

King's Fund

Projectitis

Spending lots of
money & the trouble
with project bidding

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WHOLE
systems
THINKING
working paper series

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WHOLE systems THINKING

working paper series

WHOLE SYSTEMS THINKING is a series of working papers. They offer insights derived from putting ideas into practice as part of an action research programme – ideas about partnership and whole systems which are now central to the Government's ambitions for sustainable change, regeneration and the development of action zones in employment, education and health.

The papers reflect our experience of developing and applying a new approach to primary health care in cities. Similar issues of partnership and public participation arise elsewhere in the public sector and in the commercial world. We find much in common with people from many different organisations who recognise that, notwithstanding the new political climate, things are not really going to change if we just do 'more of the same'. They, and we, are looking for new ways of working.

WHOLE SYSTEMS THINKING is not a sequential series. It does not matter where you start from and none of the papers offers a complete picture. What we hope you find are thought-provoking ideas, particularly if you are curious about the kind of problems that return to haunt organisations over and over again. Some prove remarkably difficult to influence despite the best efforts of policy-makers and highly motivated people 'on the ground' – homelessness, for instance, and under-achievement in schools, long-term unemployment, 'sink' housing estates, family poverty. Issues like these need effective inter-agency work and consultation with the people who use the services, but even this can seem like a chore rather than part of the solution.

We have long experience of primary health care development in cities and a growing dissatisfaction with change initiatives which both fail to learn the lessons of earlier investment and to deliver desired outcomes. Four years ago we were in the position of developing a new action research programme whose focus was to be the intractable problems we refer to above. These may be recognised as 'wicked' problems. They are ill defined and constantly changing. They are perceived differently by different stakeholders and in trying to tackle them the tendency is to break them into actionable parts, which often turn into projects. We reasoned that if they could be recognised instead as issues for an interconnected system to tackle together, then they may become more tractable.

We chose to shift the focus of our work away from attention to parts and onto 'the whole' and thus to the connections between parts – how things fit together. This led us to explore ideas related to systems dynamics and the 'new science' of complexity. This has resulted in our designing a distinctive set of interventions which link ideas and practice and which we have called *whole system working*. This is a new development approach which does not offer certainty or guarantee success but it has rekindled our enthusiasm and that of many of the people with whom we are working.

We hope the ideas in these working papers enthuse you too. Because of our roots, many of the examples come from the health sector but we believe the concepts and the practical methods of working whole systems are widely applicable.

*Pat Gordon, Julian Pratt, Diane Plamping
King's Fund
June 1998*

Whole Systems Thinking

The Urban Health Partnership is an action research programme on inter-agency working and public participation. The work is in London, Liverpool and Newcastle and North Tyneside, with health agencies and their local partners in housing, local government, commerce, police, transport, voluntary sector and local people.

Further information is available from:

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Projectitis: spending lots of money & the trouble with project bidding

THE GOVERNMENT is about to invest heavily in health action zones, employment action zones and education action zones. These are flagship initiatives designed to tackle the 'big issue' of social exclusion in all its ramifications. Many different government departments are key players. Scores of agencies 'on the ground' will have to find new ways of using money, both new and existing budgets, and innovative ways of working together if the investment is to pay off.

The Social Exclusion Unit at Number 10 has the formidable task of pulling all this together, learning from past experience, assessing what works and what doesn't, and then making it happen. Cutting red tape and banging heads together may be part of the strategy. Offering 'development money' as an incentive is another. Already it seems that the Government has concluded that 'a little spread thinly has often cost a lot but done no good'.¹ This may be good news indeed if it focuses attention on how to use short-term investment to bring about lasting change. Even spread thickly, development money won't produce the desired results if it merely buys 'more of the same':

*If we always do what we always did
We'll always get what we always got.*

The big question is whether, this time round, we can use the investment as 'learning-how-to-do-things-differently' money, rather than 'try-to-fix-it' money.

This was one of the questions facing the London Health Partnership when we began four years ago. We had a substantial development fund for an innovative programme on urban primary health care. We also had many years' experience in the King's Fund of funding demonstration projects in inner city primary care. We consulted widely about how the money should be used and found no shortage of ideas, but a passionate concern that competitive bidding for one-off projects was deflecting people from what they considered to be the

'real work' of their organisations. The consultation in London was reinforced by people from other cities in the Urban Primary Care Network which meets regularly at the King's Fund.² We therefore began to re-consider the meaning and impact of projects, the most common device for spending development monies.

The disturbing conundrum is that in a world of chronic resource constraints the provision of additional money can be viewed by its recipients as more of a problem and a distraction, than a welcome windfall.

There are good reasons why those responsible for developing services in primary care view these occasional injections of developmental cash with suspicion. Like many therapeutic interventions they can be of dubious value and carry known risks of unwanted side-effects. In this case the iatrogenic complication is an acute organisational inflammation known as 'projectitis'. Projectitis, like most unpleasant conditions, takes hold in the presence of a particular combination of environmental and host factors.

The environment is typically characterised by the sudden availability of significant new funds which must be spent (or at least committed) within a short period of time. Mechanisms for deciding how to spend the money need to be established immediately. These must satisfy the demands of probity and accountability of the fund providers. Such standards are often rigorous, in part, because these funds have usually been made available by diverting them from their original destination. Their deployment for new purposes is thus conducted against a backdrop of the pained cries and critical scrutiny of unexpectedly deprived resource competitors. 'Opportunity cost' usually becomes a political rather than accounting concept.

Under pressures of time and the demands of an open and transparent process, the mechanism for spending money will probably involve bidding. Bids will be invited from those interested in new funds for

legitimate purposes and will be evaluated against established criteria. Those bidding will not be given much time to create viable bids. The project is the unit of currency best suited to acquiring time-limited, non-recurring money which must deliver tangible results and be publicly defensible. Projects are best suited to winning the money but least suited to delivering sustainable change and most likely to generate violent immune reactions in the host.

The project is a particularly tricky customer. It looks like a fairly harmless and temporary organisational device but is in fact a paradigm – a whole way of thinking about the world which can distort the priorities of the host organisation and play havoc with the delicate balance of internal relationships and managerial accountability. The central problem can be split into four elements.

- Projects ostensibly exist for one purpose: to deliver products, artefacts, objects, technologies, services, etc. deemed to be of value to the resource supporter of the project. However, projects require organisational structures and people to deliver these artefacts. For the duration of the project these people are often provided with a focus and clarity of purpose rare in everyday working life. Under such conditions they rapidly attain a combination of differentiation and momentum which disrupts formal managerial lines of accountability, informal networks and organisational priorities. It could be argued that such independence and disturbance of set patterns are necessary if innovation is to occur but innovative opportunities for these teams are limited. They exist to deliver agreed artefacts. Senior management within the host organisation needs to be convinced that the artefact the project will deliver is worth the disruption entailed.
- Projects are often justified by reference to the learning which will result from them – the pilot leads the way, the learning is distilled and the 'best practice' rolled out. However projects are ideally suited to addressing well-defined problems. Indeed project 'scoping', which includes the definition of the problem and the project objectives, is an essential component of the initiation phase of any new project. Projects can restrict admissible learning because they contain

the built-in assumption that formulation precedes implementation, whereas much contemporary management thinking accepts that implementation must, to a considerable degree, drive formulation.^{3,4} The challenge is to maximise the ratio of learning to investment and this requires experimentation. However the process of inviting bids, creating acceptance criteria, working through a project framework and evaluating outcomes may not be the best way to meet this challenge.

- Project teams need the support of those who command resources. They will continue to support the project for as long as they believe that the project will deliver the artefact and that the value of that artefact still justifies the expenditure. However, under circumstances which demand the rapid deployment of time-limited funds a circular argument develops in which the dominant criterion by which artefacts are valued is the degree to which they justify the initial commitment of funds.
- Those with the money must spend it rapidly in defensible ways. Those who dreamt up the conceptual design of an artefact to be delivered by spending the money must be seen to be entrepreneurial and innovative. Those project teams charged with creating the artefact are sometimes provided with a formally sanctioned escape route from the daily grind and their traditional managerial lines.

From very different perspectives these interests converge and create a fertile ground for collusion. The key criteria for spending the money can become the water tightness of the case for spending it rather than a genuine belief by anyone that the project will deliver valuable outcomes.

Once the project is under way, the issue of appraisal arises. Is the project delivering? This can be handled in at least two dysfunctional ways, both driven by the discrepancy in time scales between the project and its environment. Inappropriate appraisal can be *either*:

- too quick. This is a use of project appraisal by the project sponsors to further demonstrate the rigour of their approach to probity and their preparedness to take tough decisions. Such demonstrations need

to be enacted shortly after the project is initiated if they are to have impact. Thus, a common scenario is premature withdrawal of project funding because 'it isn't working', severe disruption to the organisation delivering the project and outrage and loss of morale within the project team.

or:

- never. Project teams can disappear, like Japanese soldiers in the Philippine jungles, continuing to fight battles which everyone else has forgotten. It is often not in anyone's interest to find them and discover if it was all worthwhile. The time-limited project funding runs out, the teams disperse, the artefact they created withers and quietly dies.

If management in provider organisations see successful bidding as leading to disruption, loss of morale, managerial distraction from their core business and the creation of artefacts of questionable value, it is not surprising that they are often not overjoyed by the arrival of new one-off resources. This pain can rarely be justified by reference to the learning which results and is of relevance to the organisation and the wider system. The processes described often teach participants more about creating credible bids and successfully jumping evaluation hurdles than they do about the problem which the project is addressing.

Are there other ways to spend time-limited funds? The problems described above are the result of trying to implant a clear linear process into a chaotic world when the outcome of that process is insufficiently valued to justify the effort. The aim of spending the money should be to enhance the capacity of organisations to deliver services, not to create a process which undermines that capacity.

The spending of time-limited public money is a complex problem and as with other 'messy' problems the concept of transferring 'good practice' is of little help. We may not be able to say how to do it but we can give some indication of what a successful outcome might look like.

SYSTEMS THINKING

Many of the intractable problems in the area of primary care result from the irreducible complexity

of the system. These will not be resolved by encapsulating small subsets of the system and effecting change in these isolated and protected areas. The change needs to be 'real time' and in the real world.

LEARNING AND LEARNING TRANSFER

To learn from experimentation and then transfer that learning to other settings is difficult. It requires effective teachers, unambiguous experimental results and comparability of organisational context. An isolated project is unlikely to achieve this combination. Learning needs to be effected by those engaged in the wider system: it is they, not the transient project worker or evaluator, who need to understand the system which they use and in which they work.

SCALE EFFECTS

The behaviour of tissue cultures in a Petri dish may be a poor predictor of the epidemiology of mental health in a community. Some learning can be scaled up to the larger system, others cannot. In the realm of primary care, where much of the complexity results from the relationships between organisations and the range of professionals within them, small-scale experiments confined to individual organisations or professional groups are of limited value to the mainstream.

OBJECTIVE SETTING

Projects are the perfect vehicle for delivering artefacts whose important design attributes can be specified in advance. This is why the best project managers frequently come from the engineering disciplines. However, the important attributes of health care systems often emerge over time, are recognisable only in retrospect and are counter-intuitive. Such systems development does not readily fit into the confines of projects. Other mechanisms need to be developed to provide rigour to the developmental process and time-specific targets by which the performance of developers will be assessed.

RISK MANAGEMENT

Spending public money in new ways is risky. However, this risk can be minimised if the money is deployed, by those accountable for it, only in tightly

managed increments to achieve specified and politically justifiable objectives. The trade-off with this approach to risk management is that the resultant projects will have a value limited in the ways discussed above. Political forces and public accountability are part of the system. Attempting to manage their impact through a transparent bidding process and evaluation criteria creates an unreal world in which the opportunities for systems impact and transferable learning are minimised.

The public, politicians and resource competitors cannot be excluded from the process and the risk cannot be reduced to zero. Risk acceptance rather than avoidance is essential.

In summary, the issues are these. The need to spend money quickly and in defensible ways pushes funding agencies to invite bids for ways of spending that money. In its turn, the need to bid for time-limited funds pushes the bidding agency to the early definition of projects which will deliver artefacts to a schedule. There are problems with projects, and they are often not the best vehicle for delivering what the bidder most needs and wants. Such ill-

conceived projects, implanted in the organisation, will fail to deliver fundamental and valuable change and can cause wider disruption and distraction.

These issues of spending money chime with common sense and experience. If you have a significant budget for purchasing Christmas presents, but don't start shopping till 4pm on Christmas Eve, you are likely to end up with a handful of inappropriate gifts which will be met with polite incredulity by their recipients. You will have done your duty in buying something but the present is doomed to moulder in a cupboard and your relationship with its now owner will not be enhanced.

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Urban Health Partnership Summary

Originally set up in 1994 as the London Health Partnership, the Urban Health Partnership is a five-year development programme to generate a distinctive programme of work on community-based health services. It was set up as an alliance of charitable foundations, government and private sector chaired by Liam Strong, then chief executive of Sears plc, and managed by the King's Fund, one of the contributing foundations.

The Partnership was formed at a time when the Government was investing heavily in projects aimed at 'getting the basics right' in primary care through the London Initiative Zone. The programme grew out of the King's Fund experience of supporting demonstration projects in primary health care in the city.

The brief

The brief was 'to do things differently and to add value to the many good projects which foundations can choose to support at any time and to the Government's current investment in improving the basics of primary care.' This was to be a 'learning fund' to find new ways of using relatively small amounts of development money to try to impact on mainstream investments. It was recognised that there would be no 'quick fix'. We were charged with developing an innovative programme. We interpreted innovation not as a search for novelty but, in industrial terms, as the stage which follows invention and prototype and focuses on bringing a design into production.

The purpose

- To find new ways of using development monies to bring about lasting change
- To add value to efforts to improve primary health care in cities, particularly services for older people.

The focus

The focus of the programme is improving services for older people because they:

- tend to have multiple needs and experience of chronic ill health
- tend to make use of a wide range of services
- often live alone and are relatively poor, like many city-dwellers
- have a lifetime's experience, are often resourceful and want to contribute to the communities in which they live.

The focus comes from our early consultation with health and social care agencies. This revealed no shortage of ideas but a passionate concern that competitive bidding for short-term project funding was deflecting people from what they thought was more important work – the intractable issues – such as mental health services, care for children in poor families, care at 3am and care for vulnerable older people.

The geographical focus is London, but from the outset it was clear that the issues facing London's health services were mirrored in other cities. A parallel programme was started in Newcastle and North Tyneside and in Liverpool. An urban primary care network was formed and meets regularly at the King's Fund to exchange ideas and information.

Resources

Funding is from the King's Fund, Baring Foundation, Special Trustees of St. Thomas' Hospital and the NHS Executive. Contributions in kind were made by London First, McKinsey & Co and Sears plc. At local level financial and other resources were contributed by both statutory and independent agencies.

Phase one

Once the focus had been decided, our next step was to consult elderly Londoners to hear their *personal* experiences and try to turn these into opportunities for improving services. We set up London-wide meetings and we ran local workshops in four districts to learn about the *barriers to change*.

Personal experiences

The concerns older people raised in these initial meetings have been repeated over and over again as the programme has developed. There is such consistency that these concerns must be seen as lessons of importance not because of their novelty but because of their familiarity. They include: safety and security, access to services, affordable and accessible transport, independence in the home, admission and discharge from hospital, information about services.

These are concrete problems and it is not difficult to see how they inter-connect. People who plan and deliver services and those who use them recognise that responses must be multi-agency, that users must be involved, that professionals must collaborate – these are not contentious issues. What we found was not a lack of intention but a scarcity of effective practical methods for making them happen.

Barriers to change

We worked in four districts at neighbourhood, general practice population, operational management and policy levels. Each workshop brought together between 15 and 30 people already working to provide services for elderly people in their patch. The system of care around elderly people involves many agencies and individuals extending way beyond the statutory services. It was this complexity we wanted to understand.

For example, in one district we mapped the progress of a hypothetical elderly person with a minor stroke being taken to the Accident and Emergency Department at 10pm. It gradually became clear that people in one part of 'the system of care' around admission to hospital knew little about the reality elsewhere, and that what appeared to be a solution in one place merely shifted the burden, often in ways which were unintended and counterproductive.

In another place there was widespread agreement about the importance of mobility and transport, whether by mini-cab or ambulance or an arm-to-lean-on, and yet transport services were seen to be quite unconnected to other local services.

We learned that if the right people are brought together they can gain a much clearer

understanding of the 'big picture'. And that the people who use services bring crucial insights into the way the system actually works, rather than the way it thinks it works. We concluded that anything which helps the health and social care system to understand itself as a whole is likely to lead to better judgements about using resources to bring about lasting change.

Phase two

We began to develop the approach we have called *working whole systems*. The ideas which underpin it are useful where there is a willingness to see issues like hospital discharge or homelessness as beyond the ability of any one organisation or individual 'to fix'. Such issues are complex. They cross boundaries and require communication and partnerships. One of the key insights from systems thinking is that while each element of a service may be organised and managed in a way which appears effective, the system as a whole may perform badly and its capacity to learn new ways of working may be limited. Despite the hard work and good intentions of many people in many agencies, the whole often fails to function as well as the parts. In health and social care the people who suffer as a result are those who most need inter-connected services. We began seeking ways of making *the whole system* the focus of our interventions.

We began by seeking partners from anywhere within a local system – health authority, trust, local authority, general practice, voluntary organisation. What we were looking for was local partners who:

- do not believe there are quick fixes
- do not believe that solutions lie in 'one more push' using the same old ways of working
- are serious about partnerships, by which we mean more than simply coming together around money.
- are serious about involving people who use services

We knew that the system of care around older people stretched way beyond the statutory services and was therefore likely to mean working with large numbers of people. We learned about and experimented with a number of methods of doing this, including Future Search, Open Space

Technology, Real Time Strategic Change, Appreciative Inquiry and Time Dollars.*

We are working in a number of sites in three cities – London, Liverpool, Newcastle and North Tyneside. The work begins with a burning local issue – for example, how to improve hospital discharge; how to prevent lonely deaths; how to avoid last year's winter bed crisis. First, we engage the stakeholders who bring together people with many different perspectives on the particular issue of concern. We then design 'whole system' interventions which always involve working with many types of stakeholder; always engage local people in active participation; sometimes include working with large numbers of people simultaneously over two or three days. The purpose is to uncover local solutions to local problems. The 'newness' or difference comes from working to:

- *identify the system-wide issue* – not more analysis of problems but seeking common cause. For example, being able to move from hospital discharge as a problem for the acute trust to the system-wide issue of how can we make going home from hospital a positive experience.
- *identify the appropriate system for that issue* – not 'just the usual suspects' but the minicab service, police, ambulance, housing associations, community groups, churches, all taking part alongside more traditional players in the statutory and voluntary sectors.
- *find new ways for this system to recognise itself* – getting the 'right people' together which means many different perspectives and cross-sections of people from within as well as between organisations.

* For more details on these, see Further Reading below.

- *discover solutions within the system* – this is a critical difference: the belief that ordinary wisdom is enough and that with sufficient diversity and mix of people, new possibilities emerge.

The purpose of working in these new ways is not to replace existing ways of working, but to add value when existing methods have limited impact. These new methods have clear objectives focused on making new connections, involving users as experts and generating possibilities for new action.

Evaluation

The programme is being evaluated by a team of locally based researchers led by Professor J. Popay of the Public Health Research & Resource Centre, University of Salford. The evaluation shows that we are succeeding in:

- designing and testing practical ways of working which lead to collaboration between statutory organisations and their communities
- creating enthusiasm to re-engage with long-standing problems. This happens at all levels – chief executives, hospital consultants, councillors, police, nurses – and helps make change more sustainable
- engaging significant numbers of older people. They have crucial insights into the way the system actually works, rather than the way it thinks it works
- spreading the techniques beyond the initial focus on older people to, for example, housing and urban regeneration.

Some of the difficulties lie in sustaining the interest of key groups over time; promoting equal voice for all participants, and understanding how to support local action in different sites. We continue to work on these and to develop our ideas further.

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... ideas about partnership and whole system thinking now central to the policy agenda on regeneration and sustainable change.

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