Really Learning

Developing people and services in health care

We need to talk about Francis ....

If Ronseal made Inquiries what would they say on the tin?

What are Inquiries for? For learning, for censure, for comforting those affected? For recommending or even mandating changes to structures and processes? Yes that too, perhaps that mostly, to 'stop it happening again'.

Is that what Ronseal would write on the tin? I don't think so, I don't think that is what Inquiries are really for, but let's see.

My role is helping people to learn, so I like Inquiries. Remember Zeebrugge? 188 people drowned when a ferry set sail with its bow doors open? The subsequent Inquiry revealed in fascinating detail the behaviours, attitudes and culture that allowed it to happen. Does the name Beverley Allitt ring a bell? Her murder (by insulin injections) of several patients on her ward was the subject not only of a formal investigation but a vivid description of everyday life in Grantham Hospital by journalist Nick Davies.

At the time I was running a Masters in Health Management and used both of these accounts as the basis for a week long module on ***Really*** Managing –asking over and over again 'what would *you* do now? (at this encounter, this meeting, on overhearing this conversation, receiving that note,.....). To the almost invariable response of 'collect more data, report it to X, find out Y.....' I'd say again and again, 'no, ***now***, right ***now***, what can ***you*** *do* right ***now***.'

That taught me two things.

First: it is only in the transcripts of inquiries into tragic events that we see organisations as they really are (the conversations, email exchanges, petty day to day interactions that are the way they work). This is not the way they are normally presented to the world. Much of the detail brought to our attention in these reports feels distasteful, outrageous or even alarming partly because we never see it described elsewhere, although in truth it is not as uncommon as we would like to think.

And second: people confronting behaviours that make them feel uncomfortable do not challenge them.

Exploring this with those 'students' (mid career clinicians) we found that it's not exactly that they feel helpless (although they may) but that they see themselves as neutral observers of what they have just

witnessed and fail to recognise that there is no such thing. They fail to see that, routinely, in our interactions with others, the responses we make (or don't) either encourage or discourage the behaviour we have just observed. We either challenge or we endorse, there is no neutral option.

Learning this is vital, for individuals, for services and for organisations - and Inquiries can be hugely valuable in providing excellent material for this kind of learning, for reflecting on how to deal in the moment with those behaviours we feel uncomfortable about, for helping people think through and practice how to live out their values in these day to day interactions. That value is very great and we must use it to the full.

A few weeks ago I gave a terrific group of post grad students (mostly doctors) , an extract from the first Francis report (http://www.midstaffsinquiry.com/pressrelease.html). Again they found it difficult to commit to actions they would take. They talked of encouraging complaints to PALS or to the Chief Executive, of taking issues to other meetings, never what they themselves could do. Their feelings of helplessness and lack of agency were palpable.

But of course they feel that. We don't teach our young professionals about life in organisations, about how to influence, how to deal with the inevitable organisational politics, about behaviours that achieve results and those that don't. Again that's a use of the material from Inquiries: to teach them about this, and help them become effective organisational citizens. What a fantastic outcome it would be from Francis 1 and 2 if we used its descriptions to develop programmes in organisational literacy for our young professionals joining their first organisation.

But it isn't what Ronseal would write on the tin.

I'll return to that later.

Can we believe what we read in Inquiry reports?

There was something else in that discussion: the story from the report didn't make sense they said, clinically it didn't hang together. They assumed poor communication from clinical staff to patient and family.

But this is an important point we often forget: that the experiences described by relatives are just that, recollections of what they experienced, sequenced together into a coherent narrative. They aren't a faithful objective description of what happened, they are inevitably snippets of events, emotions, and understandings, all seen through a particular lens. When repeated over time these stories become firm in people's minds, and invitations to add or amend recollections are seen as hostile. This is true of all the stories we all tell, about ourselves, our holidays, family, work, and life in general.

Of course when these stories are about NHS care they are very significant and we must take them seriously, investigate and respond empathically, but we must also not make them bear a greater weight than they can support. We mustn't assume every detail actually happened and in that order, and then act on that assumption.

At the time covered by the Francis reports I was undergoing treatment for breast cancer. How I would have loved a bunch of flowers! They were totally banned. Because of the targets about MRSA and the need for boards to take absolutely no risk (real or imagined), flowers were banned almost universally

across the NHS. So I'm perplexed to hear of patients drinking from flower vases because they had no water. I wonder what to make of it, whether this was evidence of some staff being particularly caring in allowing flowers for someone who they could see would benefit from them, or unobservant and uncaring, or whether this was a tale that grew in the telling like so many of our memories do. Hearing it being denounced to the world without any hint of doubt by the secretary of state did not convince me one way or another.

Let me be clear I am simply reflecting on what happens when experiences become stories –memories that have been stored- rather than freshly felt and amenable to re-interpretation. I am not doubting the honesty of the patients and their families, far from it, just suggesting that they are remembering things the way we all remember them – as mixtures of reality and impressions, complex emotional responses to situations, tinged with love, anxiety and worry.

So we need to take very seriously the spirit of these personal recollections, feel the pain of the people describing them, use them to understand more about how things go wrong and also how people make sense of unfamiliar situations, and remember that factual inaccuracies are inevitable, so inevitable we should avoid making headline grabbing claims based on them.

Living forwards and looking backwards

After reading the executive summary of Francis 2 and the blame it attaches to the Board at Mid Staffs, I looked up some of their Annual Reports of that time. Were there clues here that the Board warranted Francis's censure? Not that I could see. The attitudes, claims, and language were all very familiar, almost identical to those of other NHS Boards and Board members I knew. There were few if any references to the complex intractable cultural problems that Francis 2 reports the board as inheriting (and blames them for not addressing). So clearly they had done what many others would do – focus on areas where they *could* make a difference, those where the energy of the wider system was supporting them, for example gaining foundation trust status, their NHSLA rating etc.

Let's imagine being that Board appointed with a remit to address longstanding cultural problems, and finding that the people who appointed us and now performance- manage us take no further interest in how we are addressing these problems. Instead they encourage us to focus on other priorities: FT status, and the myriad of formal endorsements needed for that.

How does that feel?

My memories of that time include watching people making constant efforts to decode targets and diktats – were they *really* important? could they be safely ignored? The clue wasn't in the diktat itself but in the behaviours of those monitoring them. The reputations of those (individuals and organisations) not tuned in to this and taking all the targets seriously suffered badly from supposed 'underperformance'. It was at this time that 'reputation management' entered the language and became a major concern.

How, as an executive board member in Mid Staffs would you have gauged the priorities of the local NHS hierarchy? How much of this would you discuss with the rest of the Board? How comfortable does that feel? Reputations of exec directors were partly based on their ability to 'deliver' their Board.

Can you feel the pressures and tensions and dilemmas? Faced with insistent demands to cut costs and bring financial performance into line with that elsewhere, and with protests from clinicians about staffing levels, tighter and tighter deadlines being imposed from people expressing little interest in patient experience, I think I might feel a little like a rabbit caught in the headlights, what about you?

Should the Board have known more about what was happening on their three problem wards and A&E than they did? Did they fail to take statistics seriously enough? Does their behaviour about coding suggest that they did know and tried to cover it up?

All these claims have been made but no-one *knows*. No-one – not me, not you, not Francis.

These are serious charges so let's think about this.

Of course they should have taken much more interest in all kinds of information about their care, **so should every Board - but they don't.**

Oodles of really useful data is constantly being collected at great expense in terms of staff time and passed on to those who demand it without being properly scrutinised by the individual, team or organisation generating it. **That is an NHS –wide scandal**. It has been for at least the 25 years that I've been observing it.

I first encountered it when Dame Edith Korner insisted in the late '80s that community nursing staff collect data and send it to the DH. This was described as an exercise in 'feeding the beast' by those required to do it, and was complied with resentfully and sullenly, in spite of the best efforts of local information managers who tried to encourage staff and managers to use this information to improve care and make best use of resources. (I was one of those so I still remember our frustration!). So my experience is that this scandal is largely due to the attitudes of clinical professionals and has never been adequately challenged either by their professional leaders or by local boards.

So this attitude is not peculiar to Mid Staffs, it is an NHS wide behaviour pattern that Mid Staffs would have found it very hard to challenge alone. It arises from the nature of the relationship between government and the professions that I have written about elsewhere (http://www.reallylearning.com/Free_Resources/Really_Managing_Healthcare/why-reforming-nhs-book.html).

Should the Board have responded differently to the HSMR stats? Did they deliberately seek to mislead by changing their coding practice?

Personally I cannot imagine anyone was being deceitful. From what I know of Boards and their members I think they will have been flummoxed by their position as an outlier in a statistical process that was something of a mystery. Then in trying to understand it they will have been very open to a (not-unrealistic) possibility that they and others were coding differently from the mainstream. Were they too ready to believe this? Possibly. I think I might have done the same – and that you might too.

But it will happen again and again until the professions accept that taking responsibility for good coding and for using statistics are an **essential, valuable** and **exciting** part of the professional role.

This will be forced upon them, unless there are enough enthusiasts within the professions themselves to drive it forward, because the world is changing – 'big data' is here. But is it reasonable to judge Board behaviour then by what will be standard behaviours of tomorrow?

When we are contemplating the culpability of the Board we do well to remember that use of this data is still an emerging, immature and contested field, with differences of view about the value and validity of some of the presentations of data and statistics, and the of the inferences drawn from them. http://www.lrb.co.uk/v35/n07/paul-taylor/rigging-the-death-rate And some of its strongest advocates (the strongest of whom also have a financial interest in promoting its ability to highlight differences in performance (http://drfosterintelligence.co.uk) appear stridently oblivious to the epistemological assumptions they are making.

As Francis appears to make the same assumptions and to base his castigations and recommendations on them it is worth considering these. Fundamentally they confuse and elide situations that are distinctively different. The next few paragraphs need attention – but are important so stay with me if you can!

In the '70s, systems Scientist Russel Ackoff coined the distinction between puzzles, problems and messes, and more recently David Snowdon coined the term Cynefin to talk of 'domains of knowing: the known, the knowable, the complex and the chaotic'.

These are far from abstruse concepts, they are vital to our understanding of health care and to our use of data and of the statistics drawn from them. There are real dangers of treating complex (messy) situations as though they are fully understood (known) puzzles and vice versa. They require different behaviours of our health care professionals (and managers and boards) and we need to know how to support the right behaviour for the right occasion.

Where we are dealing with puzzles, there are right and wrong ways of doing things , it is very helpful to have protocols and if people do not adhere to them we are justified in castigating them if they refuse to use them. In these areas of healthcare, systematisation and standardisation is helpful, they make good use of resources and (as long as enacted humanely) offer good outcomes for patients.

When we are dealing instead with a complex situation there are no right or wrong answers, just better or worse ways of proceeding. Here we call on judgment, intuition, and professional wisdom built up through practise. Complexity theorists call this 'muddling through elegantly'. And here things will sometimes go wrong, even with the wisest approach, greatest competence and excellent intentions. And when that happens there is the very great danger of what the same theorists call 'spurious retrospective coherence' – we might also term it hindsight.

This is when- looking back later- it appears that action A led to outcome B and that the people taking action A can be blamed for B. However only in puzzle situations does taking action A invariably lead to B. In complex situations A only results in B if M and X do not take place and they themselves are the result of F, P and J which may or may not emerge from X, Y and Z.

The person choosing to do A has no option here but to muddle through as elegantly as they can, drawing on wisdom and intuition as much as on knowledge. Sometimes they will succeed and outcome B will be averted, sometimes it will not. And we cannot and must not blame them. What we must do is encourage them to reflect openly on what has happened so that they and others can learn from it.

Censure and blame make this impossible – not just in this one instance but in fostering a wider culture of risk aversion and protocolisation.

In other words: things look very different when living them forwards from looking back at them afterwards.

Statistics, too, need to be used differently in puzzles and messes.

In health care puzzles (e.g. the best procedure for patients entering A&E with a myocardial infarction, or a stroke) statistics can highlight where practice needs to be improved. I would still argue that the stats are more useful in the form of questions to understand why protocols are not being implemented rather than supporting a leap to blame, but there would certainly highlight concerns about performance, training etc.

In complex areas of health care statistics cannot be used in this way. And their proper use is to ***inform the questions*** to be asked of those involved, not to ***be*** the answers. Thus, here, the statistics themselves are valueless without the abilities to frame insightful questions, help everyone involved make sense of what is happening and help them move forward in light of that sense–making. Without these other abilities the producers of the statistics sound inappropriately self righteous when they take to the media to blame others for not immediately acting upon them. And their self righteousness makes it all the more difficult for them to convince those trying to interpret the data in order to help those 'muddling through', that the stats should be taken so seriously.

They need to understand the limitations of their work, and convey those, otherwise their confidence will mislead Inquiries and others into listening to only one side of the argument.

So, with apologies to Lionel Shriver, we *need to talk about Francis*

Before we leap to implement 290 recommendations we should remember that Francis is a lawyer. Not only does he not know health care, he brings to it a forensic mind, that is one used to dealing with puzzles that have right and wrong answers, and to reaching judgements of guilt and innocence. He does not bring wisdom and insight because healthcare is not his field and he cannot. He therefore consults experts and takes their answers to his questions as reflections of reality – when they are far from it.

We could argue that one needs a good level of insight even to frame questions that are useful, certainly that is needed to interpret answers.

Perhaps the biggest danger of this report is due to his failure to grasp the concept of complexity. Without this, he severely castigates people for talking 378 times of hindsight (or the benefit of hindsight), suggesting that lack of knowledge about how to proceed in those circumstances was a failure. But in novel, complex situations like this the appropriate behaviour is, as we have seen, to muddle through elegantly, there is no blue print to follow. Certainly previous Inquiries will have illuminated other confusing situations but the extent to which their insights can be applied in any particular situation is limited. Francis is guilty of spurious retrospective coherence. Francis' failure to examine his own underlying assumptions in the face of hearing this 378 times from competent, well intentioned people is rather amazing.

He clearly fails to recognise this ability to muddle through elegantly as the only way society has of dealing with uncertain situations, and as something essential for us to retain across society in our professions. (The sabotaging of this by some economists who simplistically equate professionalism with 'capture of the means of production by vested interests' is one of the greatest dangers of our times). And it is a skill, a craft, a mental state that we need to foster in our professionals and those managing complex situations. We do not do so, indeed we frighten people away from using it, if we blame them when despite their best efforts things go wrong.

As my own areas of knowledge, wisdom and intuition do not extend to all of those covered in the report I will limit my examples of Francis' lack of insight into the health care arena to that of leadership which is my field. Here he has chosen to seek definitions and descriptions from the very people responsible for development of many of the current generation of leaders (and, incidentally with a vested interest in one of his prescriptions – for a national programme of leadership development) and to use their answers to lambast the Mid Staffs management and Board. In doing so he fails to recognise the woeful lack of credible research evidence (or even research method) to substantiate even the *concept* of leadership. There are many ways of viewing leadership (for example it can be argued to be an emergent property of a system just as much as a shaper of it) and some are more helpful in health care than are others, but none of this is reflected in the report. Instead we have censure based on a very limited understanding of it.

To a lawyer, consulting experts and acting on their advice seems sensible, to a sociologist, an anthropologist, or many historians it would not. It is *insight* that we are looking for, not *answers*.

Francis misses the point because he is part of the problem

So we should hesitate before deciding to implement his recommendations, We should consider whether Francis and his Inquiry are part of the system, part of the mindset, that is the problem; and whether the behaviours of finger pointing and blame and the reams of new policies and recommendations, that he models for us here, are what have got us to where we are, and whether it is time for us to refuse to engage with them.

As the systems theorists have long said, every system is perfectly designed to achieve the results it is achieving. It is the overall system, including politicians and policy makers, the NHS chain of (strict) command, the think tanks, professional bodies and royal colleges, and advisors from the big 4 consultancies, as well as those in provider, commissioner and regulator organisations , that has resulted in what has happened in Mid Staffs. It is perfectly designed to do so, ***and is almost certainly doing so right now in a hospital near you***.

It is, then, vitally important that we ignore Francis 2 and its recommendations because not only do they leave the fundamentals of the system unchallenged they frighteningly strengthen them.

So what should we do?

The Mid Staffs Board apparently (according to Francis) knew of longstanding attitudinal problems in some areas of the Trust yet failed to tackle them. The SHA and the wider system also knew of those problems (they are common after all) but chose instead to focus on their gaining Foundation Trust status with all that that entailed. In doing so they forgot that one of the major reasons for the whole

apparatus of FTs is the belief that, as FTS, organisations will have the incentive to tackle exactly this kind of problem.

This is what our current system does. It robs every initiative of its spirit and purpose and turns it into a lifeless, onerous set of performance managed deadlines.

So instead of castigating the people involved in Mid Staffs we **should invite them to help us understand how to design a system** that does not lead to the helplessness they appear to have felt when faced with complex intractable problems, that does not require them to focus on other priorities at the expense of these, and does not blame individuals when it is the system itself that is at fault.

To do this we need to bring together people who do have wisdom and judgment about health care, with those who can challenge them constructively and valuably into thinking creatively, collaboratively and in the interests of all, so that they can together challenge the wider system. It may be that Don Berwick is in this sense an inspired choice to lead this. Sadly it looks as though the seven committees he has set up (or set up for him) are manifestations of the same system that needs changing.

What recommendations would you like him to make?

Personally I would like him to recommend the introduction of management! *Real* management I mean, not the command and control structures and behaviours we have now which leave the NHS almost tonally ***un***managed.

Managing people is about supporting, challenging and enabling them to be their best. It is vital, vitalising, enjoyable, rewarding and hard. It takes time, courage and energy but yields a huge return on that investment. It is needed at every level of the service, especially right at the front line, where it needs to be done by more experienced clinicians with their juniors.

The NHS has had it in pockets, at different times in its history, it went largely out of the door in the wake of general management, and has now been replaced by commandment. Policy initiatives pass through a lengthy chain of command, with each layer adding more detail to the instructions on the way. They do this to justify their role and because they cannot bring themselves to trust that the layers beneath them will implement them properly unless they do.

Imagine instead having good (real) management conversations going on throughout the organisation. Wouldn't our current culture of command and control seem strange - and so much less successful?

So, what would Ronseal write on the tin?

I suggest they would say 'Public Inquiry: protects the reputation of the system by finding scapegoats at local levels'.

It is difficult to see who in particular is responsible for this purpose, and whether it is indeed a conscious decision taken in order to protect governments and the reputation of the wider service, or whether it reflects a prevailing mindset among many in the technocratic elite that spans policy makers and senior managers in a wide range of services and industries (http://www.amazon.co.uk/Voltaires-Bastards-Dictatorship-Reason-West/dp/1476718962/ref=sr_1_5?ie=UTF8&qid=1369137241&sr=8-

5&keywords=john+ralston+saul). But we saw it in action very clearly in 2006, when in many areas PCTS and acute trusts were very sensibly and fairly (and rather extraordinarily) sharing financial deficits and risk between them. When suddenly the financial crisis became apparent it was made very clear from the centre that only one organisation locally must carry the whole deficit and also the can. In the ensuing blame and censure, and 'turnaround', careers were ruined and organisations and their patients suffered from drastic cost cutting measures that were only necessary because other players were not allowed to share the pain and develop collaborative solutions. Instead they were classed as 'good guys' contrasting with the 'bad guys' who must be punished. To an observer like me this was shockingly unfair and yet it raised little in the way of comment, indeed to even think this way felt slightly dangerous.

But this assumption that the system is fine and that it is only individuals that are performing poorly cannot be sustained. We must stop finding scapegoats to protect the system itself from censure, and examine, really examine, the system itself. We need to ask questions like:

- where does the money go? When it leaves the treasury where does it go, and from there where does it go, and from there,.... and how much reaches or directly benefits the front line?
- how does this layer and that add value to the front line? How does it justify its existence to the front line and to the tax payer?
- how does this activity/regulation/directive support, enable and challenge those on the front line to give of their best?
- how does this activity/directive/regulation model the kind of compassion we want to see on the front line?

So I suggest it is time we made a new tin, next time we have an Inquiry lets label it: 'finds out, thoughtfully and with great care, the underlying reasons why good people in the NHS are not offering good care, and tries to do something about it'.

Perhaps Berwick could sack his committees and try to do just that?

Its vitally important that someone does.

Valerie Iles

May 2013