Leadership in the NHS: learning from Gerry Robinson

The recent BBC2 TV Series by Sir Gerry Robinson (GR) was based on his investigative activities at Rotherham General Hospital (RGH). Generally well received, the title was directed at whether or not he could “save” the NHS. No doubt this banner is catchy and provocative, but should the primary emphasis be on the organization “learning” not “saving”?

As a very experienced manager of effective change in both large and small organizations, the underlying message in everything GR said and did was the essential need for committed working together by everyone.

Parochialism impedes effectiveness. But persuading everyone to sing from the same hymn sheet is not achieved by written dictat. It must be put across in face-to-face meetings in which everyone is exposed to, and debates this simple message. It may be strange to accept the logic that seamless patient flow through the healthcare delivery process is what governs effectiveness. Furthermore evidence strongly suggests it is achievable by working smarter, not by working harder. In other words “effectiveness” equates with “ease of performing”.

The scenario

A major problem encountered by GR was the varying perceptions of time scales to achieve effective change. Much of this could be traced to lack of experience by the “players” in being actively encouraged to participate in “live” improvement projects. Yet the magnitude of the time scales quoted were alarming. Frequently these were many months rather than just a few weeks which GR regarded as more appropriate for setting up a pilot run. Often such exaggerated time scales were caused by fragmented sequential, rather than single meeting consultations with all parties being present. Not only is there then a huge domino effect on the delay, but all kinds of misperceptions arise as messages are subjected to bias or rumour.

Innovations need to become a way of life. It may seem strange that huge advances have been made in the “what” of patient treatment. Individuals, when treated in the NHS, now have much greater life expectancy compared with prospects even a few years ago. Such improvements are headline making, glamorous, and immediately satisfying to those involved. Not so in the more mundane world of healthcare delivery, or the “how” of the process.

People matter

As GR discovered, there is no shortage of constructive ideas in hospitals. There is, however, a huge problem in creating the atmosphere to elicit them and following through to encourage the “local experts” to believe things are really going to change. All too often in the NHS prevarication is the bane of progress!

At RGH, it was many times confirmed that effective change could indeed be triggered by internal catalysts already working at the coal-face. The necessary combination of ideas, planning capability, and enthusiasm was indeed found amongst “players”. Their capability was scantily related to their place in the hospital hierarchy. This is to be expected, and the conclusion to be reached is that these catalysts should become project facilitators irrespective of their position as secretary, technician, nurse, or doctor.

Improving throughput requires group activities led by the person most appropriate for that particular project. What this means is that two different projects in the same specialism can be propelled by quite different people from within the group, but each would be the “best choice” for that particular innovation. This is informal group self-management. Maybe within the NHS this should be emphasized as “management” with a small “m”.

Teamwork

Action in the (GR) innovations culture is based around teamwork. The “local experts” accept responsibility for analysing the bottleneck, designing an improved system, and then implementing the solution. But the emphasis is on consultation and
agreement on steps to be taken, setting realistic time scales, and deputing team members to do particular things. Elsewhere this approach to teamwork is often called a Task Force i.e. the group are tasked, empowered and suitably supported in engineering their important project. It is the management's role to encourage and enable such activity. They must also identify any specialist skills needed to achieve their goals.

Activity based economics is just a plea for realism in comparing various competing “what-if” solutions the team suggests. Deciding between alternatives must be based on transparent analyses of the proposal. This trade-off must be capable of giving a clear lead on any perceived benefit. If spending money on extra staff will considerably increase operating theatre (OT) throughput, with its associated huge benefit to hospital reputation and income, then this must not be aggregated with “top down” accounting which may contrarily indicate the need for a freeze on appointments. Nothing is gained from encouraging staff to innovate, and then not backing a solution which demonstrably benefits everyone. In such an atmosphere it is very unlikely that staff will be so collaborative next time around.

Outcomes

Experience in many areas of management suggests that simplicity of design and implementation is best. So it is not surprising that this emerges as a dominant GR guideline for improving RGH performance yet further. Effective progress is made by understanding simple analytical techniques such as the empirical Pareto curve. This concept seems to apply to most areas of human endeavour. Hence in any given scenario about 80 per cent of the problems are due to just 20 per cent of the possible causes. So by concentrating efforts on these top sources of ineffectiveness we can rapidly improve system performance. It is, of course, the local experts who collectively have the experience to sort out such situations by sifting the available evidence.

Practical de-bottlenecking is essentially aimed at enabling seamless flow of patients in the healthcare delivery system. The preferred pathway to achieving this is well-known. Eliminate any unnecessary steps, engineer delays out of the system wherever possible, and sequence movements of patients to reduce waste time. Hence having identified OT as a key business element in the hospital, GR encouraged the "experts" to find ways of greatly increasing "cut time". As RGH discovered, once encouraged, surgeons, anaesthetists and nurses working together were responsible for greatly improving “cut time”.

The GR modus operandi

GR intuitively works towards achieving change via an integrated set of ten informal guidelines. To what extent do these appear to have influenced the teams working on improvement projects at RGH? What can be found is that there is much correlation. Every improvement is manifestly driven by a coal-face person acting as catalyst. This is sometimes an individual medical consultant, sometimes the clinical director, sometimes a nursing sister etc. Furthermore this involvement is also likely to be the best route for determining really effective time scales for change. As a consequence the local players “own” effective in enabling seamless patient flow than the alternative of protecting "turf" and functional boundaries.

Self-generated ideas have clearly emerged from many levels within RGH. This is to be expected once the group of “local” experts are explicitly tasked with pinpointing a problem, working out plausible solutions, and then given firm backing to engineer the new way of doing things. So it is established at RGH that GR’s guidelines of focus; expertise; catalysis; and team-working are particularly powerful. But all of the guidelines appear highly relevant to “local expert” led hospital innovation.

Continuing improvement

Alas, there are a number of factors which inevitably may still affect outcomes. As in all cases, caveat emptor must be the watchword. Will everything just regress to previous levels once the GR impact has faded away? Did people collaborate as just a one-off? Was the GR success really due to the simple language and ideas used, or was it due to his unusual degree of persistence? Did GR have a magic bullet enabling him to detect hitherto unseen problems of great impact?

All will no doubt be revealed in due course, but the omens for continuing improvement are good. At the very least, “coal-face” players of all levels of seniority at RGH have taught themselves that effective improvement programmes are possible, even in their difficult environment.

Furthermore the chances of success with new projects will be much higher via the GR modus operandi than bringing in management consultants to perform the task and who then walk away. Doing it yourself is much more effective than listening. It is also likely to be cheaper and quicker. Critically “learning” is now owned by the hospital "players", and not by outsiders.

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This is a shortened version of “Leadership in the NHS: what can hospitals learn from Gerry Robinson – the programme?”, which originally appeared in Leadership in Health Services, Volume 21 Number 2, 2008.

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