What it feels like to work in the NHS – a look at system instability

As a leader of a hospital, as a Doctor or Nurse at the front line, as a Project Manager in the back office or any other roles within the NHS and possible the wider public sector, then I have a question; is this what it feels like for you and your organisation today?

| What it feels like	The impact
Time horizons seem to be getting shorter	Long-term strategies are replaced by spontaneous reactions
Plans are in a constant state of flux	Individuals and teams are confused and ambiguity prevails
We jump straight to the solution without understanding the problem	The wrong solution is selected
Any idea is a good idea; we try to implement everything	Demand exceeds capacity to deliver change, nothing gets implemented
The trial phase of the change is suspended, we just do	We don't know if the solution works
Change resource is constantly switched between initiatives	Progress stops during transitioning
The capacity for assurance grows disproportionality	The capacity to improve diminishes
Meeting frequency and volumes are intensifying	The ability to follow-up actions becomes near impossible
Change & Operational management boundaries are becoming blurred	Operational delivery always takes priority and change stops
The governance is seen as the change	Compliance becomes the job of the change agent
Leaders have stopped leading	Leaders become managers
Unacceptable behaviour has become acceptable	Staff tell leaders want they want to hear, not what is reality
My delegated decision rights have been suspended	Staff become disenfranchised
Distributed leadership has manifested into command and control	Initiative & innovation stops; seeking approval prevails
Deadlines are imposed	Quality of deliverables is compromised in order to meet dates
Rising failure demand as we struggle to get it right first time	Deteriorating productivity and performance
Performance data is based on failure demand	Critical decisions are made on this baseline performance data
Growing interference from external system partners & regulators	Relationships deteriorates and partnership working stops
We are losing sight of our purpose and vision of our future	Progress has stopped

These are the **symptoms** and the **impact** upon individuals and teams when organisations and wider systems begin to **de-stabilise**. The impact upon the patient and taxpayer is just as profound as the outcome of this downward spiral manifests itself into a deterioration in the quality of care, longer waiting times and rising costs.

Lack of funding?

Is this all down to a lack of money... or is there something else at play?

"No 10 insisted that there would be no emergency cash injection for the NHS in the coming weeks and claimed that the A&E problems were not unusual for winter. A downing street source said: "Theresa May doesn't believe in quick fixes. There are stark variants in performance trust that are not explained by cash injections." The Time 11th January 2017.

Could a legacy of poor process and structure design, variable operational leadership and failed attempts at change have left care systems with rising failure demand, rising clinical risk and significant 'locked in' cost. A cost exasperated by the need to manage that uncontrolled failure demand with temporary variable resources and an ever-expanding capacity of assurance.
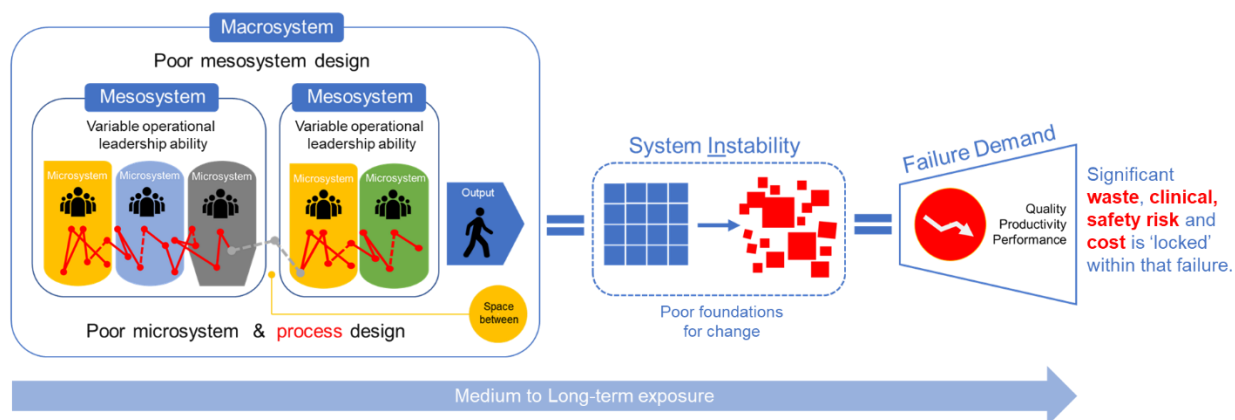
Failure Demand?

Failure demand represents the waste found in the care system; when patient care isn't done at the right time in the right place by the right person with the right skills, with the right tools and the right information. When patient care isn't done right first time. It can manifest itself throughout the care system, what follows are but a few examples of that failure;

1. **Quality of Care** (Quality)
   a. Patients deteriorate as flow through the care system slows and delays are frequent.
   b. Staff time is consumed chasing up services, information and colleges and as such have less face to face contact with patients, less time to care.
   c. Carers and community services have no date when the patient is likely to leave hospital so they can't plan or prepare.

2. **Access to Care** (Performance)
   a. Poor system flow means patients using urgent care services can't move to the next treatment stage waiting up-to & over the 4-hour standard.
   b. Patient on the 18 weeks' referral to treatment pathway suffer delays as the variation in the unplanned care system consumes planned capacity.
   c. Patients on the Cancer care treatment pathways suffer delays as the variation in the unplanned care system consumes planned capacity.

3. **Cost of Care** (Productivity)
   a. Inaccurate capacity planning leads to services and microsystems being overwhelmed; temporary capacity is added rapidly at cost.
   b. Scheduling failure: a mismatch between discharge and the demand for beds often results in the commissioning of more beds
   c. First event patient recovery & re-enablement assessments are performed separately by multiple highly paid professionals

Process & System Design

The car for most is a necessity, but even as a necessity our decision to purchase will be influenced by its design; if it didn't then all cars would be the same. You can imagine the designers sat in front of their computers and even today making their clay models; creating the exterior shape and interior style to appeal to the customer; fusing brand image, innovation and safety regulations into a new vehicle.

Did you know there is another team of designers?

A team often referred to as System Designers or Engineers who have the task of discovering and designing the process to make the car; to map the step by step tasks, understand the human activities, the skills and behaviours needed to complete those tasks. Forecasting the capacity; the people and facilities (space, equipment, tools, systems to capture quality, performance and productivity data) they will need to meet the demand. How to best group these activities and the individuals into effective multi-disciplinary teams (MDT) who will be responsible for each aspect of production. How to capture process and outcome performance information so each team understands their contribution to the production of the car and to be able to flex their capacity to meet the fluctuations in future demand. They collaborate with Systems Designers and Engineers from partner organisations within the wider macro system; the suppliers, logistical transporters and distributors. In the design of seamless production pathways supported by frameworks of operating which cut across multiple organisations and managed by co-produced and co-owned capacity management and co-ordination centres.

To manufacture a car is a complex process, a process which both influences and is influenced by the organisations and system in which it operates. As highly skilled professionals; System Designers and Engineers use evidence based methodologies, tools and techniques, working with the Car Designer and Production teams to discover the best design to manufacture the car. The car industry is but one example of where system discovery and design is critical to the delivery of the goals of that industry others include the Airlines and Railways.

It is often said that health and care is nothing like building a car, but the principles of patient care are the same; care is delivered along the horizontal pathways by multidisciplinary teams (MDT), it is those MDT's that form the multiple clinical microsystems. It is each microsystem which is responsible for a sequence of activities along the patient's pathway of care. It is the microsystems that when grouped together form the meso system (the organisation). Care systems are complex processes, processes which both influence and are influenced by the organisations and systems in which they operate.

So why is it in health and care systems we don't approach the discovery and more critically the design of our pathways, microsystems and organisations with the same rigour. Why don't we use System Engineers; those who are specialists in system, process and cultural design? Their role is to discover and design the process of care; to map the step by step tasks, understand the human activities, the skills and behaviours needed to complete those tasks. Forecasting the capacity; the people and facilities (space, equipment, tools, systems to capture quality, performance and productivity data) they will need to meet the demand. How to best group these activities and the individuals into effective multi-

disciplinary teams (MDT) who will be responsible for each aspect of care. How to capture process and outcome performance information so each team understands their contribution to care of the patient along the pathway and to be able to flex their capacity to meet the fluctuations in future demand. How best to group the MDT's into microsystems and how best to group the microsystems into stable organisational design structures (Meso systems). How best to group the meso systems into stable macro systems of care. Systems of care where capacity is coordinated 'live' to match fluctuations in the demand of that care.

Why is it assumed that front line clinical, and social care teams, Operational Managers (skilled in their own practice) are also highly skilled and capable System Engineers? Why is it assumed that care system design is just an add onto the day job? Care systems are complex, they are a combination of multiple structures, processes and patterns of behaviour.

Variable Operational Leadership

Variable operational leadership capability drives the creation and acceleration of system instability. The political environment in which the NHS operates has and will continue to create significant challenges for leaders. This has a part to play in the ability of operational leaders to lead consistently, but only a part. So, what else would contribute to this variability; capacity or is it capability?

Capability, actions & rituals	The impact
In-ability to define and articulate the **what** and the **why** of a new future state of being.	Staff don't understand and thus are not inspired, not energised and can't mobilise around you.
In-ability to see and understand or to want to see and understand the **big picture**. To discover how the **design** of the processes, microsystems, meso system (organisation) and the macro system in which operate are performing.	Individuals and teams are under pressure to achieve challenging if not unrealistic targets. Target which are based on flawed designs and/or lack the right process and outcome information on how they are performing or how to improve their performance.
Strategies are created in **isolation** and **commanded** down.	The idea becomes an imposition, ownership belongs to the few and not the many.
Relentless pace setting, without regularly checking to see if the teams are still with you.	People are left behind, they become lost, don't know what direction to take and so default to what the know; the **past**.
'Ivory tower' syndrome; the decision-making process done in **isolation**.	Staff are disenfranchised as their views and ideas go unheard.
Distributed leadership manifests into **command** and **control**. Delegated decision rights are suspended.	Initiative and innovation **stops**, seeking approval prevails.
Inconsistent decision-making.	Rapidly changing and what appear to be conflicting priorities creates confusion for teams and makes it difficult to prioritise work in a sequence which will help achieve; financial targets, performance targets or to meet the overall objectives for the service, quality patient care.
Lack of understanding about what is causing the system to **fail** and how to **change** the system.	For individuals and teams, perpetual firefighting becomes the norm as time and resources are not focussed on discovering the root cause of the problem and thus design the right solution.

Does a competent and technically knowledgeable Medical Doctor make an effective Divisional Director, does a technically knowledgeable and caring Nurse make a good Chief Executive? In a drive to push the 'clinically led agenda' and a focus on managerial competency has the NHS fundamentally missed the point about leadership; behaviour. The NHS Leadership Academy among others have in recent years started to drive this behaviour agenda focussing upon emotionally intelligence, but is enough being invested at this level and at the provider and commissioner level to accelerate this agenda?

How many leaders from board to ward are still being appointed because of their technical capability not their ability to lead others? What criteria does the regulator follow when appointing an interim Executive to 'get a grip' of an organisation?

The leadership capability, actions and rituals of any leader are much less important than the collective leadership provided by members of the organisation' or system in which they operate. A consistent approach to the distribution of leadership is critical in creating a stable operational environment. That consistent approach is both supported and influenced by the design of the organisation and system in which that organisation operates.

As providers and commissioners come together and new organisational entities are formed is a new capability dynamic now required; in affect the missing piece of jigsaw? System and organisational design; structure, process, behaviour and ability to deliver that design through the science of change.

Organisation Design

I often wonder if you asked a sample of Chief Executives to 'dust off' their organisational design plans; how many would be able to show a blue print which describes the key **building blocks,** both physical and psychological which constitute the organisation they lead? A design built around cohorts of patient conditions and not around the hierarchy of professionals or the need to equalise staff numbers in divisional designs so they look even!

- How many would just put in front of you the organogram, their hierarchy of direct reports?
- How often do they sit down with their team; design, review and monitor the health of the overall design?

The same can be said of microsystem leaders as it can for macro system leaders.

Failed attempts at change

I'm not sure what's worse; cost improvement programmes (CIP) **masquerading** as **improvement** and **change** when in fact they are nothing more than crude budget cuts. Or improvement programmes initiated with good intentions and enthusiasm but focussed on the wrong thing (because we **think** we **know** what the problem is), led by Operational Leads who are not skilled in the science of system and process design and cultural change. Significantly underfunded to a time-scale that was never going to be achievable.

As a consequence, the legacy which teams have to operate within is flawed, unstable and probably worse than it was before. Individuals and teams disenfranchised, possibly now in conflict and the whole organisation or system left with dysfunctional processes and structures. A workforce ill equipped in terms of capacity and capability to meet the demands of patients and customers, a demand which the change was meant to address. Re-repeating this failure creates a constant state of disruption and uncertainty, individuals and teams begin to associate change with failure, of making the job harder, the respect and thus the trust in the leadership dissipates and relationships begin to breakdown. A mindset of apathy sets in as people lose sight of the future and thus look to past for certainty and any sense of stability.

System instability – a poor foundation for change

As health and care looks to integrate and change into new care systems; bringing together multiple organisations to work as one is a significant challenge, a challenge made near impossible if just one of those organisations is unstable.

System instability whether at a meso (organisation) level or even at a macro level is a poor foundation for transformational change. The irony; to bring stability to a system requires you to change it.

To change it requires you to understand it; discover the flaws in the processes, the poor organisational design, the non-existent performance frameworks in which teams have to operate, the variable leadership, the lack of capacity and capability to change, the culture of apathy. To understand this enables you to change it, to design effectives processes and pathways of care. Effective microsystems to support those pathways, an organisation design which supports the microsystems and enables individuals and teams to understand their contribution to now but more importantly tomorrow and beyond. To develop leaders who have the emotional capability to distribute their leadership, to coach individuals and teams to see a new future state of being. To seek help from those with the capability in systems discovery and design, in the science of change to support those teams to reach that new future.

To bring stability to a system, a system as complex as a hospital as complex as social care; requires new thinking, specialist skills, investment in time and resources.

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