

Swimming together or sinking alone

Health, care and the art of systems leadership

By Richard Vize



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Leading healthcare systems

It is difficult to believe, but there has never been a better time to be a healthcare leader. However slowly and imperfectly, the NHS, local government and their partners are beginning to rebuild the health and care system around the needs of patients and communities rather than institutions and bureaucracies.

Under the Sustainability and Transformation Plan (STP) process announced in December 2015, leaders are coming together to take on two big challenges – shaping services around local needs, and doing so in a way which is financially sustainable.

This collaborative approach has profound consequences for leaders throughout the system. Increasingly they are required to move away from organisations and hierarchical structures to operate in networks across their local health economy. Barriers between primary, secondary and community care are becoming ever more permeable and, for the first time since the creation of the NHS in 1948, local government is a major partner in shaping and delivering care.

While the central bodies still wield control, the STP process has given local leaders the collective responsibility and at least some of the power to decide how they should best respond to the challenges of demography, the changing nature of illness, increasing patient expectations, the opportunities provided by technology and the constraints of public spending.

STPs are the moment when health and care leaders have begun to think of themselves as working in patient-focussed systems rather than isolated institutions. The demands of patients and the financial requirements of government will keep pushing leaders down this road. This Institute of Healthcare Management report is designed to help leaders understand the values, culture and skills they need to survive and thrive in this world.

Written by journalist and policy expert Richard Vize, *Swimming together or sinking alone* is based on interviews with experienced NHS and local government leaders. Through their insights we have analysed the difficulties these new, highly pressured networks are experiencing, and identified how healthcare managers need to think and act differently to make systems leadership a success.

Jill DeBene
Chief executive
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Learning to swim

The announcement of STPs was met with considerable cynicism: "Initially the thought was 'here we go again'. It felt a very centralised, box ticking exercise in which we had to be involved or there would be a difficult conversation. We were not clear about the opportunities."

But health leaders quickly accepted that, whatever the limitations of the STP process, the shift from focusing on individual organisations to thinking about systems and local health economies was the right way forward: "We know that to solve our problems the only way is to work with the system; we will never solve it on our own. I am absolutely clear that we're only going to succeed together."

The impulse to work together has been strongest in areas with the biggest difficulties; a sense of crisis focusses minds on the necessity of change, because the alternative is insolvency or clinical failure. Conversely, some of the most fraught discussions have been in areas where everyone is just about managing – inspection results are acceptable and financial targets are largely being hit. For these organisations, there is a fear that even modest service changes could destabilise their precarious balance.

"Significant problems can make the STP process easier because you have a mandate for change. The challenge is those who are doing okay now but will not be viable in three to five years, and getting them to recognise that. I have been saying that they will be destabilised anyway."

But there is a big difference between collaborating through self-interest and making the leap to working in the interests of the system first and your organisation second. As one manager put it: "My worry is that when we think our own organisations are at risk [from what we decide], that will really test the relationships. At the end of the day my board will not thank me for saying 'I think we should invest £20 million in social care to get everyone home earlier'."

Progress towards systems thinking varies wildly between different parts of the country: "When I see the best of people I see them absolutely thinking 'system', absolutely putting their own organisation and personal aspirations to one side. Then in other meetings I think it is so far off system leadership it's incredible."

As leaders from different parts of the local health economy edge closer, the thought processes can resemble the 'prisoners' dilemma' – the optimum outcome for everyone is to work together, but an individual might benefit from breaking ranks: "They are thinking 'what if we behave as doves and they behave as hawks?' They are worried that they might get caught out and be taken advantage of."

In areas which are working well, the conversations around the STP are beginning to develop "one version of the truth" among system leaders – in other words, there is a shared understanding of the needs, threats and opportunities: "The process has forced us to have conversations which means we now have the relationship to really understand the pressures."

In one area, building a fuller picture of the demographic pressures over the next 15 to 20 years moved the debate from constantly talking about the growing number of old people to a focus on paediatric and maternity services. This is a powerful example of how robust evidence can stimulate new ways of thinking: "Having the directors of public health in the room made the difference; you could see people's eyes light up. The evidence base has been good. We are not using anecdote and allegation."



“The thought processes
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Building trust

The bedrock of systems leadership is trust. Without it there is no system, just individual institutions manoeuvring, negotiating and compromising: “The first thing is trust. The whole thing is based on understanding and trust.”

Trust in turn depends on the values of the individuals and their commitment to doing what is best for patients and communities. This requires shared ownership of problems and solutions. One leader observed: “Where I see [collaboration] working well it is due to individuals and their values as well as the depth of relationships. That depth comes from the personalities and building trust around collective ownership of difficult problems, as opposed to people who are

coming together now because they have to and they can't survive on their own – but they would prefer it if they could.”

Trust requires humility, notably from the leaders of major acute hospitals, who need to recognise that the contribution from the social care director or community services manager has just as much value as their own. All leaders should spend more time understanding the value of other parts of the system.

“Trust requires humility”

Organisational development – learning on the job

Shutting a group of people in a room and expecting trust to develop, shared ownership of problems to evolve and common solutions to emerge will almost certainly end in failure. STP leaders need to invest time and effort in their own organisational development (OD). With everyone under so much pressure, suggesting that STP leaders establish an organisational development programme may seem naive and idealistic. But it is essential.

The concerted STP timetable means leadership teams do not have the luxury of getting to understand each other's motivations, drives and leadership styles and discuss how they are going to approach the task before they get stuck in. Everyone has to learn on the job. The important thing is that the need for organisational development is recognised, and the work of the STP is seen as a learning as well as a practical process.

Some STPs are already doing this: "If people learn together, they work together. But you need to do it in parallel; we haven't got time

to do things in sequence. So we've got real life stuff happening and at the same time we've got a review that happened about our operational styles and how good are we about doing stuff together across the system.

"As a result we have a very active OD strategy including one for the top team. We meet every week for two hours [to work on this] and have been for the last four months. The OD leadership strategy has to be part of the enabling mechanisms. There are other enablers such as estates and so on, but the big one is OD."

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Authentic Leadership

Unguarded comments are revealing: “Someone said to me ‘what you don’t realise it that we are at war with them.’” Leaders who earn trust have the integrity to behave the same in private as they do in public. The CCG leader who was overheard saying “how are we going to shaft the acute?” had evidently not understood that. If those charged with systems leadership are simply going through the motions, they will be found out and ultimately the STP process will fail.

Authentic leadership means role-modelling the values you articulate in every conversation and every meeting: “The key bit is when it is embedded in their being, as opposed to being something they intellectually talk about. Do they live and breathe it? Is it mirrored in all their behaviours?”

But it is not enough to sit there smugly admiring your own authenticity; leaders must help others understand the values and behaviours they need to make all this work. That means “thinking about what sort of interventions might be helpful to people; how can we frame conversations to help people move on in terms of their approaches?”.

One manager who has a values-driven approach to leadership said: “I’m very focussed on servant leadership – doing the right thing for the people we serve and the people we employ, rather than coming from a more hierarchical, heroic leadership style which is all about me and my organisation.

“The journey I have been taking my organisation on is about deeply embedding values-based approaches of collective, appreciative leadership as a philosophy which is aligned with how I want to see people practice. That creates the environment where people do the right thing even if it is difficult for them rather than what is easy or in their own best interest.”

“Authentic leadership means role-modelling the values you articulate in every conversation”

Uniting the science of care with the art of politics

A seismic change has been the direct involvement of local government in shaping health services, including several council chief executives playing a prominent role in STPs.

Local politics can be baffling and frustrating to NHS staff; one manager described how an affluent rural council was constantly at odds with its more deprived urban neighbour when it came to the distribution of services. In other areas, political sensitivities around local government elections have caused difficulties: "The electoral cycle is a real issue. Councillors saying 'don't do anything until after May' is a problem. Having local government is a blessing and a curse."

But NHS leaders are coming to understand that building political support can be critical in shaping and driving through change. In the current financial climate, local government politicians and officers are constantly making tough calls on local services, so they know what it takes to win public acceptance or ride out controversy. So how should NHS leaders make the most of their relationship with local government?

"These things are countercultural for the health service. The NHS is a very patronising organisation and its only engages with other people when it wants them to do what it wants. People have slowly learned that if they want to reconfigure services they can't do it without local politicians being on side. But we don't realise that the politician is sitting there thinking 'oh, you never deigned to speak to us before, and now you're coming along because you want our help!'"

"Building a relationship with local government means listening, not telling them what needs to be done"

Building a relationship with local government means listening, not telling them what needs to be done then asking them to rubber-stamp your plan. No one expects the NHS to solve social care's funding problems, but through their social care and public health teams, local intelligence – including what councillors pick up on the doorstep – and deep understanding of building services round a sense of place, councils can make a major contribution to shaping the health and care system.

"Get local politicians' insights into the problems that you are trying to solve through your STP. The best local politicians are inspiring and bring insights which the NHS is not very good at. They see the wider picture – what really is driving demand, why people really turn up to A&E – because they spend their lives talking to local people and have a much broader insight into the possibilities for tackling those issues. They will offer solutions that are different to the usual NHS solutions."

NHS managers who understand the value of local politics "are engaging with them on the same level, and saying 'this is a public service problem, how are we going to solve it together', rather than 'how are you going to help solve our problem?'"

Public health staff can help NHS leaders understand how local politics works. "NHS managers are getting more skilled at working with their local counterparts, but we have been brought up very differently. NHS staff are used to being in an environment where if they know something is evidence-based and well thought through that's what counts, whereas our colleagues in public health understand the need to appeal to a particular constituency and what might send a negative message [to local people]."

Freshly cooked or reheated?

The speed of decision-making imposed by the STP process – which can mean people with only limited experience of working together trying to solve problems which have festered for years – has so far provided little opportunity to rethink care pathways from the point of view of patients. Consequently, plans have often been “largely reheating old ideas”.

One manager revealed that a non-executive director on their board “said ‘hang on, isn’t this the plan from five years ago?’ The solutions are rather conventional; I don’t see much innovation in purpose or method”.

Some areas have even struggled to develop a better understanding of their population’s health needs. “We’re just polishing the same data,” one person admitted. Damningly this was attributed to “a lack of curiosity”.

So far, discussions have been heavily focussed on closing, merging or moving acute services rather than the more painstaking, detailed work of looking at the end-to-end experience of patient journeys, and how connections between services can be made more effective and efficient: “People understandably go for the system architecture, which is not the answer.”

With STPs conducting their meetings in the language of acute trusts and their problems, other perspectives that should be at the heart of the conversation – notably mental health, social care and primary care – have all been getting too little air time. The distorting lens of acute services can be so powerful that other parts of the system are forced to recalibrate their own work in the language of hospitals, such as using delayed discharge data as a proxy for community services outcomes.

One manager said that to get a hearing they have to demonstrate how they will help the acute trusts make savings: “We have to show the money to get our foot in the door. Then we can lay the quality on top of it.”

Allowing one perspective to dominate is the antithesis of systems leadership, and will mean that the STP plan will be institutions first, patients second, systems virtually nowhere, rather than patients first, systems second, institutions third.

“Allowing one perspective to dominate is the antithesis of systems leadership”



Engaging the staff

Staff engagement in STPs so far has been minimal to non-existent, because there has been neither the time nor the management capacity to do it. More worryingly, little thought has been given to how it will be achieved in the coming months.

Clinicians have to be part of leading and shaping the reform drive; ultimately the STP process is about changing the culture, behaviours and processes of clinical staff, so without their willing involvement the whole exercise will stall: "Clinicians need to be leading this – it can't be a management-led process."

This is not just about engaging consultant doctors and social work directors. Involving senior staff is relatively easy; the difficult part is creating an environment in which middle managers and junior staff feel empowered to think and work differently – collaborating across organisational boundaries and putting the patient rather than administrative systems at the heart of what they do. In other words, creating a culture and systems which empower people to do the right thing.

"Junior clinical staff are quite isolated from all [these discussions about systems]. It is about getting them to understand the impact of their actions on the rest of the system. Otherwise they will carry on doing what they've always done. That's what accountable care systems

are – clinicians with the patient in front of them having ownership of that whole patient and the spend on that whole patient. Until we have that way of operating we are just playing around the edges."

Many leaders are optimistic about the willingness of staff to support substantial change, because they see the shortcomings of the old silo-based, acute-focussed way of working every day: "I think a lot of people will be up for that, because they are sick and tired of going around like a hamster wheel getting nowhere. We need to describe this in terms of a totally different approach. When I talk to some of the consultants managing long-term conditions they are really up for this because they are fed up with looking at patients from an acute perspective."

Others agreed: "The vast majority of staff are committed to the mission. They don't just turn up for the money, so if you can actually engage them in the process and say I really think we can do this better and I want you to help us in shaping it, then mostly they will say 'great.'"

"Clinicians need to be leading this – it can't be a management-led process."

Engaging patients and public

“We have spent a lot of time producing documents describing the problem. We now have to get on with delivery and engagement. The next two years has to be about getting out and having those difficult discussions.”

The NHS has a poor record on patient and public engagement. Its default approach is announcing a decision and inviting comments, with the intention of fulfilling statutory obligations to consult rather than listening.

But for some STPs, the engagement phase of the plans is a chance to bring the conversation back to the core objective of building sustainable services around the needs of patients and communities.

“Patients and the public are untouched in the STP journey at the moment. Rather than looking at it negatively, that’s a fantastic opportunity to do things differently.”

As with staff engagement, the objective is not merely to secure acceptance or approval, but to hear ideas, adapt plans and change behaviour. For example, central to reducing demand for services is encouraging patients to play a much more active role in the management of their own care: “We won’t get away with it without the patient helping us to make the change.”

“You have to put in the hard yards to get people to go with you.”

In recent years, plans for moving resources from hospitals to the community have repeatedly risked being derailed by public and media scrutiny; although patients and the public see the benefits of being treated in the community rather than in hospital, it is hard to convince people that community services will be an adequate substitution. Some STP leaders believe this scepticism can be harnessed to drive the change: “The patient can be the great broker this. They are a fantastic asset. Having patients as part of the change process rather than a recipient is absolutely fundamental.”

Health leaders should engage with the public in just the same way as with their own staff and local government – treat them as equals: “We are not going to solve any of the NHS’s problems without engaging patients and the public as equals. If we really do want people to stop going to A&E there is no point in just lecturing them.”

NHS managers need to undertake engagement “with humility. There is some great research by the University of Texas which says that most senior managers believe the biggest obstacle to change is staff and/or customers. Actually it’s senior managers; they are the biggest obstacle to change. If you have a bit of humility and go out and talk to service users and frontline staff they often have the solutions, and if you deign to engage with them they will go with change with commitment rather than resistance. You have to put in the hard yards to get people to go with you.”

Do we have what it takes?

Management overstretch may be the biggest threat to STPs' ability to continue as effective networks. Virtually every part of the country has serious concerns about whether they have the management capacity and skills to deliver these ambitious plans. Over the last few months STPs have been run on goodwill and long hours, but that will be insufficient as the engagement and implementation phases approach.

"If this is supposed to be the big transformation plan you can't do it when it's bits of people's day job to drive it through. The scale and speed of change in the NHS and social care means it can't be part of someone's job – it has to be the job."

Finding more staff to drive this through is seen as "inevitable" by some, while others fear the tendency of national politicians to see NHS management as an avoidable overhead means STPs are doomed to be under-resourced: "Ministers do not understand this at all. It is frightening. Whether MPs and ministers don't want to understand or don't have the experience, they simply don't see the scale of the problem, and therefore the scale and capacity required to address it."

One manager highlighted how he had personally spent at least 50 hours navigating the public engagement around the "tiny change" of closing a small unit with few patients: "Managing public anxiety is going to take a huge amount of time, going along to church halls to meet three people. Once we talk about patient pathways that is going to unleash a huge amount of work."

When it comes to public consultation "clinical time will be critical, because one white coat is worth a thousand suits", but clinicians will be just as hard-pressed as managers to dedicate time to winning the public around.

Meanwhile, leaders will have to move from negotiating over a big picture document to nailing down exactly what has to change in each organisation; every one of those steps will require yet more negotiations and countless detailed actions.

Central to delivery will be a shift in gear from managing services to leading change: "This really does require leadership but at the moment it just feels like NHS management."

One leader described getting the capability to deliver the scale and complexity of change as "a big problem".

"In the early days of austerity most of the savings were fairly transactional – back-office systems and so on – but what we have to drive now is whole system change. That requires a much more sophisticated leadership approach – a lot more patience, a lot more political cunning, skills which I don't think are present to any great extent."

Transformation is being held back because it is being grafted onto existing systems, structures and cultures which are resistant to change: "If our job really was to unite community and acute and social care then we would run it in a new way. Apart from [NHS England chief executive] Simon Stevens cajoling us, the incentive is not strong."

To make change stick, "infrastructure, systems and behaviours all have to come together, so you have to think long and hard about the how. So there is how organisations come together and we move away from purely silo driven [setups] to joint boards and all that. Then there is securing senior buy-in, so you need a strategy for chief execs and the senior directors, and then you have the middle tier that can either support or block it. So you have a complicated web of organisational development and learning programmes".

As well as outstanding leadership, project management skills are vital: "If you have Prinz designed project management looking properly at resources, timescales, capacity and needs and map it all out, it doesn't half work. It is having that rigorous process for identifying what needs to be done. The NHS loves the creative phase up front, it doesn't like completion. It hasn't got enough people who doggedly determine what needs to be done, and execute, execute, execute."



"The NHS hasn't got enough people who doggedly determine what needs to be done, and execute, execute, execute."

Creating the environment for change

STP leaders who complain about the role of the central bodies in the change programme need to set an example locally of how it should be done: "STPs need to practice what they preach."

Time and again there have been complaints that 'the centre' is providing the wrong incentives, but for frontline health and care staff, the STP is the centre. Local leaders need to be relentless in demolishing the barriers that their own staff experience in joining up services – community mental health workers with acute consultants, social workers with A&E staff, and so on."

"The role of a manager is to clear the rocks off the runway"

The imperative for leaders to clear the way for staff to deliver change and work differently was a key message from our interviewees: "You have to take some risks as a manager. The role of a manager in the private sector, by and large, is to clear the rocks off the runway. It is not in the NHS. We put people together who have got completely different cultures, different rules, different budgets, and say 'right, work together in a seamless way.'"

Creating momentum and belief will require some early victories: "We have to demonstrate some of the successes. If it's all jam tomorrow it will be too late, so some of this has to be about taking risks and doing early wins."

It's a marathon not a sprint

In the face of intense financial and demand pressures, there is inevitable tension between the desire of the central bodies to move fast enough to outrun the problem and the local reality that sustainable change takes time and excessive speed will derail reform. Perhaps the toughest leadership job will be managing that tension.

"One of the biggest challenges we will face as leaders over the next few years is staying steadfast in achieving change in a measured way and resisting what will be a natural temptation for the centre to be saying 'hurry up, we need this quicker'."

But if we don't do it properly it won't work. How do we hold to that when there is so much anxiety in the system?"

"If we don't do it properly it won't work"

Breaking free

The Sustainability and Transformation Plans are not creating problems; they are exposing the shortcomings of decades of silo working. By bringing together leaders across local health and care economies and encouraging them to focus on the needs of communities rather than organisations, they have shown a way to escape the relentless cycle of crisis management and short-term fixes which fails patients and demoralises staff.

The shift from a hierarchical, centrally controlled health service driven by the needs of hospitals to place-based health and care systems driven by patients and communities demands leadership of the highest standards. As well as relentless energy and hard work, leaders need to role-model the values and behaviours of systems leadership in everything they say and do.

Concepts such as trust, humility and engagement are not ideals to be pursued at some future point when there is less pressure; those days will never arrive. On the contrary, they are essential for leaders to meet the challenge of building high quality health and care around the needs of patients which the taxpayer can afford.

“Leaders need to role-model the values and behaviours of systems leadership in everything they say and do”

Afterword - stark choices

The publication of the Five Year Forward View in 2014 provided a compelling vision of integrated, preventative, community-based care, while the idea of allowing local areas to determine the best solution for their communities from among a number of care models demonstrated a willingness to address the long-standing problem of excessive central control stifling innovation.

But within months the rapidly worsening debt crisis among the acute trusts threatened to derail the entire reform project. Sustainability and Transformation Plans are an attempt to find a way through profound tensions in the system – between central and local control, between dealing with the immediate financial crisis and planning for the long term, between prevention and treatment, and between organisation and system.

STPs can be seen as an attempt to use a moment of crisis to change the culture and practices of the entire health and care system. NHS England and NHS Improvement have challenged local leaders to face up to problems in local health economies which have been left unresolved for years, even decades.

STPs are simultaneously highly centralised and highly decentralised. While the centre has been driving an extraordinarily demanding timetable for decisions and applied massive pressure on organisations to meet their spending targets jointly and severally, by NHS standards there is also a high degree of local autonomy. The localist flavour of STPs is reinforced by the involvement of local government, encouraging local health leaders to see services through the lens of place and community rather than institution.

The most difficult parts of the STP process are ahead – persuading the public that the goal is to build a 21st century healthcare system and not simply cut back a 20th-century one, and then making it all happen.

The biggest risk to the STP process is the extreme optimism bias of the financial plans. In an effort to meet demanding budgetary targets, local areas are making big promises for the savings they can achieve with a little hard evidence or detailed planning showing how it will be done. Many of the savings plans will fall short.

The NHS has a dysfunctional relationship with money. Whether it is a period of investment or cutbacks, it never seems to have the right amount to stimulate change. Meanwhile other parts of the public sector – notably local authorities – have been taking huge amounts of cost out of their systems by exploiting technology, moving customers online, merging and outsourcing their back office infrastructure, and changing, sharing and selling their buildings. The record of the health service in all these areas is lamentable. The STP process – particularly the opportunity for local public sector organisations to pool resources such as buildings and replace obsolete IT with integrated, cloud-based services – offers huge scope for higher productivity at lower cost.

If these opportunities are not seized, the biggest risk to the NHS is that it will fall further and further behind public expectations of how it should use technology to provide seamless, personalised and timely care which fits into our busy lives, and how it should be caring for us in our old age.

At present, few people opt out of the NHS to go private. But if the health service cannot meet modern expectations of service quality, there is a serious risk that in decades to come more and more people will choose to make other arrangements, leaving the NHS as a provider of last resort more akin to Medicaid in the US than a comprehensive service for all. Private, app-based services are already encroaching on everything from primary care to screening.

By the standards of other developed countries our spending on healthcare is low, and this needs to be corrected. But simply pumping more money into the NHS will not solve the fundamental problem that it struggles to work as a lean system and adapt to meet changing needs.

The opportunity for change presented by the STPs has to be grasped; collaboration across local health economies has to be the way forward. National leaders have to “clear the rocks off the runway” – including changing the money flows and regulation which drive so much dysfunctional behaviour – while local leaders must see themselves first and foremost as change agents of the entire health and care system – empowering their staff to do the best thing for patients rather than be constrained by dysfunctional organisational structures and cultures. This is probably the toughest challenge the NHS has ever faced.

As one of the leaders interviewed for this report put it: “In my own team we were discussing transformation versus business as usual, but business as usual is transformation. There is no part of the system where I want you to just to maintain things. That has gone.”

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