CM: Welcome to Doctor Informed. Brought to you by the BMJ made in collaboration with THIS Institute and sponsored by Medical Protection. Doctor Informed aims to take you beyond medical knowledge. We're talking about all those things that you need to be a good doctor but which don't always involve medicine. We've been hearing a lot about the problems of healthcare, but we also want to talk about solutions. Whatever we're going to do to fix healthcare, whether it's bullying or burnout or patient safety it's going to require change. And change is hard.

I'm Clara Munro and in this episode of Doctor Informed we're going to be talking about that dreaded phrase, but it's always been done that way. And today joining me to hear from some experts and offer some expertise of his own is Graham Martin. Thanks for joining us back on the podcast, Graham. Can I get you to reintroduce yourself to our listeners?

GM: Hi Clara, yes, I'm happy to. So I'm Graham Martin. I'm Director of Research at The Healthcare Improvement Studies Institute at the University of Cambridge.

CM: Lovely. So the title of today's episode is 'But it's always been done that way.' And it's probably a bit triggering for people who work in the NHS who…I'd be surprised if no one had heard that adage before, especially if they've ever tried to initiate change. Have you ever heard this, Graham in your work?

GM: I have and I think it's probably fair to say that you hear it quite a lot in the NHS. I think it's also fair to say that you hear it in all sorts of other fields as well, and particularly large organisations. I mean that's something that we might get into a bit later on. It's one of those clichés about bureaucracies as well, is that they're very good at doing what they already do, but they're less good at adapting. So certainly not unique to the NHS. It's not unique to healthcare. It's a challenge for everyone but there are ways to try to address it as we'll hear later on.

CM: Do you think there's a reason why it predominates more in healthcare than other fields or do you think that that's… I just wear a healthcare hat, so obviously I'm probably going to think that.

GM: I don't know that it does necessarily exist more in healthcare than in other fields. I think again it's a stereotype which perhaps has a thread of truth to it that is something that can take hold more easily in large bureaucracies and perhaps in public service organisations, partly because they tend to be large bureaucracies. Now there've been lots of efforts to try to change that to make organisations more dynamic in the public sector and the private sector. Some have been more successful than others. But I don't think it's fair to say that a public service organisation or a healthcare organisation is inevitably going to be bureaucratic and grinding to a halt and finding reasons not to change. And I don't think that's true of the organisation necessarily, and it's certainly not necessarily true of the people in that organisation.

CM: Do you think it's more to do with size? And I'm generalising here, but I suppose public sector organisations tend to be bigger than private sector organisations which can be big, but can also be quite small. And I'm thinking particularly about conversations I've had with friends who work in the private sector who maybe have worked for a big company and then they've gone to a smaller start-up where suddenly they are a bigger cog in a smaller machine, rather than a small cog in a huge machine. And their reflection is often that more bureaucracy and more resistance to change is created when you're in a much larger company. Do you think that might have something to do with that?

GM: Yeah, I mean I think there's certainly some truth in that. So size is a cause of complexity but size also necessitates ways of dealing with that complexity and ways of dealing with the size. So bureaucracy, actually if you look at the history of bureaucracy and the theory behind bureaucracy, the whole idea of bureaucracy is to try to give structure to and to organise the chaos that can come from lots of functions, lots of people working together. And actually a well-functioning bureaucracy in the classic notion of the word, and not the pejorative sense in which it's sometimes used is quite well equipped to deal with that kind of complexity and deal with the challenges that arise from lots of people doing lots of things with distinct functions who have to relate to each other.

And it is good at that up to a point. But it can also cause its own problems in terms of the overhead that goes with decision making and arguably in terms of the way that bureaucracy tends to perpetuate itself. So again, it's a cliché and sometimes it's used by people to attack bureaucracies and to attack the healthcare organisation, not necessarily with good faith intentions. But there is some truth in the notion that bureaucracy perpetuates itself, bureaucracy is very good at creating more bureaucracy.

So the difference between something like the NHS which is a big organisation and perhaps even more importantly a complex organisation with lots of different things going on, lots of different people working to slightly different purposes who have to be coordinated, the difference between that kind of organisation and a small start-up as you say, is huge. And that's to do with size, it's to do with what's already in place, and it's to do with the way you have of trying to coordinate. So it's much easier to coordinate a smaller number of people. It's much easier to coordinate in a simpler organisation where perhaps the purpose is a little bit more straightforward as well. But even those start-up organisations will very quickly start to encounter the kinds of challenges that bureaucracy is partly a solution to but also can sometimes perpetuate and give rise to more of.

CM: So that's probably a really good time to bring in our first interviewer. And that'll be come up right after this message from our sponsor.

S: [Advertisement]

CM: And now our interview with Penny Pereira.

PP: Hello, it's great to be here. So I'm Penny, I'm the Manager Director of Q at the Health Foundation which is an independent charity committed to bringing about better health and healthcare in the UK. I've been at the foundation for about a decade, so focused on our leadership work, our work on how you improve patient flow through healthcare organisations. And how you can learn and innovate through networks.

Before that I've worked in the NHS, so mostly supporting clinical teams to improve care. I've alternated between national roles and working in local trusts mainly around London. I've been leading the Q initiative for the last six years. So Q is a community of thousands of people across the UK and Ireland who are collaborating to change health and care for the better. So it's all about bringing together people with a whole diverse range of skills, knowledge and perspectives and trying to make it easier for those people to inspire and support each other. So yeah, anyone can apply to join for free to become a member, and to make the most of what Q has to offer, but we've also got loads of insights, tools, resources, to support people in their improvement work, that's available to everyone whether or not you're a member. So yeah, that's how I spend my time.

CM: I'm really glad you answered my first question actually, which was what is the Q initiative? Because I've not heard of it before which is shameful.

PP: It really is. [laughter] Four thousand six hundred members and climbing every day. You can join at any point.

CM: One of the other editors just mentioned to me before I came down here, are you not a member of the Q community? I'm a member of the Q community, it's fantastic. So yeah, so that's a definite prod for me to do a little bit more work about what it is and how to get involved.

I'm interested from obviously your vast experience working in the NHS and now with Q. There are loads of models, there are loads of theories, there are loads of books about enacting change. In reality I'm sure clinicians do not always find this easy to do. And the title of this episode is 'But it's always been done that way.' And I would challenge anyone in the NHS not to have heard that little phrase before.

PP: Oh gosh. I mean you're so right, change is hard. It can take a long time. I suspect that is true to an extent across industries. I think there's definitely cultural aspects to it. But I think it's also woven into the processes and the systems, the structures that we use that can get in the way of actually iterating and improving care. The language that you use around it's always been done that way, that tends to lead you to think about actually, there are some laggards, there are some people who are resisting change because of vested interests.

But actually I think that way of thinking about it, it can actually make it harder to get to a good place. Because I guess if you really want to understand and create the conditions within which people are going to really engage, they're going to commit to working with you to designing and introducing a version of whatever change you want to achieve that's actually going work and that's going to last beyond the point at which you're pushing people to do it, then actually you need to get out of the mindset of assuming that other people are being resistant because that's just a common phenomenon. And really, really listen to try and understand what is the set of reasons why people are resisting this particular change.

A key principle for improvement for me is not all change is an improvement. Even the best ideas need a lot of iteration and support and actually people who are challenging you, the resistance you get, is part of the process of making that better.

CM: You've talked about projects that have succeeded, and I'm interested in this idea of success in how you define success in innovation and healthcare.

PP: Oh. I mean I think it is inherent to improvement that you should start off really being clear about what success looks like and defining that well. You may need to change your definition of success as you go along. But rather than have an abstract generic measure of success I guess I would say you should always have a set of goals and you should have a way of measuring that. And you should probably also make sure you have a balancing measure. So a measure that tells you if you're actually going off track and making things worse, which is obviously possible.

I mean linking back to our other conversation, there is success that you can achieve on a small scale and there's a certain set of measures that you could look at there. I guess I'm increasingly interested in the things that will enable adaptation at large scale. And I think if you want to create something that's going to be able to be adopted and make a difference on a bigger scale then there's an additional set of things that you need to take into account. So you need to understand the conditions that made it possible that you could introduce that particular change.

So often it's not just about the change to the clinical process or the pro forma, it's about the other things that sat around that that made that possible. So that if you try and implement that in the next ward or in another hospital, often it's not the specific change to the pro forma that will make the difference. It's the other stuff.

CM: In terms of unintended consequences of change, do you have a strategy either personally or through Q about measuring unintended consequences? And I guess it's the old phrase you can't please everyone all of the time. Is there some situations where you have to say okay, this isn't going to work for everybody but we've got this greater goal to reach. An example I'm thinking of, always go back to surgery because it's what I do, but we've obviously got this huge surgical backlog and a few places I've

worked I've said right, we've got these consultants that can get through 12 hernias in a day, we'll put them on the list and we'll smash through all these hernias. And in no time the backlog will be gone.

Obviously the unintended consequences, you then aren't training more surgeons. So in ten years' time when those surgeons retire you've got an untrained workforce and it's the balance between getting through things but also… Getting the job done but also making sure that you're not creating an unintended consequences. Is there, in your process when you're implementing change, do you have a way of managing that? Or do you trial it and then come back and have another look?

PP: Oh gosh, that's a big question. [laughs] Let me… I guess in relation to the example you've raised around waiting lists, yes, there's the risk around the training of the next generation of consultants. But actually in the short term there's so much greater challenge around balancing the morale, the capacity of the staff, making a change, and the operational imperative to be getting through backlogs in care. And that's just going to be with us. It's going to be so significant for the coming years.

And one of the things that we've seen from conversations I've been having with colleagues in the different countries, the UK and Ireland is the phenomenon that those places that have greatest pressure in terms of waiting lists and where there's the greatest pressure just to be pushing the activity through, are also the areas where people are likely to get so burnt out and so pressured. And where actually what you need is not just putting through the activity but you've got to create the space to be able to step back and actually think more holistically about the care that's being provided. And create an environment where people then have the opportunity to actually take a bit of time out to understand and design their processes. Not just because that's going to enable a better solution that doesn't have as many unintended consequences. But also it'll be really important for morale.

So I think the specific question of waiting lists is going to be a really prime example of what we need to be paying attention to. I guess the other thing that your question made me think about was an example from when I was doing one of my earliest improvement projects trying to introduce opportunities for people to book their own surgical admission and their own outpatient appointments. And there were a whole set of people who had an interest in the changes that we were making. Obviously there was the surgeon, there was the [laughs] theatre staff, there was the medical secretaries, we were introducing a whole set of changes all at once. There was the management who had to set targets that we wanted to reach.

And actually systemically trying to map out the different perspectives on what was going to be important to those different people was a really important part of the process. I think what I look back and realise is that it's very easy to then spend time focused on the people who you feel are most important and are holding most weight in that immediate context. So I look

back sometimes with shame at some of the changes I introduced because actually I did pay more attention to the consultant who ultimately had greater power to make a difference as to whether the change I was introducing would sync or swim. But actually I put much less weight on the people who were staffing the call-in centres and what they were telling us.

And it was much harder to get a perspective of actually what was important to service users, and not just the patients who we had on our panel, but actually those people who might not be coming forward. So I guess that process of understanding all of the different steps and who's involved and then thinking about what those different people need is probably necessary in order to get to a point where you are considering the different… Through having visibility of what all of those people can see, you'll avoid having lopsided solutions because you'll have greater visibility of all the different considerations.

I guess that needs to be given some weighting that isn't just about who's most important to you now. But really making sure that you are covering the bases in terms of the things that you're paying attention to.

CM: I can hear when you're reflecting on that, that that's obviously something that feel quite strongly about, and that you thought I don't want to do that again. Is that something that you think you can teach people when they're making a change about how to make sure that they're listening to all the right people? Or do you think that that's just something that comes with experience that you've learnt over time?

PP: I think there are a set of easy to use pragmatic methods that help to…so pay attention and listen. So sometimes those are process methods. So mapping your different stakeholders or in the Q community there's something called liberating structures which is just taking off. It's a whole set of really little processes that you can use in meetings to make them both much more fun and much more genuinely inclusive. And they only take a few minutes to implement and it just creates a different kind of conversation. So I think there are process things like that that make it easier to be a leader who is able to pay attention to a different range of voices.

Certainly I wasn't exposed to that early on in my career. It's made a big difference since I've been able to have those tools. But I mean ultimately improvement, it is also about leadership, it's about people. It leads you into places that require you to examine your own approach and way of thinking about change. And so at a certain point it does call you to dig a bit deeper in terms of what you're paying attention to, issues of power, issues of relationships and hierarchy. I think over time the technical sides of improvement should become easier and more straightforward. I think they continue to be an important part of the mix. But it's actually the human and relational, the political side of things which you learn to pay more attention to perhaps.

CM: I think my first reflection when listening back to that interview with Penny was this idea of where the power is held in terms of where we think about…who we think about is important when we're making a change. I think generally in the NHS the person that's at the centre of any change is always going to be patients. That's obviously incredibly important. But I was really interested to hear Penny talk about how actually those stakeholders, whether it's doctors, nurses, allied healthcare professionals, managers, how actually those changes can affect them positively and negatively. And how often we don't always think about that whenever we're trying to make a big change. Is that something you've experienced?

GM: Yeah, I think it was a really good point from Penny and I really liked her turn of phrase. I think she talks about lopsided solutions, which is actually right. They may well be solutions but they are solutions that address some aspects of the problem better than others. And as she said, often the temptation is to look at the people who can really veto this if they want to, the most powerful people who are often the consultants or perhaps the senior managers. And that's fine, I mean it's really, really important of course to ensure that you bring those people onside because they do have that power of veto. And so if you fail to get them to engage then you're probably on a highway to failure.

But if you end up with solutions that don't take into account the views of others, then A, you're going to annoy a lot of people, B, you're going to come up with things that don't necessarily work. And C, you're going to come up with things that may have unintended consequences. And that's because a very wide range of people often have a different perspective on the problem, and actually will help you to understand the problem in the round. And very often, and I mean the things that you talk about in terms of operating theatres, but also you can think of flow through hospitals, these are really challenging issues because they cross boundaries. Because changing one part of a system can have an unintended consequences for another part of a system.

So in order to get to a solution that at least has a chance of working and that doesn't piss people off, that does engage people, and does take full advantage of the understanding they bring to that problem, is really important to try to engage the full range of different people, including the ones who seem less powerful.

CM: Yeah, and I think some of these concepts and topics that Penny brought up I thought okay, I could see myself using terms like that to try and talk the same language the people who I need to get onboard, who hold the money. And a lot of that language does have a useful purpose, but sometimes it can turn people off frankly. And sometimes, and I think this is perhaps the most dangerous bit, is when these kinds of…the same terms are used for different purposes. And sometimes that can certainly happen with stakeholders. So stakeholder management from a comms perspective might mean a very particular set of relatively powerful stakeholders. Whereas the stakeholders you're trying to involve, as we've just said, in a

change initiative, are going to go much, much broader than that. And it's about trying to ensure you give the respect and importance to people who might be missed out.

CM: I want to go back to some of the things you've said, but I think now is probably quite a good time to bring in the interview with Moira Durbridge, because she comes up with some really practical examples that we can build on. I think about some things that you've just said. So here's my interview with Moira Durbridge, Director of Safety and Risk at University Hospitals of Leicester NHS Trust.

Doctors find it really difficult to accept failure, it's not really built into the way that we're trained. Is that something that you've seen in the work that you've done clinically and in the more managerial and corporate side?

MD: I think that is right. But I think increasingly as we become much more of an improvement minded organisation and as improvement methodologies are more accepted, I think people understand that to embark on a QI journey will often involve things that don't work and fail, and that's fine. And that testing, some things you test work and some things you test don't. So at the early stages of COVID we tested the virtual ward environment. And what we thought would work very well and easily, some things didn't. They were much more of a barrier and a burden, and other things worked well. But incrementally you improve.

So we started virtual wards for COVID, for COVID patients. And then more for COPD patients. And then for heart failure patients and now for AF patients. And what works well for one group may be subtly different for the next group. So I think encouraging people to understand that, whether we call it failure or things that don't work, is part of the journey and it's to be expected. So people shouldn't be discouraged by that. They should expect that to happen. But reflect, learn and refine, and then move on.

CM: I think one of the massive barriers in my experience, and do you know what, I used to think it was maybe UK or NHS centric. But I was actually editing a paper on how to reduce pre-operative testing earlier by some Canadian authors. And they had mentioned something which was, I don't know, it was so reminiscent to me of any time I've tried to make any change in the NHS. They said one of the massive barriers was people's attitude of it's always been done this way. And as soon as I read it I thought okay, maybe this is a healthcare thing rather than a UK or an NHS thing.

In your role how do you guard against that? How do you guard against that barrier of people saying well, we've always done it?

MD: So you've hit on an incredibly crucial issue in transformation. Doing the change is sometimes the easy bit. It's about the cultural elements. Because cultural norms are often comfortable. People know what they are. They're comfortable within that environment. And doing something different

suddenly may mean that you're working environment is different or the times you come into work is different. And that usually creates a tension.

So it's about is this the right thing to do? So the lens through which I try to view success is what impact will this change, this transformation have on the patients and public of Leicester? And if you can be really clear that this is what best in class looks like or this is why the change has merits to the patients, then most people can get behind that. But the things that trip you up are usually the cultural bits. And getting people on the bus in terms of the journey of change.

So I don't think that can be overstated about dealing with those issues. That said, Clara, doing innovative change can be incredibly motivating. So starting new technologies, making a change which significantly improves outcomes or length of stay or experience for patients is I guess what we all come to do, isn't it? It's why we came into healthcare. And so that can be very motivating for individuals and for teams, and to be part of that and to celebrate that down the line can be very powerful as well.

So I think a lot of this is about storytelling. This is where we are. This is what best looks like. Why wouldn't we want to be best? This is the journey that we're going to be on. And getting people, as I say, on that journey, working with you. That's how we've tried to do some of the transformational change.

CM: And I think that we use that cultural all the time clinically. I mean if you've worked on critical care I'm sure there's been a fair few emergencies there. And I remember, one of my bosses once said to me if there's an emergency the best way to get everyone onboard is to say the patient is sick, we need to do this thing, whatever it is, and it focuses everyone, everyone in theatre stops chatting or whatever. There's some bleeding, we need to stop it.

And I think that's almost exactly what you've just described in a sort of strategic and managerial lens, is we're all here to serve the patients, let's try and get onboard with this. Yes, it's easier and it's more comfortable to do what we've been doing forever. But that's not going to change things.

Has there been an example where that's been the case and you've managed to shift that culture?

MD: Within our current transformation programme one of the big items is theatre transformation. And that's because if we're going to get through the backlog of 104 week patients and patients have been waiting a very long time for diagnostics or procedures, productivity and efficiency is really important. So sweating the assets in our outpatients in theatres, so that we see as many patients as is reasonable, so that patients at the back end of the queue are waiting less long. And the mortality associated with that is reduced.

So we've had to look at how theatres work, how they're organised, how they work together, start and finish times, downtimes. And all of that is very emotive to people who work in theatres. Getting the people…is that if we

can change some of the ways we're working we can move the needle on the backlog and patients waiting. And that's been a really successful model. So we've done a lot in theatres and some of it's around process and some of it's around booking and some of it's downtime. And some of it's around environment and space. But there have been very significant gains, and that will have a powerful and positive impact on the backlog.

I think that's really… I mean you've touched on a really interesting point there which is if you are asking people to change are you offending them, that the thing that they're doing at the moment isn't valuable. And being able to navigate making that change but also explaining to them it's not that what you're doing is bad, it's just that we could do it better…

MD: I think it's also about the storytelling. So people are good people who are coming to do a good thing. But if you give them some of the narrative most often they'll find a lot of the solution. And if they can see the patients that sit behind this, and they can buy-into the story, they'll usually buy into the solution.

A top down dictate about changing something rarely works. And rightly so possibly. But people understanding the narrative, the story, their part in the solution, as I say, can be quite empowering. And also I think setting the tone. So we have a chief executive who says you have the solutions, we're here to help enact them. He always says I'm usually the least informed person in the room. You've got the ideas and the innovation but we're here to help.

I think giving people permission and power and authority to do this is helpful too. And I think that compassion leadership approach has really changed. So I look back ten years ago and it was much more draconian and much more performance management. Now I think it's much more collaborative and learning. I do accept of course if you're a junior doctor and you're working on a reasonable estate and the on-call room that you go to is shocking and there's no hot food at night, it won't feel like that.

But our view is making staff's lives just that little bit easier and listening to what's really important for staff will help them do the transformation, the improvement and all of that, and I'm sure that's right. And I think that is a responsibility of the board and executives. Equally I think it's an important responsibility for consultants. Because we know for students and doctors in training that the greatest impact on their behaviour today will probably be their consultants'. So their consultants' desires and wishes and behaviours. So ensuring that we are looking after the senior medical staff so that their culture and behaviours and performance also is congruent with what we're trying to do in compassionate leadership. So that students and trainees can feel they can ask questions, they can challenge, they can innovative, they can contribute, they can sit on committees, they can be part of it. That is a really empowered organisation, a fearless organisation. And that's what we're seeking to become.

CM: So let's say I'm a junior consultant and the F1 comes to me and says Miss Munro, Clara, whatever they're calling me these days, I think that we could be doing this a lot better and I want to change this. What can I say to them as a compassionate leader to enact that transformation, to encourage that?

MD: So the first thing we say, always say thank you. Thanks very much, thank you for coming and raising it. Because sometimes people…they're really anxious about either saying a concern or offering what better might look like. So one, we would say thank you. Two, if you can, take them for a coffee. Now I know that isn't always easy, but it is sometimes, you can do that sometimes. So take them for a drink. And then say tell me what you think better looks like. Tell me what this looks like to you. Tell me… So encouraging the conversations, encouraging the dialogue, and then the consultant to phone the QI team or the transformation team and say can you put some support around this? Is anybody else doing it? Can it be plugged into a bigger piece of work?

So those are the sort of mechanisms. But really it's about encouraging the conversation. And pointing them in the right direction of somebody who might be able to support, and giving them permission to try a change and testing it and then measuring for improvement and seeing is this in patients' benefits? Does it work?

CM: And just to come full circle on what we started talking about, especially given how terrible we are at failing or admitting that…framing things as failures when actually they're just things that didn't work, is there anything that we can do as clinicians that when the F1 comes back and says okay, I tried a thing and it didn't work, what can I say to them or what can I do for them that doesn't frame that as it didn't work, that's a failure.

MD: So I think my response to that with a junior would be why are you surprised? It's the understanding that failure is part of a journey to success. Sometimes you strike gold and you can implement something and refine it and develop it and it will succeed. But usually the pathway to success is trial and error and testing and retesting. And so learning to fail and fail fast and fail and moving on. But it's the reflective bit about this not working is not failure, it's part of the journey to what better looks like.

CM: One of the things that I've churned over quite a bit since that interview with Moira was this idea of testing and expecting failure, rather than testing because you expect to succeed and if you don't succeed you've essentially failed. And one of the things that we talked about before we started recording that interview was how that differs in tech, in the tech industry. And I wondered if you had any reflections on that?

GM: Yeah, I mean it's a really good message and it's one of those things that we kind of know in our heart of hearts. But it's so easy to forget it that actually anything that's worth pursing, any achievement is really going to be result of an awful lot of effort and probably an awful lot of failures along the way. So just understanding failure differently is really, really important,

normalising failure I suppose as a way point on the route to success. And there's something really about the culture of how to make change, of what's involvement, and that accepting that the number of failures is going to outnumber the number of successes by several fold. But it's part of the process.

CM: I think that's the first time I've ever heard anyone articulate that, especially anyone from transformation change background, to say there are going to be more times that this doesn't work than it does, is such a simple thing, isn't it? But it was such a light bulb moment for me. I went oh, right, okay. I can get a bit more comfortable with that then, I can be a bit more okay with the fact that everything we try and implement in healthcare isn't going to be perfect.

I wonder how much of that is wrapped up in the organisational culture because we're dealing with patients and health rather than machines and bits of tech.

GM: Yeah, maybe, I think that's an interesting point. And Moira talked a lot about trying to create an improvement minded organisation, was one term that she talked about. And she talked about a fearless organisation and these are names that have been applied to organisations in various sectors. I think you might be onto something there that… It's more high stakes, isn't it? Because you get something wrong in patient care and clearly it can have really adverse consequences. And I guess that can be quite chilling and quite sobering in terms of what you do. And I think there's the other aspect of what you're saying there, is that everyone realises, because we use the technology ourselves, that there's betas and there's bugs and there's revisions and all the rest of it, it's more visible that you're going to have to go through a development mental process with technology.

We somehow have a different kind of approach, don't we, to organisational things. And what's at the route of organisational things is relationships between people and making processes that improve those relationships and making the more productive, create better outcomes, make life easier for people. And somehow I think…I wonder if we're just slightly less tolerant of our own limitations as people in doing that. Relationships should come naturally to us. Technology is new and exciting and bold and innovative. But actually we need to think exactly the same way about how we organise. And it goes back to what we were talking about right at the beginning about how bureaucracy actually is a brilliant innovation or started off as a brilliant innovation that tries to facilitate coordination between complex groups of people trying to do things together. But it's not the be all and end all, and actually it's perfectly acceptable that we need to innovate in that. And that's what a lot of improvement work focuses on.

CM: I've got this image in my mind now of the download for NHS 10.3 coming out and everyone rushing to download it, and then the NHS becoming really slow like iPhones do as soon as you get the download. I think I hear what you're saying about high stakes but I think to try and turn that on its head,

going back to what we talked about before, about people holding risk in different sizes of organisation, it is more high stakes. But then the reward is bigger when you get it right, and I think maybe that's something that we don't think about enough.

We're more… And I wonder if that's where this culture of it's always been done that way… It's more comfortable and it's safer to stick with that oh, it might be dangerous or dangerous to patients if we try and change things. But actually what people don't say is yes, but this also might be awesome and change things in a really good way. And when Moira talks about how to get people on the bus, I've been thinking a lot about how to get people on the bus. And I wonder if part of it is that, it's yes, this is a risk, but if it pays off it could work really, really, really well and improve things.

GM: Yeah, I think that's right. So I work in a university and they say that herding academics is like herding cats, it just can't be done. And again, that's…you don't want to exceptionalise about particular sectors. That's true of universities, it's true of healthcare, it's true of many, many different organisations. Particularly organisations where as we've said earlier on people have different perceptive, different preoccupations, different backgrounds. And seeing the big picture is actually really, really challenging in its own right.

And I thought what Moira said about storytelling actually was absolutely brilliant. It sounds a little bit soft, a little bit fluffy, doesn't it, storytelling. But I think the key point here is that this isn't about, I don't know…it's not about PR. It's not about mission statements and all of that kind of stuff. It's not about fiction either. This is about actually showing people what might be possible. So it's perspective, future oriented storytelling. So exactly addressing that point about what we could change here if we really embrace it.

And I think the other key function that Moira was talking about in terms of storytelling was again, that linking a little bit of the picture that any individual or any team can see to the big picture. That this isn't just change for its own sake, it isn't just being shaken up and having all these challenges to what you're used to for its own sake, it's actually for a purpose and we're all part of a big picture here.

CM: I think those stories are going to become so important. I mean I was thinking about…you can't read anything about health at the moment without reading about backlogs and waiting lists and what healthcare looks like post-pandemic. I think balancing the fact that there is a workforce who are exhausted and tired and burnt out because of a pandemic, but also now who are feeling I think constantly like they're having to apologise to patients for long delays and long waits. And then somebody comes in and says hey, we can make a change and it'll all be great and patients will be seen like tomorrow.

And I think actually taking that huge problem of a 6.2 million I think it is now, waiting list, and balancing that with what are you going to see in change on the ground, that takes somebody who's really good at storytelling and getting people on that bus. And I…

GM: Yeah, so I think that's right, 6.2 million at the time of recording.

CM: Yeah.

GM: And I think Moira really recognises that and she's got lots and lots of experience in this. She talks about the need to sweat assets and I think that's clear and that's one way of doing these things. And you've got to be really, really careful that as you're sweating the assets you're not sweating the people as well. And there are some forms of change, and if you can find them then it's brilliant, that hit that sweat spot of making people's tasks easier, at the same time as making the system that little bit more productive.

But I think the other thing that Moira was talking about that seems really important in that regard, and which is a real complement to the storytelling, is doing what you can. And sometimes it's little things, but again, they show a commitment to just recognise the challenges that staff face.

CM: I think her comment about the chief exec, I think at her trust she's specifically cited the example of stepping up and saying look, I'm the least informed person in the room, tell me what you need to make this work. That links back to a lot of the stuff we've been talking in these episodes about, compassion, about being a better colleague, about vulnerability, and I think you're exactly right. You cannot solve this huge, what feels like an unsolvable problem by sweating the assets if the assets are people who don't have anywhere to park and they don't have a locker and they haven't eaten. That is just not going to work. So you've got to get the basic stuff, and Maslow's hierarchy of needs, you've got to get that sorted first.

Have you seen examples where you have seen people at the top come down and do that really effective, that compassionate leadership?

GM: Yeah, I've seen good examples of that and I've seen bad examples of that. And I think you're exactly right. It's about compassion, it's about vulnerability. But I think the other thing that that kind of approach to leadership is about is actually about realism and about acknowledging that I'm not just saying that I'm the least informed person in the room to make myself one of the lads, [laughs] and kind of fit in and value other people. I say it because it's actually probably true. Okay, I've got a great helicopter view of the organisation as a whole and I can probably tell you a bit more about the finances. But in terms of what's going on right here, right now, what the problems are, what will make a difference to patients and to staff in terms of improving, I'm definitely the least informed person in the room.

And I think sometimes leaders walk the walk or talk the talk rather, and sometimes they really understand that that's the case. So there's quite a lot

of approaches out there in the research literature to how you can try to do that. And one thing that again is…I'm not sure if it comes from the private sector originally, but it's common in the private sector, it's common in hospitals as well, are these leadership walk rounds. Sometimes called patient safety walk rounds in the healthcare setting. And in Toyota they've got gemba walks, so that's part of lean production.

But basically the idea behind all of these concepts is very similar, is that senior leaders come down to a particular unit within hospital or a production line or whatever it happens to be, and they commit to listening and they commit to genuine dialogue and they commit that they will then, having listened and having seen what the problems are, come back to the staff that they've spoken to a week later or a month later or whatever else. So it's a lovely idea. And you can completely imagine that sometimes it goes very, very nicely and sometimes it goes dreadfully.

So we've done some research on this, there's lots of papers on this and there's some really interesting terms of phrase in terms of how it often goes. So one paper, I think this was in healthcare, that talks about these leadership walk rounds called it seagull management. And the reason they call it seagull management is you get these seagulls coming in, causing a lot of fuss, getting in the way of everyone and leaving a load of…what seagulls leave behind after them. [laughter]

And sometimes it's just not set up in the right way, so people think it's an inspection. So they start dusting surfaces before people get there. They brief them on what they should be saying. It's like a CQC or an Ofsted inspection or something like that. They roll out the red carpet, and that's lovely, I'm sure that the visiting dignitaries have a lovely time and feel really welcomed, and they will learn absolutely nothing and they will be able to do absolutely nothing about it.

So it comes back to a point I made earlier on that these tools are often pretty simple in a way, there's no like magic 50 page protocol for how you do a leadership walk round. You can probably summarise it in half a page, a few bullets. But how you do that and making sure you do it in a way that is faithful to the original intentions, that's where the magic lies.

CM: So that's it for this episode. Thank you to our guests, Penny Pereira, Moira Durbridge, and thanks to you, Graham, for joining me again. Bye for now.

GM: Thanks, Clara. Bye.

CM: We'll be back soon with some more advice on making change. So subscribe on Apple Podcast, Spotify or any other major podcast app. If you've enjoyed what you've heard or found it useful please do rate and review us. I'm Clara Munro and this is Doctor Informed.

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