

Human Processes Keith Harrison-Broninski

The Change Challenge

I often write in this Column about the UK National Health Service, since it is a fascinating case study of the challenges to a modern public sector organization – and there are lessons for the private sector too. With 1.7 million staff the NHS is the 5th largest employer in the worldⁱ, and has the classic problem that comes with size – i.e., how to introduce change at scale and pace. A famous statistic is the average of 17 years it takes a proven healthcare innovation to make it from the laboratory into standard medical practice – or, as they say, “from bench to bedside”.ⁱⁱ

A recent political attempt to solve the problem by organizational re-structuring has attracted widespread criticism:

Experts said the reorganization, which is estimated to have cost about £3bn, had caused “profound and intense” damage to the NHS with one saying former Health Secretary, Andrew Lansley, would be facing disciplinary action if he had been a doctor.ⁱⁱⁱ

Many administrative staff were given handsome redundancy packages when their employers were abolished, hired again almost immediately at consultancy rates by the replacement organizations, then eventually given what amounted to their old jobs back – often at a higher salary:

Senior NHS managers have shared more than £300,000 in pay rises as a result of the Government’s reorganization of the Health Service, despite remaining in apparently identical posts.^{iv}

And despite daily media reports on the drastic shortage of doctors and nurses, and chronic management problems, the NHS appears not to be streamlining its bureaucracy:

Today, according to official statistics, there are 274,000 managers supporting doctors and nurses. They outnumber consultants nearly seven to one.^v

Attempts to sort out the situation from the top continue, now under new leadership. In the meantime, a parallel exercise has started – a social media campaign to challenge top-down change and empower front line staff to deliver improvements themselves. Clinicians across the NHS regularly create and successfully trial service changes that deliver both cost savings and improvements to patient outcomes – but then struggle to see the changes taken up in other departments/organizations, or even commissioned on a long-term basis in their own department/organization. Attempts to share learning about implementation of the changes, such as NHS GATHER^{vi}, are welcomed by clinicians but struggle to obtain sustainable funding and

are neglected in messaging from senior staff. The key problem is not innovation (coming up with ideas), or adoption (proving that ideas work), but rather “diffusion” – replication of successful change elsewhere.

So why is diffusion failing? Analysis of over 7500 contributions to Phase 1 of the “NHS Change Challenge” reveals 10 commonly occurring barriers to bottom-up change:^{vii}

1. Confusing strategies

Our organizational strategies hold us back, they fail to provide a clear ‘call to action’ to change things from the bottom up. They reinforce inflexibility in our business structures, as well as leadership that is controlling.

Often there are so many priorities, it isn’t clear what we should do. This leaves us fearful of stepping up without the autonomy to deliver change effectively.

2. Over controlling leadership

Despite some efforts, we still rely on command and control leadership rather than coaching and nurturing. We perceive that we do not have the freedom or trust to create change from the bottom up.

It’s not that our leaders are bad – they just do not have the right skills. This leaves many staff feeling afraid of speaking up, which restricts bottom-up change.

3. One-way communication

Often our leaders communicate at us, rather than with us. We are not open and transparent with each other.

We also do not have enough formal/informal ways of connecting creative people. Part of this is because there is a lack of both soft skills training and technical systems to support communication.

4. Poor workforce planning

It feels like we either don’t have enough people or enough time to get involved in driving change from the bottom up. Some of this is because we often don’t have the right mix of skills in our teams. We have a skills deficit because we are failing to nurture our people and organize the right mix of talent.

Having the right number of people with the right skills requires us to work in partnership with organizations outside our own, something we are not very good at.

5. Stifling innovation

There is no shortage of ideas among health and care staff. The challenge is a shortage of processes to capture ideas and a lack of leaders who truly empathize with the needs that we see.

Senior leaders are trapped in inflexible processes. And we fail to embrace ways of taking part in low cost, low risk experiments to test ideas.

We must utilize the diverse experiences of stakeholders, including our patients.

6. Playing it safe

Our hierarchical, centralized structures either make it too difficult to access funding and support for ideas, or we end up funding too many projects with not enough resources.

It seems that a lack of clarity on what’s needed from leaders, plus a fear of

doing something new from the bottom up, leaves us supporting low risk ideas involving the usual suspects.

7. **Poor project management**

When developing and implementing projects, we tend to value inputs and action rather than value and outcomes; it means we're kept busy, with no room for effective bottom-up change.

We underestimate the complexity in which we are working and we blame inflexible processes and lack of resources.

However, how change is led from the top and explained to all, and how we are trained to manage and implement projects, ultimately undermines bottom-up change too.

8. **Undervaluing staff**

For us to have a positive mind-set and ultimately ensure the wellbeing of our people, we need to treat each other with compassion, as much as we would our patients. Alas, we don't always do this.

All too often we do not feel connected to our organization's purpose and do not feel that we have a real stake in its future. Feeling like a cog in the engine, rather than a value-adding individual, makes us feel undervalued, disengaged and even ill. Why would we proactively get involved in change?

9. **Inhibiting environment**

Our physical environment can stop us meeting people and connecting ideas. The closure of sites has put a burden on the remaining organizations. And, as we all know, our IT systems do not help us access knowledge and share information.

10. **Perverse incentives**

The incentive system and performance management regime creates disincentives to support bright ideas that might create better outcomes for patients, but which would lose the organization income.

It creates incentives that leave us stuck habitually supporting self-serving projects.

Much of this may seem familiar to you. The above barriers are common in the private sector, and in much smaller organizations than the NHS. The 1492 contributors so far to the NHS Change Challenge suggest that 11 building blocks may be able to support bottom-up change, and again these are relevant to organizations of other types and sizes:

1. **Inspiring and supportive leadership**

Leaders need to inspire and support their people.

This means taking forward ideas to improve their organizations based upon their quality rather than their author; a less hierarchical structure, where people have a greater understanding of each other's roles; and "distributed leadership", where people are trusted and talent is nurtured.

2. **Collaborative working**

Collaboration between peers within and between organizations leads to broader operational and personal benefits.

Operationally, change programs are more effective, allowing us to improve the outcomes for people and populations, and collaborative working builds more supportive working relationships, which is essential to improve people's

wellbeing.

Peer collaboration therefore nurtures a more positive mind-set and the desire and connections to drive bottom-up change.

3. Flexibility and adaptability

To deliver bottom-up change, we need flexibility within the system – both in terms of the formal organizational structure and day to day processes.

This will allow organizations, teams and individuals to more successfully adapt to the changing environment in which they are operating.

4. Smart use of resources

We must try to find ways of doing more with the resources we have. The world's most successful organizations are more resourceful than their competitors. By adopting a resourceful mind-set and providing appropriate staffing and skill mix, we can try to deliver change within our current means.

We should aim for smarter project selection: doing the right projects well, rather than trying to do too much with not enough resource.

5. Autonomy and trust

Increasing people's sense of trust gives them the confidence and permission to deliver change. This makes the most of the knowledge and passion of people working in health and care.

We need to work within acceptable clinical parameters, remove the fear associated with failure and foster a no-blame culture of reflection and learning upon what does, and what does not, work.

6. Challenging the status quo

Everyone is able to create and identify great ideas; organizations need to nurture and embrace the creativity of all their staff to challenge the status quo and deliver real change.

A large part of this requires health and care organizations to experiment more and share their learning, for the benefit of all.

7. A call to action

We must consistently articulate a clear call to action for everyone who works in health and care. To do this we need to clearly articulate the purpose and meaning of our organizations.

This will ensure alignment within organizations and across boundaries, and inspire contributions to the mission from the bottom up in a way that ensures every person is moving towards the same common goals.

8. Fostering an open culture

A commitment to transparency and openness creates a more positive environment. Openness allows learning to be shared across boundaries and shows to the people we serve and our colleagues that we have integrity.

The most open organizations are the most innovative.

9. Nurturing our people

We need to prioritize the training and development of health and care staff. However, we cannot be stuck in traditional mind-sets and must develop the right mix of skills in the right places.

This would support and nurture our people to take local leadership of the changes that are needed.

10. Seeing the bigger picture

Teams and individuals need to be given the space and freedom to make long term improvement plans; large changes cannot happen overnight, and we will only be able to dramatically improve the health of populations by successfully planning for the future.

11. Thought diversity

Organizations that value dissenting opinions as much as coherence and conformance are more effective at creating change; thought diversity allows the creativity of our people to flourish and good ideas to be discovered.

Phase 2 of the NHS Change Challenge is now underway, in which contributors are invited to identify solutions. I will report back on its findings in a future Column.

Author

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ⁱ www.bbc.co.uk/news/magazine-17429786

ⁱⁱ www.uclpartners.com/news/transforming-healthcare-along-an-integrated-patient-journey

iii www.independent.co.uk/news/uk/politics/governments-reorganisation-of-the-nhs-was-its-biggest-mistake-say-senior-tories-9790247.html

iv www.dailymail.co.uk/news/article-2594694/How-NHS-managers-given-huge-pay-rises-doing-job.html

v www.dailymail.co.uk/debate/article-2661970/Death-bureaucracy-As-learn-NHS-bankrupt-read-excoriating-attack-managers-senior-consultant.html

vi www.nhsgather.net

vii www.clevertogogether.com/public/news/changechallenge-results-of-phase-one