicians' biases for the new while keeping engagement from front-line teams who have long-term experience; and navigate differences in the definitions of success.

2. **National programmes are expected to fix health care's biggest problems, but there are nuances in understanding what these problems are.** In the pressure to find and quickly implement solutions to problems, programme designers rarely factor in enough time to explore and build a nuanced understanding of the problem and potential solutions.

"It can be quite easy to run very quickly at standing up a programme [...] without stepping back and thinking about whether that is genuinely the right way of solving the problem."

This means that leaders of national programmes should consider problem identification "mission critical"; the problem in question should be explored from different analytical, economical and emotional perspectives. It is then important to establish a clear scope and priorities for the programme's intervention(s) that addresses the identified problem and is deliverable nationally.

3. **National programmes in health care navigate a distributed power structure and multiple stakeholders.** The complexity of the stakeholder map for health care programmes means programmes require a considerable focus on engagement and communication tailored to different audiences.

"You might talk about oranges, apples and pears to the treasury, but fruit salads and trifles to the NHS."

This means that leaders of national programmes should understand their stakeholder landscape, power bases, how decisions are made, motivations and drivers of behaviour, and creating opportunities for influencing and learning.

4. **National programmes in health care require multiple and varied strategies for influencing decisions and behaviours**. Interviewees' experiences suggest that national programmes should consider how to influence and align decisions and behaviours.

"The plan was that we want as many people with skin in the game as possible."

This means that leaders of national programmes have to plan how to use:

- Incentives that can be tightly controlled and influenced, such as funding, additional staff resource, regulation, monitoring and performance management;
- Guidance and adaptable specifications that provide slightly looser and adaptable levels of influence and control; and
- Opportunities for encouraging (but not controlling) buy-in through programme support, evaluation and learning.

5. **National programmes in health care need leaders who are adaptive and credible on many levels.** A range of desirable characteristics of leaders of national programmes were identified. These are, at times, contradictory and include: being proactive and responsive to opportunities; being open to input but decisive; a connector and interpreter, but also willing to challenge; political astuteness, and a creator and leader of their teams.

"The government priorities move on. [...] The phrase I've used is we need to surf every wave that comes along."

Implications and next steps

Responses from the interviewees, and the variety of national programmes they were reflecting on, suggest that the high-level content of a framework to guide the design of national programmes will be consistent across the diverse portfolio of potential future programmes, with some nuances that will need to be tested further in the co-design process.

Feedback from interviewees is that, while there is no one winning formula for successful national programme design and implementation, guidance based on learning from previous programmes would make a contribution. This would bring to life the challenges programme leaders face, and provide some tools / advice for navigating them.

Section 1: Introduction

Background to this project

National programmes are a set of activities run by national bodies which aim to secure large-scale improvement or service change in public services or policy. In health care, the wide variety of types of national programmes reflects the diverse range of service delivery, political objectives for the health and care system, and views about how to make improvements. They tend, by nature, to be complex, delivered across diverse contexts, and high political priorities.

The design and delivery of national programmes is one of the principal ways the Government and its arm's length bodies reform services at scale. A significant proportion of the UK's national income is spent supporting them[1], and they are central components of all political parties' manifestos.

There is a rich literature, existing knowledge base and published guidance available to those responsible for designing, delivering and evaluating such programmes. However, bespoke guidance for policy makers to support design of complex programmes specifically in the health care field has been lacking. This forms the overall rationale for the Health Foundation's support for this project.

Aim and audiences for this project

This project is being carried out to fill a gap in the current evidence and support available to programme leaders. Much of the existing evidence and guidance is diffuse. It is often cross-government and not specific to the particular requirements of health care policy and services delivery. The tacit knowledge, know-how, and people's experience of delivering programmes in the sector is rarely captured and shared in formalised, structured ways. This project therefore set out to capture this information and bring it together into a practical tool that individuals and teams can use in the future.

The overall aim of this project is to co-design practical guidance[2] on how to design and deliver health care programmes. The intended audience is staff working in health care organisations, particularly those with a national policy role. The guidance may take the form of a framework which policy teams can use to inform their decisions. It should answer the question "what does good look like when designing complex national service change programmes in health care."

[1] In 2024, the Infrastructure and Projects Authority reported that the Major Government's Project Portfolio, comprised of 227 projects, had a whole life cost of £834bn. This included several major healthcare programmes.

[2] Given the current uncertainty about the format and structure of the final product, throughout the report, 'guidance' and 'framework' are used interchangeably.

The framework will draw on existing guidance on good practice, the knowledge from those that have been involved in these programmes, and a wider consultation with senior public servants. It starts from the assumption that there is guidance already available for those designing and running these programmes but that a new product of this sort will build on what is available. This is because it will:

- Capture the tacit and experience-driven knowledge which those in senior posts in the sector possess.
- Incorporate a user testing phase – to follow this output – which aims to make sure the product is suitable for those who might use it in future.
- Benefit from the mix of experience the Health Foundation, THIS Institute and Ipsos teams collaboratively bring to delivering and steering the project. This includes their different experience of analysing, researching and collaborating with national programmes.

There is a large potential audience for the product. The main target audience is public servants, working in the NHS, the Civil Service, or other public bodies. They will work for the organisations which fund, design, deliver and evaluate programmes at the national level. These staff will spend time on programmatic work, as opposed to the core business of the organisations. The product could also potentially be of interest to people working in other policy areas, or jurisdictions (locally, devolved health and care systems), and academic / other researchers.

About this report

Ipsos was commissioned to conduct 'think-aloud' formative interviews with up to 20 stakeholders who are experienced in running complex programmes in health care. The aim was to elicit the tacit knowledge that people have gained through their involvement in the design, delivery or evaluation of these programmes. The discussions were semi-structured, but highly tailored to the individual's programme experience.

This is a report summarising the findings from these interviews. It is a key interim output of the project. It summarises the findings from the interviews about what good looks like when designing national programmes, synthesising the main themes from all interviews. It is influenced by stage 1 of the project (a literature review, conducted by THIS Institute, which influenced a first draft of the framework); and will shape stages 3 and 4 which will involve further co-design and user-testing to refine the framework.

This report includes a substantial number of quotes from the interviewees to illustrate and bring to life the analysis. While the report can be read without them, they are included to enable a more nuanced depiction of interviewees' experiences and learning.

Method

The research tools, and a full overview of the methodology, are in the appendices. Key points for the reader to be aware of before reviewing the findings are:

- The name of interviewees and list of the national programmes discussed are not disclosed in this report to preserve the anonymity of interviewees.

- The list of programmes and interviewees was collaboratively chosen to represent a mix of infrastructure and service improvement programmes, with interviewees holding senior roles. The sample included individuals involved in national strategies and payment mechanisms for their role in enabling national change.

- A total of 17 interviews were conducted between December 2024 and February 2025, with a high response rate to invitations.

- Interviews lasted between 40-90 minutes and were guided by a framework prepared by THIS Institute, focusing on potential pitfalls.

- The interviews were recorded, transcribed, and analysed thematically, using both deductive and inductive approaches, ensuring interviewee confidentiality.

The main limitations of this approach relate to the following:

- **Definitions of programme.** The literature review captured a range of commonly understood definitional characteristics of 'programmes' which are consistent across policy areas and polities. However, even with the guardrails of this definition, there is significant variation in what programmes focus on. Within this sample, there were programmes with budgets that vary by orders of magnitude, and with diverse remits ranging from building national infrastructure to behaviour change interventions. In describing the findings and retaining the anonymity of interviewees, the analysis may not sufficiently explore the nuances and differences across various national programmes.

- **Potential interviewee bias:** Interviewees included people involved in current national programmes, as well as historic programmes (some interviewees had been involved in designing national programmes for over 20 years). The changing contexts and strategic distance may have influenced their responses, and how diplomatic or open they were willing to be in their assessment of success.

- **Partial perspective**: The interviews were seeking for breadth of insight of up to 20 different programmes, rather than a rounded assessment and different perspectives on a smaller number of programmes. As a result, the interviews provide a partial perspective from people in specific roles, about their leadership and actions. These views were not corroborated or explored with others who had worked on the same national programmes. The majority of interviewees were white, male and in senior clinical or civil service roles. Consultations with a broader range of staff, with varying seniority levels, was intended to be explored in latter phases of the project.

- **Potential interviewer bias**: The perspectives of the Ipsos interview team have influenced the approach to the interviews and interpretation. The role of external evaluations

commissioned to academics and private sector consultancies has come under criticism from some interviewees. Both Ipsos and THIS Institute acknowledge their role and perspective on this specific issue. This report reflects the authors' analysis of the interviews conducted. While the interviewees provided their insights openly and honestly, any omissions, misinterpretations or inaccuracies in the presented findings are the responsibility of the authors.

Section 2: What is the context for national programmes in health care

An overview of the landscape

Before reflecting on what 'good' looks like for designing complex national programmes, this section addresses two questions which are foundational to this project: 1) Why do programmes happen nationally; and 2) How does the health care sector differ from other fields of public policy in relation to the design of national programmes. These questions are considered here, as they influence the findings that follow.

Why do programmes happen nationally?

The health care sector is led by a large, well-resourced central Government department with several large arm's length bodies and professional institutes with devolved decision-making, regulatory powers and/or oversight for professional standards. Different spending and operational decisions have also been devolved to regional bodies (such as ICBs and PCNs) as well as to individual organisations (such as hospital trusts or care homes).

Despite this devolved power structure, throughout the life of the NHS, there have been many programmes driven from the 'centre'. These national programmes, despite their variety in focus, resources, and success, tend to (but do not always) focus on issues which:

1. Require centralised skillsets, legislation, authority, or 'levers'[3] (possessed by national actors) to make the change.
2. Focus on reducing unwarranted variation or to standardise practice at a national level, rather than being locally or regionally determined[4] (though some may also involve a broad model that is nationally mandated but locally designed).
3. Benefit from economies of scale from implementing nationally. This may relate to procurement of infrastructure or for rolling out something that is known to work efficiently and effectively.

[3] This term came up in several interviews– it refers to the legal, financial, regulatory, or other approaches actors can take to influence public service delivery.

[4] A national programme can be 'piloted' in particular locations (i.e. not nationally), but the definition of a national programme is that the intent, at least, is for this to influence / be available to all areas. The choice of pilot sites is often made to maximise the potential for national learning.

4 Require the level of resource to implement that requires a business case with the Treasury for approval (which varies by Department but is generally once cases reach the millions of pounds).[5]

5 A fifth, more subjective, factor is common in the politically sensitive field of health care. National programmes often focus on issues which have a high level of scrutiny or are a current national political or public priority. The 'prize' (politically, for patients, or population health) for fixing the problem nationally is often seen as significant.

A national programme may not necessarily be scoped around a single solvable or tangible problem. There is often a level of risk and uncertainty, and failure. Furthermore, the five features we identify above may not be sustained indefinitely; for example, the justification for a programme to have national infrastructure may change.

Once established as a national programme, they can attract large budgets. This is not universal, as some of the programmes examined in these interviews were delivered by small teams with relatively modest budgets (in cases, with success).

How does health care differ from other sectors or fields of public policy in relation to the design of programmes?

Each area of public policy has its own interests, challenges and characteristics. These influence how programmes are designed and run in each policy area (or across areas). The following characteristics, which apply *only to*, or *more strongly within*, health care compared to other sectors, significantly influence the design and delivery of national programmes.

- **Political resonance.** The delivery of health care services is consistently among the most resonant issues influencing voters.[6] As well as the *scale* of the interest, the number of *different* priorities national decision makers have to weigh up is striking. In this political environment, it is challenging to identify a small number of issues to focus resources on (to prioritise) through programmes. In this context, it is not surprising that the sector has a large, varied, passionate, and (sometimes) well-funded eco-system of interest groups (including charities, patient groups and unions).

[5] Other factors that might initiate HM Treasury review of business cases include if the policy is novel, controversial or if it introduces a repercussive spending commitment that might become embedded in the department's future spending

[6] Ipsos, March 2025. Ipsos Issues Index: March 2025. https://www.ipsos.com/sites/default/files/ct/news/documents/2025-03/Ipsos%20Issues%20Index_Mar25_Charts.pdf

"We tend to do it on the basis of political will too often rather than actually [whether] it's a priority. So Secretary of State says we must do, and therefore we do it rather than say, actually, Minister, you'd be better off doing something different."

- **Diffusion of influence/power.** The sector is characterised by diffused power structures. While central policy and economic influences similarly affect other sectors, those specific to health care includes the influence of patient groups, medical and clinical influence, and sector-specific financial and regulatory regimes. For example, staff may be employed within individual NHS organisations or local authorities, affecting where the long-term costs of a programme will sit. Each of these organisations are often large entities (in revenue, headcount, and local importance) themselves; with this size can come a high degree of independence, and their own change priorities and programmes. There is also a geographical diffusion of influence, and commercial market interest. For example, across social care, there are private sector providers who have different financial incentives to GPs and hospitals. At a minimum, this requires the various influences and actors to be considered in programme design, as well as enhanced levels of stakeholder management and governance requirements.

"This is actually quite an important dimension of the NHS equation. It's not just a money and service strategy. If you don't have the people strategy in there, then it's not going to work."

- **Unique institutional structure.** Over the past decade, a large proportion of the strategy setting, and policy direction, has resided with NHS England, a non-civil service organisation, with its own organisational culture, decision-making structures, and independence from Government. This was not accidental; the logic in the legislation which led to its establishment was to move decision-making about aspects of the sector to an organisation with less proximity to direct political influence, and with a staff which included high proportions of clinical and NHS management experience.

- **Professional hierarchies**. The culture within health care is influenced heavily by professional hierarchies within the clinical profession, which reflects the level of specialisation, risk and division of labour. While professional hierarchies undoubtedly exist in other sectors, the diversity of clinical roles and how they interact across different types of organisations (for example hospitals, GP surgeries, mental health providers, and community health care providers) adds a specific dimension to the power bases within health care. Managerial hierarchies outside of clinical roles is influenced by the decision-making authority of different teams or organisations (within individual or regional NHS organisations or across NHS organisations nationally) which can change depending on the policy context, level of scrutiny on a policy or

programme, or performance of the organisation.[7] Interviewees' experiences are that these hierarchies have the potential to disempower; they can disincentivise decision-making, innovation and pace of change.

"[It is] a very hierarchical organisation is probably a diplomatic way to frame that."

- **Public spending.** The health care sector absorbs a large proportion of the UK's national income, in part because of growing need, and in part because of the political resonance of health care services noted above. This draws the focus of those in government charged with assessing and monitoring spending.

Implications of this context

The challenges of delivering programmes nationally, and in a sector with distinctive features, results in a highly complex landscape. The notion of 'complexity' and how it informs actions was a common theme in interviews, in relation to all parts of the programme cycle.

Complexity relates to the uncertainty/unpredictability of outcomes, and diversity of people who are involved in, influence or are affected by the intervention. Even in cases where the interventions themselves are relatively straightforward (such as an infection prevention and control programme, a vaccination programme, a surgical care bundle), the extent of the change required to alter behaviours and organisational processes makes the implementation of these interventions complex.

"It's not just to an academic process. It's hearts, minds, politics, understanding the constraints and [...] aspirations of different organisations and how you pull those together."

Complexity also derives from the decision-making processes within the politicised and hierarchical context of the health care sector. This results in high budget, high profile programmes that may been developed without a fixed intervention or understanding of how the solution will interact with the wider system. Different people will want different things from them, want to be involved in detailed decision making, and there will be a high level of uncertainty and evolution required.

[7] A 'command and control' structure may be enforced due to national directives (such as during the Covid-19 pandemic) or in response to a specific failing in care.

"These big programmes are complex because different people have different expectations of them."

"Part of the politics and charisma that you need to get a project funded and off the ground are really reliant on a really strong benefits case. But it's often being drafted at a time when you haven't scaled the programme, you haven't done any detailed planning, you're not quite sure what funding envelope you're going to get... So I think some of this is just about data availability and the timing."

This complex environment also has implications on evidence and evaluation practice across the health care sector, which varies significantly by organisation and programme. Three themes should be considered in the design of national programmes related to the particular features / approaches to evaluation.

1. Embedding evaluations within programmes offers evaluators access to decision makers, and an ability to influence programme delivery with evidence quickly. However, this mode can also present a risk of the evaluation being co-opted by the programme, particular in a context where many health care-focused programmes are tightly associated with particular individuals, ideas/ policies associated with a particular political position, or organisational interests.

2. The position of professional analysts/ evaluators within organisations varies widely across the sector. Senior, independent analysts, supported by (analytical) professional structures, and with ready and regular access to the most senior decision makers, can be a predictor of effective decision making.

3. The differences in practice highlighted here can contribute to varied outputs (in quality and style).

With this overview in mind, the report now sets out interviewees' views on how to navigate the unique features and complexities of health care when designing national programmes.

Section 3: What does good look like when designing complex national programmes?

Thematic analysis of interview findings

To explore the question with interviewees of what 'good' looks like when designing complex national programmes, the consultation interviews considered common pitfalls in national programme design (identified from a literature review) and how the interviewees experienced these. This included topics relating to:

- Decision-making processes.
- Roles, responsibilities and capabilities.
- Governance and leadership.
- Delivery models.
- Risks and uncertainty.
- Learning and evaluation.
- Monitoring performance.
- Stakeholder engagement.
- Supply chains and procurement.

This analysis brings the interviewees' reflections on these topics together with the specific contextual features described above under the following five themes:

1. Politicised environment
2. Problem identification
3. Distributed power structures
4. Strategies for influencing decisions and behaviours
5. Expectations and skills for leadership.

1 National programmes in health care are delivered in a politicised environment

What are the key challenges for national programmes?

Despite devolution of some powers and decision-making to different organisations and agencies, interviewees were universal in identifying the centrality of politics to national programmes. What interviewees described as 'politics' related mostly to partisan decision-making and the influence of the Government's (often, in their view, short-term) priorities on their programme design and leadership.

> **"Politics is everything in health care [...] the whole of health care is governed by what the top says."**

> **"There's a big political driver for investing and trying to fix a problem and a lot of pressure to achieve certain targets [but] those targets might be at odds with [...] what's feasible."**

The principal ways that interviewees suggested that national-level politics affected their programmes were the:

- Scale and speed at which the solutions are expected to be applied.
- Mismatched expectations and priorities between those working in political roles compared to those in clinical and operational-facing roles.
- High level of scrutiny in the design and implementation of their programme.

> **"You have to have the ear of all of the clinicians in England as well as the general public and government."**

While interviewees identified this politicised environment as presenting many challenges, the high-level political attention was also recognised as essential for a specific health care issue getting to the top of the priority list and having resources assigned to it.

> **"You've got to have a burning platform. You've got to have people say, this really matters."**

What does this mean for programme design?

Interviewees identified different strategies they had used to navigate this context. The analysis explores these across three themes:

1. Having a vision that people at all levels can get behind.

2. Framing the 'innovation' within proposed solutions.
3. Navigating technocratic targets v other definitions of success.

1.1 Having a vision that people at all levels can get behind

Interviewees acknowledged that, while there may be nuances in what people care most about, or why they want to get behind a particular programme, the overarching vision should be unifying and clear. Interviewees reflected on experiences that highlight that, for a programme to withstand changes in government, the vision cannot just be politically-motivated; it has to have a unifying 'case for change' transcending parochial, or time-limited, interests.

"Find something that people can get behind or find areas of commonality."

"Get something people care about because if they don't give a toss about it, they're not going to do it."

How national programme leaders interpret the vision set by politicians and make a tangible case for a more specific programme area is a key skill – this is considered in more detail below with the discussion on problem and solution identification. Programme leaders identified that the skill (or the challenge to overcome) is how health care leaders position their programmes around a consistent and unifying vision, but can also ensure there is a 'narrative' that resonates at different levels or to different opportunities for the programme to remain a priority. This is a particular challenge for programmes that run over several years.

"Making sure that your narrative can pivot as quickly as it needs to [to] make sure that you can still demonstrate the case for change and why it's important to new people with different priorities."

1.2 Framing the 'innovation' within proposed solutions

Once the problem and programme scope have been defined (discussed below), interviewees reflected on the need for a delicate balance in how solutions are presented to different stakeholders. Interviewees cited their view that there was a bias among political actors for "innovation" and "radical ideas" to address entrenched problems, rather than returning to ideas from the past. This can present issues for programme design if the evidence base and learning from previous programmes is not sufficiently explored. It can also disengage front-line teams who have long-term experience, scepticism about politically driven change programmes, or change fatigue from being on the receiving end of constant upheaval and short-term programmes.

"[Politicians] want to come in and do new things and [say…] we're not going to do the same things that we've done before. But actually some of those things do work."

"[There's] frustration from stakeholders, they're like "okay, so we've invested this in [new programme], but how do we know that you're not just going to move on to the next thing"?

The challenge for programme design in a politicised environment is therefore to explore, then articulate, how the proposed solution links to what has gone before, while drawing out the novelty or innovation in this new programme.

1.3 Agreeing appropriate measures of success, and communicating progress

Interviewees described the pressure for quick results and the need to deliver on ambitious and potentially unrealistic targets. Identifying clear measures of success, that are acceptable to both the political decision makers and delivery teams was identified by interviewees as a challenge. For example, the interactions with the Treasury, including to sign off on budgets, agree objectives, and report on benefits, may happen before a programme has been fully scoped but will provide the basis for the targets for the programme. For most interviewees, understanding how senior programme sponsors were engaging with Treasury officials was central. There is therefore a leadership imperative to manage the tensions between what one interviewee described as "technocratic targets" (objectives agreed with Treasury/ sponsors as part of business case development) to more realistic or achievable targets that delivery stakeholders can get behind.

"What my technocratic targets are, versus, are we making the progress that we want to be making is a really important distinction to make."

Interviewees suggested that success in balancing the needs of various programme stakeholders is maximised by regular and effective communication and negotiation with the programme's political champions.

"That triangle between treasury, minister and a programme, that's where the decision making happens. They are all in healthy tension with each other. That is where you're constantly going back up [to the decision makers:] "here's your option, here's your option, here's your option," based on that tension between the politics."

"Essentially it was like misdirection and a magic trick. I'm keeping the people here who want a billion pounds of savings [updated with progress] And over here, I've got my entire team spending their time trying to work out how can they actually make this work."

What are the key points for a framework?

A framework detailing how to design national programmes in a politicised environment should include guidance and case studies on how to proactively and/or opportunistically:

- Set the vision for a programme and recognise the importance of this in generating support from the varied stakeholder map; ensure that politically-driven visions are not unchallenged.
- Develop and articulate solutions in a way that people can get behind.
- Consider the reporting and communication mechanisms for monitoring progress towards targets, acknowledging that programme targets serve different purposes for different audiences.

2 National programmes are expected to fix health care's biggest challenges, often swiftly, despite their complexity

What are the key challenges for national programmes?

As described above, national programmes often focus on issues that are high national, political or public priorities. The politicised environment can result in pressure to find and quickly implement solutions to 'fix' a perceived problem, without fully understanding the nuances of what the problems are and what the appropriate solutions may be. This can affect the programme design phase which can be rushed to rapidly understand the problem, without considering the variety of evidence and stakeholders' views on the problems and potential solutions.

> **"We collectively have become fixated on a solution to a problem, rather than whether that solution was necessarily solving the challenge we needed to solve. And it can be quite easy to then run very quickly at standing up a programme to deploy a particular solution without stepping back and thinking about whether that is genuinely the right way of solving the problem."**

Interviewees identified instances where this stage of programme design had gone wrong when:

- The boundaries and priorities for the programme are not specified well.
- Solutions are proposed before the problem has been considered.
- Vested interests of different stakeholders are not aligned around the problem.
- The problem is not solvable with the tools at the programme's disposal.
- Progress to address the problem cannot be quantifiably measured.

What does this mean for programme design?

2.1 Problem identification is "mission critical"

This was one of the most widely held and strongest sentiments from across the interviews. Interviewees recognised that designing a successful programme in response to a broad vision for change, starts with a nuanced understanding of what the problem is from different analytical, economic and emotional perspectives. This process can take time but is essential to assess whether the proposed solution is appropriate and feasible, and whether it will get support from different actors.

"First of all, we had to get people to believe there really was a problem [...] unless you believe you've got a problem, why would you change it?"

"The first step in my mind is, is there a problem? What is the problem? I had a one- to-one with [the Prime Minister of the time]. He asked me five questions. Is [this issue] as bad as people make out? Why is it so bad? What are you going to do about it? How long will it take, and what will it cost? He wasn't at that stage interested in all the answers, but he was interested in [whether I could] articulate what the problems were and therefore what I might do about them?"

Interviewees stressed the importance of this 'problem identification' process for identifying the boundaries and scope of a programme, and recognised the value of stakeholder engagement and input into this. However, interviewees recognised that national programmes may not always be focused on the 'biggest' problems or priorities from the perspective of all stakeholders. A process is needed to identify and evaluate the priorities for a national programme, and receptiveness of the context and people to implement change.

2.2 Establish a clear scope and priorities for the programme.

The size and scale of different programmes will vary considerably but interviewees did consistently highlight the importance of identifying a clear scope and limiting the number of priorities for the programme.

"The other mistake we make is to say there are 100 problems to fix in [this area of health and care], so let's have a programme that addresses all of them. [...] It's not going to happen. So what are the 10 most important? Let's do those and then move on."

"Objectively [this programme was] successful, but it was also working with a subset of a population of probably [approximately half a million] people. So you can put your hands around it, you can deal with it."

Interviewees described the process of establishing the scope and outcomes for the programme's intervention that addresses the identified problem but is also deliverable nationally. As one interviewee reflected, pilots that provide proof of concepts for a service model and case studies that pique politicians' interests are often "run by enthusiasts." As a result, they are context-specific, and have been tightly specified based on a level of resources that would not be available when scaled nationally. Interviewees identified that scaling-back 'gold-plated' pilots, using robust evaluation methodologies to assess the strength of evidence behind the programme design

assumptions, and prototyping "quite dumb," delivery models, is needed for sense-checking national programme designs.

> **"There had to be some normative design scaling back in order to make sure that actually it was worthwhile."**

> **"We make the policy and then we try to get the evidence to back it up."**

In themes that are expanded upon below, interviewees reflected on the value of stakeholder consultation at this scope-setting / 'design scaling back' phase to ensure they can firstly engage meaningfully to shape the proposed solution, and secondly, to have the necessary information and buy-in to support implementation.

> **"Don't go out to people and say what should we do? [...] Go out with a skeleton and say here's what we think, that we genuinely want your opinion, and change it according to what they say. But give them something to argue against or for [...] which when you then say, please do it, they recognise it."**

What are the key points for a framework?

- Explore the case for change in depth, investing analysts' time, and extensive stakeholder engagement to explore different perspectives of those experiencing the 'problem' in question.
- Agree the boundaries of what the programme will and will not address; secure acceptance of these parameters from political sponsors from the outset.
- Develop, test and estimate the potential impact of a range of viable solutions for addressing this challenge.

3 National programmes in health care navigate a distributed power structure and multiple stakeholders

What are the key challenges for national programmes?

Part of the complexity of the health care sector is the distributed power structure and vested interests of different stakeholder groups. Interviewees identified that this required them to spend considerable time on stakeholder engagement and communication. Interviewees consistently highlighted how essential it is that different stakeholders are engaged in an evolving approach throughout programme design and delivery, in a way that is meaningful and sensitive to the contexts of the different stakeholders. On stakeholder engagement, one strategic lead stated:

> **"You have to take the academic community with you, you have to take the regulatory community, the clinical profession and all of our operational colleagues with you [...] you have to take the entirety of the NHS, including the bureaucratic machine with you to drive transformation at scale."**

In relation to a sophisticated communications approach one programme lead stated:

> **"Securing money from the treasury requires you to act in a certain way [...] then there is how you actually deliver that into the NHS front line, which is different. You might talk about oranges, apples and pears to the treasury, but fruit salads and trifles to the NHS."**

What does this mean for programme design?

Interviewees reflected that navigating this challenge requires well designed and structured stakeholder engagement; this requires a sophisticated understanding of the different actors and their level of influence within the health and care system. As such, the tactics for navigating the distributed power structures interviewees identified to:

1. Understand the landscape and power bases.
2. Understand different motivations and drivers of behaviour.
3. Establish networks and opportunities for influencing and learning.

3.1 Understand the landscape and power bases

Interviewees described the varied map of actors in with influence on / interest in their programmes. This included stakeholders within professional regulators and unions; it might relate to the commissioning and financial structures; or it may be driven by patient groups or individuals with 'soft power' and influence within organisations. In those programmes which were intervening

to change clinical practice, the influence of clinical groups or individual clinicians was cited. Successful programme design involves considering which people need to be engaged first; what resources are needed to bring different groups on board, and who is best placed to bring those groups on board.

"Our approach is political. You need to get regions and ICBs on board. There's a huge amount of stakeholder engagement that has to happen so that everybody is bought into that one standardised approach".

The implication of this varied landscape of influences is that decisions are unlikely to be made by one individual (regardless of seniority), and in isolation of other stakeholders' interests. This gave rise to a common challenge, raised by interviewees: how can programme teams navigate varied stakeholder interests and influence without disempowering programme leadership or creating unhelpful bureaucracy in decision-making.

"Single individuals do not have decision making capability for the decisions that matter because we are in an inherently political environment [...] The executive and ministers are going to want to be involved in those conversations."

"There's a lack of empowerment and we tend to wrap ourselves up in governance to convince ourselves we're doing the right thing. But in actual fact, if we had much less of it, we'd save a whole heap of time."

A second, and commonly cited, implication was an issue of "over governance", with delivery organisations, regional delegated authorities and national organisations setting up different programme boards and stakeholder reporting requirements. Interviewees reflected that this can distract from programme delivery and decision making, or result in "tick-box" governance which does not add value.

Interviewees identified a range of tactics they had used to create more meaningful governance of their programmes. These include having an understanding of who the stakeholders are and what influences their perspectives; "sending intelligent reports" with a limited number of KPIs; cultivating "critical friends" across delivery and sponsor organisations through regular one-to-one or small group conversations; being attuned to how the programme fits within the wider landscape and priorities for the various stakeholders, and adapting to the changing requirements of a programme. This requires a clear understanding of roles, responsibilities and scope between delivery and sponsor organisations, how 'out of scope' dependencies or effects of the programme will be managed, and space within governance structures for honest conversations.

"Formal governance processes are there and they help, but I think it's really important to be honest and not just bring glowing reports that everything's fine. You have to say these risks are real, these things are happening, and be honest about that."

"Where do you govern the out-of-scope dependencies for a programme because not everything is within your control [...] When you are cutting and re-cutting the scope of a programme, it's how you govern those decisions. [...] A strong delivery model has enough governance that joins it up with the wider organisation, its wider operating model, rather than trying to exist in isolation."

3.2 Understand different motivations and drivers of behaviour

When instigating a change programme, interviewees recognised the importance of building an understanding about organisational and professional dynamics, and how the national programme interacts with them. Interviewees referred to the 'psychology' of change, the rational and irrational human motivations, behaviours, and beliefs. One interviewee spoke of the value of the field of 'organisational psychology' to their thinking; they recognised that collective behaviours and cultures affect engagement and support for the programme, and fidelity of implementation. Other interviewees referred to vested interests, professional cultures and dynamics as being key drivers of behaviours.

"You're just walking into a bear pit if you don't understand what your stakeholders think. I've seen lots of times where we've mis-stepped on that, around [professional] interests and data sharing."

Interviewees identified the value of national programme teams carving out significant time for relationship building within and across delivery organisations. This involves having the team and resources in place to undertake stakeholder engagement activities that explore, and respond to, why people and organisations behave in certain ways, what their motivations, values and concerns are, what they say publicly and privately, what is hidden, and how you can bring potentially fragmented perspectives and experiences together. This will also inform the type of support and governance that is needed to implement a change and how to communicate the tangible impact of a service change.

"Do we agree on everything? No. Are we going to agree? No, but we're going to keep talking [...]. At least we both know where we both stand."

"The stakeholders, you have to understand really carefully because they all have their self-interest, but it's about being bigger than that. It's about thinking about Venn diagrams. What is the big Venn diagram that contains everyone's interests in this area and furthers everyone's ambitions?"

3.3 Establish networks and opportunities for learning and influencing

Interviewees identified the importance of creating opportunities for peer networking and learning. This is necessary when building consensus around the features of a programme's design, as well as supporting implementation. Different examples cited include networking and sharing learning within an organisation as well as across organisations in communities of practice, online or face-to-face conferences and meeting, site-visits, team 'huddles', formal training programmes. Interviewees recognised these opportunities are often more informal and spontaneous; as such they can be difficult for programme leaders to predict or control. They need to reach beyond those already invested and bought into a programme.

"Going to meetings with colleagues and chatting around what's working, what's not working and brainstorming over a beer, all those other bits and pieces which I'm sure you wouldn't get funding for [..] reflections from the real world and just interfacing with the people who are trying to make it happen day in, day out."

"I feel like we're preaching to the choir [...] [as a community of practice] we all share that evidence with each other [...] but we can't get those non-believers."

What are the key points for a framework?

In summary, learning from interviewees on how to navigate the complex stakeholder environment and distributed power structures suggests a framework should include guidance on:

- Strategically considering who to involve, and how to make decisions on this, based on understanding the landscape and power bases.
- Designing a governance and engagement approach for bringing stakeholders along, resourcing it appropriately within the project plan, but not ceding all decision-making to committee.
- Recognising the limits of the programme's control: creating opportunities for spontaneous, peer-led influencing and engagement.

4 National programmes in health care require multiple and varied strategies for influencing decisions and behaviours

What are the key challenges for national programmes?

To respond to the political context and distributed power in the sector, the design of a national programme in health care should consider how to influence and align decisions and behaviours. A necessary consideration is what interviewees described as the different strategies or 'levers' you have, or can use, for implementing a national programme, and how long those levers will be in place.

In recognising that individuals and organisations respond differently to national programme mandates, it is likely that a national programme will need a range of levers. These include more punitive mechanisms (or incentive packages) to encourage adherence. These are controlled nationally through the programme, such as financial implications, policies, regulation, governance, performance management and operational practices. Other interviews recognised the leveraging influence of 'soft power:' of relationships, people, and appeal. These are mechanisms that can be designed into a programme (for example, by who is involved and how), but cannot be tightly controlled.

> **"The psychology, behavioural insights [...] what are people's motivations and how can you use those motivations to achieve your outcomes in a non-manipulative way?"**

What does this mean for programme design?

An implication for programme design, as one of the interviewees identified, is to bring together the understanding of the stakeholder context and power bases to inform which 'lever' to pull and when, or to pull them in unison. Interviewees referenced the following levers for national programme design that would ideally work in combination with each other rather than in isolation:

1. Funding.
2. Regulation and law.
3. Monitoring performance and performance management.
4. A clear delivery model and guidance, with some in-built flexibility.
5. Evaluation.
6. Influencing 'hearts and minds'.

4.1 Funding

Interviewees identified that financial incentives are essential for influencing behaviour. This can be punitive (for non-compliance) or provide additional income to facilitate engagement and dedicated staff capacity.

> **"We were also given a shedload of money to go and do this. So don't underestimate, you know, the actual resource to enable us to do this."**

The scale and scope of the programme will influence whether the financial levers or incentives are needed for a fixed period, or considered in the longer-term (and the influence of political lifecycles and ongoing Treasury / Departmental involvement will be a factor here). The extent to which this funding can be controlled nationally, and for how long, is also a key issue. Devolved decision-making was reported to be a significant challenge with financial mechanisms.

> **"What levers we actually have nationally to be able to make things happen and the available funding. [...] Funding was ring fenced for [the programme] but it no longer is. So we can't really make anyone do anything."**

> **"What is the control of funding? [This national programme] committed several hundred million [...] but didn't have strong levers to make sure that that actually got where it was needed."**

The time lag between the costs being committed and the benefits accruing within programmes, and where in the system the costs and benefits fall, was flagged as requiring careful consideration, engagement and communication. Interviewees advised others to consider early the long-term funding and other implications for a service or infrastructure change being initiated by a national programme. This could include, for example, the ongoing training, costs of employing staff or maintaining infrastructure, all of which may sit outside the programme's scope and lifespan. Interviewees' experiences therefore suggest that short-term programme funding on its own is not enough of a lever.

4.2 Regulation and law

National programmes may influence or require consideration of different types of regulation and legal requirements to incentivise compliance or consistency, or to ensure lawfulness. Relevant regimes may include professional regulation (which may encompass standards for education, training and skills for specific professions, where changes can sometimes require engagement with trade unions); organisational regulation (as overseen by organisations include the Care Quality Commission); and other forms of regulation (such as those relating to data protection). Interviewees reflected that, while regulatory and legal levers can provide important 'sticks' for supporting implementation, other levers are also needed to secure 'hearts and minds'.

"There was a big stick and don't underestimate the stick. [...] If you get it into the Health and Social Care act, and that's part of your regulation, you've got a regulatory framework to beat someone over the head with if they don't do it."

4.3 Monitoring performance and performance management

Performance management was identified as an important lever for driving delivery and financial allocations from the 'centre' when there is an imperative to improve performance and reduce variation. As interviewees recognised, sponsors will be accountable to the Treasury, Ministers and Parliament for the delivery of high-profile, large programmes, so they need to be confident that delivery organisations are meeting expectations.

Yet interviewees acknowledged that the performance management regimes to provide these assurances can put people under pressure.

"You're only as good as that last graph [...] So it is constant. The pressure is always on to make sure we're delivering."

It also requires astute programme leadership and stakeholder engagement to navigate the different expectations from political targets, with more realistic expectations based on operational realities.

"Targets are useful, but one has to recognise their limitations and the tendency of the system to play to a target, not to the right outcome. But that doesn't mean you shouldn't have targets."

Interviewees highlighted the importance of benchmarking as a starting point to provide an informed mechanism for engagement. Interviewees also identified different resources and tools to support teams/organisations if the monitoring data indicated a gap between expectations and reality. This highlights the importance for the performance management processes to provide added value and meaningfully hold people to account. They also need to provide a mechanism for stopping programme delivery and funding when programmes are not performing as intended. Interviewees identified that an important challenge for effective and proportionate performance management processes is when appropriate data collection processes or infrastructure does not exist; limited data collection and analytical capability is a related blocker.

"If I say 'go and do that and if you don't your job's on the line' [that's not appropriate]. It's all about how you manage people and you bring them with you. [...] is it because actually what we're being asked to do is impossible or do we need to change something?"

"You need to be driven by benefits and you then need to be prepared to close programmes down where they're not delivering benefits in an acceptable timeframe."

"I would like to see is a commitment to annual reports. [...] it holds the sponsor and owner's feet to the fire to say, I want to see a public report on this on an annual basis."

4.4 A clear delivery model and guidance, with some in-built flexibility

Interviewees reflected the importance of "making it easy" for delivery teams to implement a programme by having clear guidance and resources. They stressed the importance of not over specifying or over complicating the delivery model by having a clear 'taxonomy' to broadly encapsulate the core expected standards.

"The guidance at the top that we're producing has got to be rooted in the operational and clinical realities of the NHS."

"Understanding where the taxonomy becomes useful and where the taxonomy ceases to be useful is really important. [...] If it looks like a duck, walks like a duck and quacks like a duck, it probably is a duck. The most clever people spend all their time arguing about whether it's a mallard, a teal or something else. But it's still a duck [...] it's my job to define at which point the [differences] becomes a problem."

Interviewees' experiences suggest that the level of specificity will depend on how complicated the intervention is, for example the level of specificity for a national programme focused on infection prevention control within hospitals can be much more tightly defined than a national programme focused on implementing multidisciplinary teams in community settings. Regardless of this level of specificity in the delivery model, interviewees identified the importance of striking a balance between setting a clear scope and consistent model, with in-built flexibility for delivery teams to adapt based on emerging learning, or for the specifics of their context.

"Not everything will work the way that it is intended. Building that into your cost models, your culture and your governance [is important] so that you're not stuck delivering something which is not going to do what you thought it was going to do."

As one interviewee reflected "we fail to invest in the department of unintended consequences". While programmes cannot be expected to foresee or mitigate for all unintended consequences, prototyping solutions, designing a flexible delivery model that can be adapted based on local intelligence and data, and having clear governance structures, were identified as potential mechanisms for programme teams to respond to these. But the roles and responsibilities for implementing a flexible delivery model should be clear. Interviewees acknowledged that in the changing operational environment for NHS England, and the specific dynamic of the NHS with both devolved and national decision-making remits, the roles of different teams can be blurred.

"We get emails every single day from regions and systems asking very specific and niche questions... a lot we can't control, like what your local processes are. That's not really any of our business, but I don't think that's clear."

4.5 Evaluation

Interviewees reported that data and evaluation can be important levers in influencing people to take up a solution. However, a common refrain in interviews (and elsewhere) is that evaluations are underused as a tool to improve the design and delivery of national programmes. A key issue many interviewees raised is that evaluation findings are delivered too late.

"It's a really healthy dialogue between those who are [designing the programme] and those who are actually trying to implement it and those who are receiving the care. It's a really valuable part of that iteration. Now you can try and capture that in an academic [evaluation], but as soon as in an academic process it takes quite a long time."

"There's a multitude of ways of learning and if you really want to do things with agility and pace [the process of commissioning an externally-commissioned evaluation is] very clunky [...] it just goes to the black box and then you're shown the results at the end."

Another challenge identified, which is a consequence of the politicised environment and diversity of stakeholder interests involved, is that evaluation may be focused only on retrospectively 'proving' the programme works rather than providing information to support improvement. Some interviewees suggested that this means that evaluations deprioritise collecting data on aspects

such as unintended consequences. It also risks evaluative assessments not being used to inform ongoing programme decisions and for holding policymakers to account.

"As a national team, we've got to do a huge amount to be demonstrating why systems should still be investing in this [...]. I think a lot of that is about demonstrating the evidence base and being able to demonstrate that this works. And that's quite hard to do in a short time period if you want any meaningful evaluation. You're looking at years, but actually we need the evidence, like six months ago."

"I grapple with the fact that if this evaluation shows that it isn't working, what do we do? Because are we realistically going to stop now?"

The lack of quality data and/or infrastructure for collecting and accessing data was recognised as another challenge for high quality evaluation. An implication is that national programmes need to consider both formal and informal evaluation and learning. To do so, the programme design should consider the role and timing of an independent assessment of progress, and what infrastructure is needed to enable evaluation and learning, such as the data infrastructure for capturing and monitoring quantitative data, or infrastructure to facilitate knowledge sharing.

4.6 Influencing 'hearts and minds'

As described above, interviewees often identified the value of consistent and timely stakeholder engagement and peer to peer learning, often done in networks and informal settings, for engaging different stakeholders in the programme design and implementation. This recognises that it is so often people, their relationships, values, interests and motivations, that are the most influential lever for driving change.

"They've gone out and found the right levers in the system. So they found the willing and they've given them a set of ideas and the group have taken it forward and had huge impact."

"The plan was that we want as many people with skin in the game as possible."

"Keeping the momentum and making sure that you've got the support, you've got the sponsorship [...] takes a lot of time and effort."

What are the key points for a framework?

In recognising the different strategies or 'levers' available for influencing decisions and behaviours, the framework will need to recognise the features that will influence programme design and implementation including:

- The level of funding and other resources available, and where this is coming from.
- The psychology of change and unconscious or historic drivers of behaviour.
- Regulatory and governance mechanisms available.
- Designing performance management processes and infrastructure that provides an honest understanding of progress and holding relevant people to account.
- Guidance on developing delivery models that balance standardisation with flexibility and clarity on what needs to be tightly controlled and defined.
- Creating opportunities for communication and engagement with all stakeholders, including spontaneous peer-led learning.
- Exploring the data infrastructure and evaluation designs that can provide timely and meaningful evidence of what is working and why.

The specific interaction of these levers and whether any are more applicable for particular types of programmes would benefit from being explored further.

5 National programmes in health care need leaders who are adaptive and credible on many levels

What are the key challenges for national programmes?

The leaders of national programmes in health care may come from a range of backgrounds, including generalist civil service roles, and health management and policy backgrounds, as well as from clinical and/or academic backgrounds. Interviewees identified a wide range of skills, capabilities, experiences and temperaments needed from the leaders of national programmes. While the experience of interviewees suggests that not all leaders of national programmes in health care need to have clinical experience, it does provide credibility and expertise in the eyes of certain stakeholders, particularly when implementing clinical service change programmes.

"It almost needs a committee of clinical leaders [...] it ends up with a bureaucratic head or a political one rather than a clinically credible one."

"[The director of the programme] is uniquely positioned to hold a room whether that's a finance director, a COO, a chief executive, a clinical director, and challenge them on all elements."

What does this mean for programme design?

The importance of leadership in health care is a well-covered topic in the existing literature. It is a theme on which written reports and commentary can struggle to capture the essence and impact because it is something one experiences and learns. The interviewees were invited to reflect on how they experienced different types of leadership, and how they went about being leaders of national programmes. The diverse features of leaders or leadership teams for national programmes identified in the interviews can be summarised into the following, highly adaptive, and at times, contradictory, characteristics:

1. Being open to input, but decisive.
2. A connector and interpreter, also willing to challenge.
3. Political astuteness.
4. A creator and leader of their teams.

5.1 Open to input, but decisive

Interviewees reflected on the importance of leaders who have a clear vision, are decisive and comfortable making decisions in uncertain contexts and with ambiguity. Simultaneously it is expected that leaders of national programmes should listen, learn and be willing to change course

when something is not working. The implication is that *how* you make decisions and work through the uncertainties, and engage people so that they buy-into the direction being taken, is as important as the decisions themselves. Interviewees described an important balance of genuinely engaging with stakeholders and responding to their input, but not being too open-ended, and knowing when to bring people in at different times.

"Foxes have very good sense of smell, small eyes on the front of the head, small ears, and they're incredibly focused. We employed loads of foxes who wanted to win, who wanted to get the prey [...] And they knew how to do it because they were the cleverest person in the room. I'm a hare, I've got big ears, I've got eyes on the side of my head, a poor sense of smell. [so] you look around, you take in lots of information. [...] I listened to people, I talked to experts."

"You can spend hours and hours and hours and months and months and months on getting the right level of engagement, or you can say, look, it's bloody obvious what we need to do. Let's get on and do it and bring people with you sort of afterwards."

5.2 Connector and interpreter, also willing to challenge

Given the (sometimes) partisan and professional stance that individuals hold (informed by their, and their stakeholders', vested interests, training, culture, experience), a key aspect of the leadership role was thought to be convening and connecting different parts of the system, and interpreting different viewpoints. This needs someone who understands the realities of the NHS but is not limited by it. It relies on someone with operational, clinical, and management skills and knowledge to navigate challenges and find solutions. Programme leaders require credibility and knowledge to question data and challenge assumptions.

"The effectiveness of the job is sometimes how you connect disparate bits of the system together to achieve an end."

"My role in a lot of these things has been interpreter interpreting the politicians to the clinicians, the clinicians to the politicians, and being genuinely a middleman."

"There is a lot more thinking on your feet, agility, reading the rooms, having your finger on a number of pulses at the same time."

5.3 Political astuteness

Interviewees articulated the importance of having astuteness to navigate the political context. This includes understanding how government departments operate and interact with each other, how to work with Ministers and how decisions are made, while also being astute to "the operational

and clinical realities of the NHS". It includes having the integrity and confidence to act as a credible and critical friend to political decision-makers and "reality checking outside of the policy bubble."

"What I never did was lose sight of [the expectations of senior decision-makers], because the minute I lose sight of this, I lose my job. The minute I lose sight of [what I think, which is on the other side of the spectrum] I lose the plot."

"There were seven quite senior people who slightly different views of the world and there wasn't really a process at the top to properly navigate through that."

A common tactic for navigating the political context was "riding the wave": recognising that, with a potentially short-term focus and priority on a specific topic, they have to be prepared to make as much progress as possible for as long as the momentum was with their programme.

"You can miss a lot of waves. If you catch a wave, you can go a long way."

"The government priorities move on. [...] The phrase I've used is we need to surf every wave that comes along."

Doing this well requires a level of preparedness and anticipation among strategic leaders, so that when opportunities emerge, they can be on the front-foot with a programme that people can get behind. There is also a level of pragmatism needed among clinical and strategic programme leaders as the perfect programme may not be fully designed when the 'wave' comes, so how the programme leaders navigate this level of uncertainty, while engaging various stakeholders to work out the details around the broad vision, will determine the success of the programme.

"Nature abhors a vacuum [...] if you leave space they will fill it. So don't leave space. Suggest before you're asked."

"If we tried to design all that first, we would have missed the boat because basically there was one moment in time."

5.4 A creator and leader of teams

While also managing up (to senior decision makers) and around (to influential stakeholders and people grounded in the day-to-day realities of the programme), interviewees also reflected on the value of team cohesion and commitment.

> **"My positivity is about the team, the energy, what we're doing, our delivery."**

This highlights the importance of communicating well to create team engagement and to motivate colleagues; to protect them at times from issues and challenges, while keeping them updated and engaged with programme developments. This requires leaders to be self-aware of the attributes and perspectives they bring to a team and seek to complement that in the people they bring around them. It requires leaders with emotional intelligence to recognise the human needs and motivations and psychology of change

> **"Where it is difficult is when there is ambiguity, but it's not communicated. It's how you communicate with the wider organisation about the level of ambiguity. So are we sharing nothing? Are we sharing lots? I think it's a real challenge for leadership to get that balance right."**

> **"Diversity and balance would be the other things that I would say. I think probably in my earlier career I would have been guilty of recruiting people in the image of myself."**

Key points for the framework

In laying out the extensive range of skills, capabilities and qualities interviewees described are needed of leaders of national programmes it seems unlikely that there is a deep pool of candidates that fit all aspects of this description. The framework will need to recognise that the leadership of national programmes will likely come from many people, at many levels across the programme, and that a 'pipeline' of potential candidates needs to be planned for. The framework should specify the leadership characteristics that are important at various stages of programme design and implementation, prompting those leading the design process to identify gaps.

Section 4: Implications and next steps

Considerations by types of programmes

In selecting a diverse range of programmes, ranging from major infrastructure programmes to service improvement programmes, the interviews sought to test the possibility that different types of national programme in health care would benefit from different design guidance. The selection of interviewees was also based on the assumption that the different cultures and professional mix within the civil service compared to NHS England, and other national policy actors, compared with social care would elicit different needs for national programme design. The current analysis suggests that, while there are some nuances based on the level of resource attached to a programme, whether it is led by a clinical expert or civil servant and which part of the sector is implicated in the change, there are more similarities than differences. This suggests that the high-level content of a framework to guide the design of national programmes will be consistent across the diverse portfolio of potential programmes within health care. However, a more detailed, and larger scale comparison of different programme types would warrant further consideration in the next phase of this project.

Audience and use for a framework to guide design

The high level of responsiveness from senior stakeholders – people who have retired/semi-retired or are currently managing large portfolios of programmes – to participate in this project is an indicator of interest in the project's aim of improving the design of national programmes. However, interviewees were not universal in their agreement that new guidance was needed. This was based on the understanding that guidance already exists, the importance of learned experience (and limitations of theoretical insights), and the widely held view that a range of factors outside a programme's control can destabilise success.

> **"I think you should be very wary of saying we found the solution based on n of 1. [...] There are so many things that can happen that can destabilise the way you're going. So I think there are common factors that will help success, but there won't be just one winning formula that guarantees success."**

However, many did recognise that any effort to capture learning from previous programmes, in an engaging and accessible format, including case studies and tangible examples, could have benefits for bringing some of the challenges to life and sharing tools for navigating them.

Given that national system leadership arrangements are changing, and the Government's ambitions to implement 'shifts' in health care, it is a timely occasion to reflect on programme design, and the features of it done well. The insights generated from interviews, when considered alongside the evidence review, indicate that there are many nuances that are not captured, or readily shared, in formal programme evaluations and published guidance. The proposed

framework could therefore add value to a crowded evidence base by bringing to the fore the voices and experiences of those people that have experience of these programmes through case studies and tangible examples.

Themes for consensus building

Based on the current analysis, and gaps or nuances that are identified as missing, the following themes are suggested as potential topics for exploring in the next stage of the project. This is through the proposed consensus-building and co-design exercise.

1. Whether, and how, the framework can sufficiently and relevantly cover themes for the different scale and types of programme? For example, the different approaches needed according to:

    a. The scale of national programme (what is the balance between a large-scale ambition, or a more localised targeted approach).

    b. What is needed by different programmes to navigate centralisation v devolution / local autonomy and flexibility.

2. Effective strategies for interacting with and between the political and operational actors, and how to navigate this in different political and cultural contexts, and in response to different approaches to risk and uncertainty. What can guidance offer when there is no "one size fits all" solution and when programme design cannot plan and foresee everything, and you may be unlucky with the context at the time? Is there a case for a more formal assessment of programme 'deliverability' at the outset, particularly if different parts of the health and care system (with varied resources and capabilities) are charged with delivering the programme?

3. Stakeholder engagement addressing questions including: what does a good strategy look like that is broad and inclusive **and** more targeted, contained focusing on key influencers and decision makers)?

4. Formal evaluation v informal feedback and learning: what is a genuinely useful design for robust and timely evaluation, and for a programme that needs to be adaptable while operating within uncertainty? What are the programmatic controls to support robust and meaningful evaluative assessments to inform decision making, for example the role of internal and external analytical and evaluative expertise and capacity?

5. The specific leadership characteristics (for leading programmes in health care), and whether these differ according to type of programme and the level of risk and uncertainty?

6. The interaction of levers, the order that they should be used in, and whether any of them are more applicable for particular types of programme?

Input from THIS Institute on the purpose, design and delivery of the consensus seeking exercise will influence an updated version of the above list.

The next phase of the project provides an opportunity to address the gaps and limitations in the limited number of stakeholders involved in interviews. Specifically, the next stage of the project should aim to explore more experiences within public health programmes, social care and cross-sector service improvements, as well as seeking more critique and challenge from people at a range of levels of seniority.

Appendices

Appendix A: Overview of methodology

This section sets out the methodology which has underpinned this report. It included the following steps.

- The list of programmes to identify interviewees from was considered collaboratively by the Health Foundation, THIS Institute and Ipsos project teams. The selection was purposive to identify a balance of different types of national programme that in particular included a mix of major infrastructure programmes as well as various scales of service improvement programmes. The selection sought a balance of programmes designed from the Department of Health and Social Care and NHS England. Specific interviewees were identified to provide perspectives from different levels of involvement but were all in senior roles (principally programme leads or people with senior oversight of implementation).

- The list of national programmes included in the sample also included interviewees involved in the design of national strategies or payment mechanisms. These approaches often form part of a national programme approach (e.g. the Elective Recovery programme). These include national strategies relating to cancer, the long-term NHS plan, or payment mechanisms such as how GPs are renumerated through the Quality Outcomes Framework.

- In total 17 interviews were completed between December 2024 and February 2025. There was a high response rate to the email invitations sent by Ipsos. Just four potential interviewees (who were 'colder' approaches by the project team) did not respond. A further two responded positively to the request but interviews could not be scheduled due to other demands on their time.

- Interviews were between 40-90 minutes in length. The guide for the discussion was based on the first draft of the framework prepared by THIS Institute. This invited interviewees to reflect on their experiences broadly on specific national programmes, as well as prompting them on specific 'pitfalls' identified in the literature.

- Interviews were recorded, transcribed and have been analysed thematically. The analysis has been both deductive (drawing on the framework provided from the themes identified from the literature review) and inductive (to respond to themes emerging from the data). The analysis has been presented to preserve the confidentiality of the interviewees. Specific details have been removed to ensure quotes are not attributable to specific individuals.

Appendix B: Sampling matrix

With the 20 interviews, the intention was to speak to people involved in a spread of different types of programmes. A sampling matrix provided the suggested quota for different types of programmes/stakeholder categories of interest.

The classifications have been made by the Ipsos interviewing team rather than the interviewees and have involved some judgement/interpretation as many interviewees referenced more than one national programme and different roles they had played. The classifications are based on the main programme discussed.

1. Organisation base	Suggested sample	Completed interviews
National NHS	7	10
National civil service (DHSC)	7	6
National other	3	1
Regional	3	0
	Total: 20	***Total: 17***

2. Role in relation to programme	Suggested sample	Completed interviews
Senior leader/decision maker	5	7
Programme oversight/management	5	1
Implementing programme	5	4
Designing programme	5	5
	Total: 20	***Total: 17***

3. Type of project	Suggested sample	Completed interviews
ICT and infrastructure	3	4
'Front facing' clinical intervention	4	3
Behind the scenes clinical organisation	4	2
Improvement programme directed at all trusts/providers	3	3
"Improvement regime" directed at failing organisations	3	1
Strategy	3	4
	Total: 20	***Total: 17***

Appendix C: Interview guide

The interviews were semi-structured. The following guide was used loosely by the interviewing team depending on the time available. The focus and language used changed as the interviews went on to test emerging feedback/assumptions from previous interviews.

1. Introduction to the project and context for the interview
2. Their experiences of national programmes
3. Testing the emerging framework (exploring their experiences of the common pitfalls identified)
    - **a.** Decision making behaviour
    - **b.** Strategy, governance and procurement
    - **c.** Risk and uncertainty
    - **d.** Leadership and capable teams
    - **e.** Stakeholder engagement and management
    - **f.** Supply chain integration and coordination
4. Final reflections and close

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Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a "right first time" approach throughout our organisation.

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By being an MRS Company Partner, Ipsos UK endorse and support the core MRS brand values of professionalism, research excellence and business effectiveness, and commit to comply with the MRS Code of Conduct throughout the organisation & we were the first company to sign our organisation up to the requirements & self-regulation of the MRS Code; more than 350 companies have followed our lead.

ISO 9001

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