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Escaping the turnaround trap

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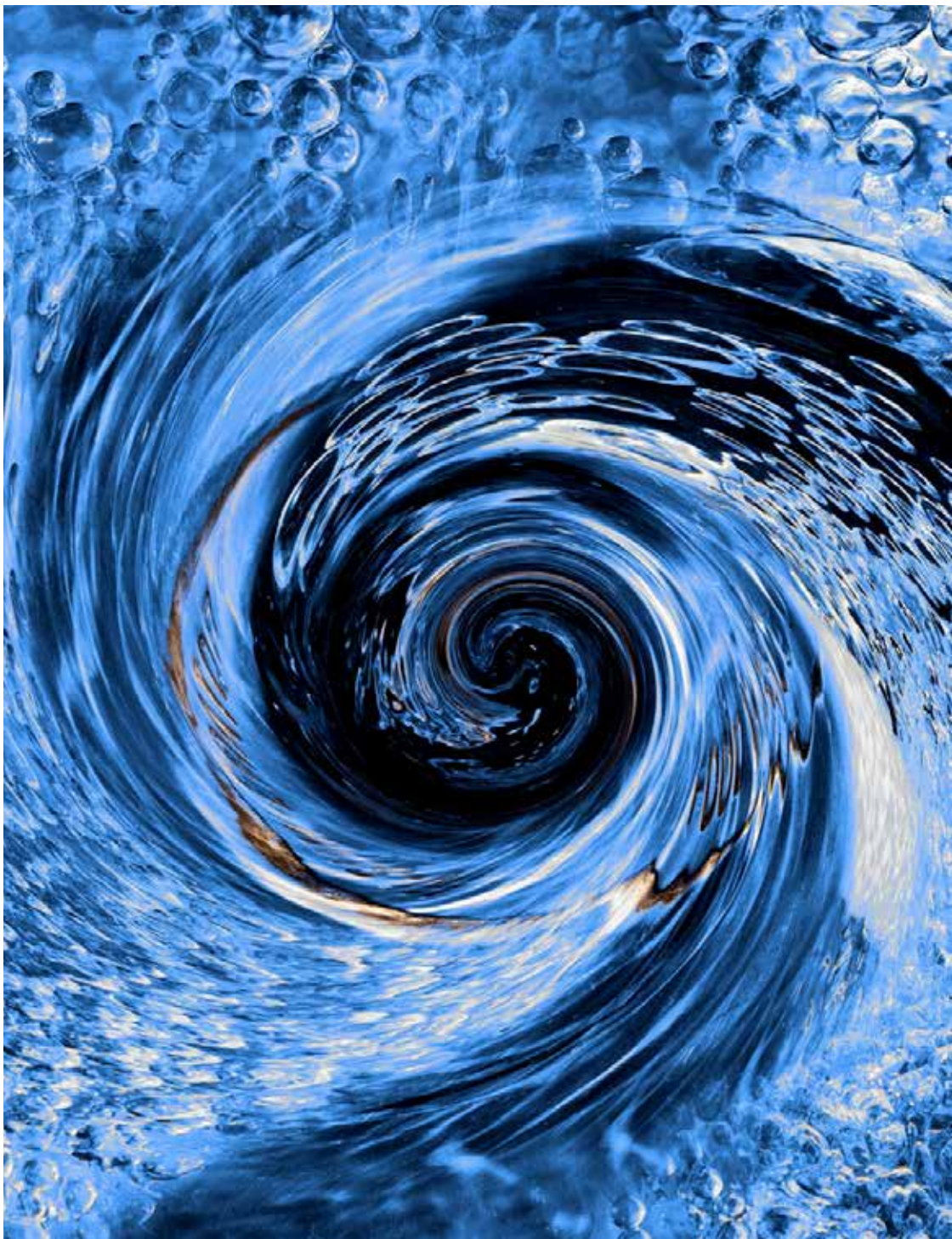

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Escaping the turnaround trap

Done well, a recovery phase can be used as a catalyst—or jolt—to move a hospital trust towards a sustainable improvement in performance. Done poorly, it can leave the trust in a "turnaround trap".

Can "failing" NHS hospitals ever be high performing, or are they doomed to a succession of "special measures", "turnarounds", and "success regime" programmes accompanied by a carousel of changing leadership? Hospital leaders in these situations often tell us that the challenge of delivering performance is all consuming, crowding out everything else and resulting in a lack of "head space" to think about the longer-term question of what it will take to sustain the improvements made during the intensive recovery phase.

In this article, we share some perspectives on these questions based on our experience of working with about 20 NHS hospitals that faced a range of performance challenges over the past five years. In particular, we share some observations and lessons on the phases of transformation and how an intensive recovery phase can both build the momentum needed to escape the turnaround trap and serve as a platform for ongoing improvement and sustainable culture change.

The turnaround trap

The NHS is operating under enormous pressure. The combination of rising demand driven by an ageing population, lifestyle factors, and increasing patient expectations, coupled with flat funding, is causing NHS hospitals to have to do more with less, or let quality, financial, or operational standards slip. The majority of hospitals are in danger of being overwhelmed by these pressures, with 62% of providers forecasting a 2016/17 deficit.[1] As of Q1 of the 2017/18 fiscal year, 93% of trusts had failed to meet emergency access (four-hour) targets,[2] and 59% were rated as "requires improvement" or "inadequate" by the Care Quality Commission.[3] NHS Improvement (NHSI) launched the financial special measures (FSM) programme in July 2016; 11 trusts have had intensive support since then (two have been able to exit the programme).[4] The UK population feels very strongly about the NHS: "[It's] the closest thing the English people have to a religion", as one former senior government minister described it.[5] Against this background, the resulting media attention, political interest, and regulatory demands can ratchet up the pressure on hospitals, effectively making it harder for them to focus on implementing the radical changes that are often more sustainable.

In reality, though, it is not organisations that experience pressure but rather the people who work in them, and NHS hospitals are full of people who are willing to go the extra mile to deliver the best possible care. There comes a point, however, at which the elastic is stretched dangerously thin, and goodwill and energy run out. Staff morale regularly tops the list of foundation trust finance directors' concerns,[6] and in 2016 37% of NHS staff reported that work-related stress had made them feel unwell in the past year.[7] There are now well-documented gaps in critical positions, such as emergency department consultants and intensive care nurses; the turnover rate of nurses in the NHS now averages over 15%[8]; and in 2015 more than one in ten chief executives held interim positions.[9] It is an open question whether the NHS will be able to continue to attract and retain the staff it needs to meet demand in the longer term. One medical director we spoke to put it like this: "Workforce is a key risk. We can no longer assume that people will want to work in the NHS, as we have in the past."

In the short term, the instinctive response to the performance gap is often to "stop the bleeding" by taking a command-and-control approach to spending or daily operations, and to sign up to the ambitious targets and improvement trajectories

required by the regulators. These programmes can feel overbearing, even petty (we have seen Post-it notes being rationed!). All too often, they are ignoring the human dimension of change and the need to understand individuals' mind-sets, build capabilities, and change behaviour at scale to deliver a new way of working that is fundamentally different—more fulfilling as well as more productive.

It has long been said that 70% of change efforts fail to achieve their goals, and our research has found that the main causes are either that employees resist change or management behaviour does not support and reinforce the change.[10] In other words, a sustainable approach to performance improvement needs to recognise the importance of mind-sets, capabilities, and behaviours, and give as much emphasis to improving what we call organisational health as to improving actual performance. Otherwise, short-term gains in performance can damage organisational health. This is the "turnaround trap".

To escape the turnaround trap facing NHS hospitals, a much stronger focus is needed on the people agenda, including leadership and organisational development, capability building, decision-making, delegation, and accountability. It is largely these factors and management practices that define—or limit—culture and, therefore, the extent to which an organisation is able to deliver against its true potential. Achieving this requires a new approach to performance improvement, one that stretches beyond the horizon of short-term pressures to the higher ground of longer-term continuous improvement founded on a healthy organisational culture and a motivated and reinvigorated workforce.

In this article, we share some perspectives on what we have learned through our recent work on operational, quality, and financial improvement programmes with hospitals. Our hope is that this article will contribute to the debate about what leaders and regulators can do to deliver short-term performance imperatives while, at the same time, fully engaging the workforce and strengthening organisations to put them on the path towards a culture of continuous improvement. We begin by introducing the concept of the *three horizons of a transformation journey*, and then focus on the first part of the journey—*performance recovery*—to share our insights and experience on how to take these first steps along the journey to make it sustainable in the long term. Finally, we share some reflections on the latter part of the journey (*clinical and operational transformation* and, eventually, *continuous improvement and organisational agility*), and how performance recovery can be used to transition towards the end state.

Three horizons of a transformation journey

In our experience, the journey from a distressed hospital facing a combination of financial, operational, and quality challenges to a strong and well-performing system leader typically takes three to five years, a much longer time frame than most turnaround programmes. Many of our clients find it helpful to think of a transformation as a journey of three horizons from short-term and urgent *recovery* to longer-term self-improving *agility*.

Laying the journey out this way can help create a long-term vision and aspiration that is both attractive to staff and sets out stepping stones to long-term sustainability and continuous improvement. In fact, in our experience it is important to pull forward some of the transformational changes that would generally be considered part of the second and third horizons; implementing them during the first horizon allows hospitals to keep the focus on transformation rather than "grip and control". Our observation is that too many NHS hospitals become stuck in the first horizon, never managing to transform but rather remaining mired in the turnaround trap. Although this paper focuses on the first horizon (performance recovery), it also highlights how this phase can be set up to avoid the turnaround trap and lay the groundwork for success in horizons 2 and 3.

Let us begin with defining the three horizons. Exactly what falls into each of these horizons and their duration will be specific to each organisation and their context, but to characterise some common themes we would describe them like this:

- **Horizon 1 (years 1–2): performance recovery.** It is important to understand the scale of the challenge and root causes of the performance gap, and to focus on making some rapid changes to "stem the bleeding". This is usually a must step—the second and third horizons are simply not credible without demonstrable success at this phase. However, this first horizon is also an opportunity to begin to make changes in management practices and culture to strengthen the organisation. These might include developing a narrative (change story) explaining why change is necessary and the benefits of doing it, increasing the pace of decision-making, clarifying who is accountable for what, and creating transparency by providing reliable performance information based on good quality analytics. Our experience is that, done right, this can act as the jolt needed to jump-start the car, as it were, and be a positive experience for staff, who start to see that there is a more effective way to turn ideas into action to reduce waste, waits, and patient harm.

- **Horizon 2 (years 2–4): clinical and operational transformation.** Here, the emphasis shifts from tactical improvements to a more systematic, fact-based approach. Teams work on improving clinical and operational processes often challenging the status quo (e.g., by making best use of new technology or by starting with a "clean sheet" to eliminate legacy issues and historical work-arounds). In addition to embedding the management infrastructure described in horizon 1, horizon 2 should also include a focus on integrating skills building with improvement activities. At one teaching hospital, for example, we provided weekly training sessions to help teams to follow a structured and consistent problem-solving approach to move from an initial idea to a prioritised implementation plan. Done well, this approach allows a cohort of 50 to 100 staff to learn a toolkit and a set of skills that they can continue to apply beyond the recovery phase. A key point here is that the capability building must be fully integrated with the "real work" so that people learn by doing and the recovery phase becomes an organisational development intervention.

- **Horizon 3 (years 4–5): continuous improvement and organisational agility.** Increasingly, we see the five-year end state of this journey as a hospital that is continuously self-improving, based on a learning culture and an agile operating and managerial model. What does this mean in practice? It means that the organisation is able to respond rapidly to changes in the local system or in demand without the need for decision-making to be dependent on the executive team and associated time delays. In turn, it means that the organisation can quickly improve outcomes, patient experience, and operational and financial performance. Practically, this requires a substantial devolution of responsibility and decision-making to frontline teams who are supported by high-quality data and have the capabilities and confidence they need to design and implement changes to the way care is delivered. We recognise that this devolved model runs counter to the recent direction the NHS has been taking, with a strong role for central regulation. In a sense, we believe that a well-set-up devolved model, with full transparency of performance (clinical, operational, and financial), appropriate talent management, and continuous learning/improvement mechanisms, will deliver best results. Many other industries and companies are deliberately shifting towards a more agile model to cope with increasing pressures and a more uncertain environment, and so there are many examples to draw inspiration from, including other hospitals (see the sidebar, "Case study: Agile hospital of the future—Mayo Clinic, USA").

We also recognise that in the current environment there is a paradox between short-term recovery pressures and a long-term vision of a devolved model. The only way this paradox can be resolved is by thinking ahead to the clinical and operational transformation, and pulling forward elements of the next horizon of transformation (e.g., creating radical

Case study: Agile hospital of the future—Mayo Clinic, USA[1]

The Mayo Clinic is a great example of agility in practice. Headquartered in the relatively small town of Rochester, Minnesota, the Mayo Clinic has developed a highly successful business as a destination hospital. In 2016, it attracted patients from all 50 states and more than 140 countries. It is among the handful of US academic medical centres that are routinely applauded for high-quality patient care and has very strong loyalty amongst employees.

How do they do it?

Leaders at the Mayo often talk about the two key reasons behind their success: their strategy of improving quality as a driver to improve efficiency, and the importance they place on the staff feeling joy at work. These strategies are so effective because they leverage intrinsic motivators to incentivise staff—meaning, purpose, collaboration, excellence, and flexibility in work:

- The Mayo has about 60,000 staff who are organised into teams of roughly 20 people, each of which is led by one of approximately 3,000 leaders (e.g., amongst the 4,100 physicians there are 242 teams).
- Each team has a clear purpose and visibility into their performance (as a team and as individuals within the team).
- Staff are trained to deliver improvements (43,000 of the Mayo's staff have completed a value-improvement programme) and are empowered personally to make daily decisions to improve performance, holding themselves accountable to the rest of their team.
- Each year all staff are asked to complete a simple nine-question survey about their team leader to identify those with leadership issues; when a problem is identified, the team leader is offered coaching and support to improve (the organisation has about 1,200 full-time coaches). Crucially, the Mayo makes appointment decisions based on these survey results.

1 Taken from a talk at The King's Fund 2016 annual conference given by Dr. Stephen Swensen, Medical Director, Office of Organization Development, Mayo Clinic (US), November 2016, (https://www.kingsfund.org.uk/audio-video/stephen-swensen-delivering-high-quality-compassionate-care).

transformation experiments, putting in place foundations for performance transparency all the way to the front line teams and even individuals). For example, as part of our support to a major teaching hospital, we helped it apply a user-based design approach to rethink the model for the fracture clinic. Together, we found that about half of the clinic's patients did not need to attend their appointments (based on their initial assessment in primary care); their needs could have been met in other ways, eliminating the need for these appointments and dramatically improving access for those most in need. So, it may be more effective to take a more transformative approach by fundamentally rede-signing a clinical service rather than try to achieve savings by optimising the existing service model.

Equally important, the cultural shifts described within horizon 2 will be more successfully embedded if work starts on these from the very beginning of the journey, so that all stakeholders—from leadership to the frontline—play an active role in the problem-solving and solution-development process, not just execute orders. This approach is often considered too difficult or too slow to factor into a turnaround process, but our experience is

that leaving the cultural shifts until later is a false economy—the payback on early staff engagement is significant, as is the downside of not doing so.

Making recovery sustainable

Several theories of change recognise both the need for and the difficulty in "unlearning" old ways of working before transformation is possible (e.g., Kurt Lewin's classic three-stage process: unfreeze, change, refreeze).[11] In the NHS, the prevailing paradigm of central grip and control has become engrained. Most staff perceive a "turnaround" as an even more extreme version of the same thing and question the logic of how it is expected to solve underlying problems.

We have found that an intensive turnaround or recovery phase can be the perfect opportunity to "unfreeze" the organisation, not just by challenging established ways of working but also by demonstrating a much more focused way to deliver change, one in which good ideas can be implemented faster to ensure that change actually happens, benefitting patients and making life less stressful for staff. The effort can be powerful and energising for staff, who often describe their experience of trying to bring about change as being like wading through treacle, which has caused them to give up long ago.

Given the legacy of previous failed, or short-lived, turnarounds, we have found it absolutely critical for leaders to develop and share early on a **compelling change story** that engages staff and gives them a credible answer to the question, "What will be different this time?" The three horizons can be a useful framing for answering that question appropriately: "The turnaround is not simply about recovering performance; it is also an opportunity for us to take the first steps towards a fundamentally different way of working that will improve care for patients and fully engage staff in improvement."

Too often, the recovery phase (horizon 1) is seen as unnecessarily tough and something of a blunt instrument, after which more engaging transformational work can begin. However, this ignores the impact on staff energy and morale. In contrast, an approach that brings forward elements of the second and third horizons, and that sets out a longer-term journey towards an end state, is inspiring for staff and can energise them from the outset.

Ten steps for effective recovery

Data from NHSI suggests that a majority of UK acute trusts are in the recovery phase—they have significant, visible performance issues (usually, both financial and operational), with a need for an immediate and rapid solution (Exhibit 1). The latest NHSI provider segmentation ratings show that 11% of NHS acute, acute teaching, and specialist trusts are in "special measures", with another 40% receiving "mandated support for significant concerns". Indeed, just 12 hospital trusts (8%) fall into the top category, with no potential support needs required.[12]

We have worked with around 20 NHS hospitals as part of a performance recovery effort. Some of these efforts have been as part of NHSI's Financial Improvement Programme (FIP); in other cases, we supported the hospitals independently on financial recovery, recovery of A&E performance, and quality "special measures". Additionally, we have supported hundreds of corporate recovery and restructuring situations globally, across all industries. These efforts have allowed us to identify some lessons we believe are worth sharing:

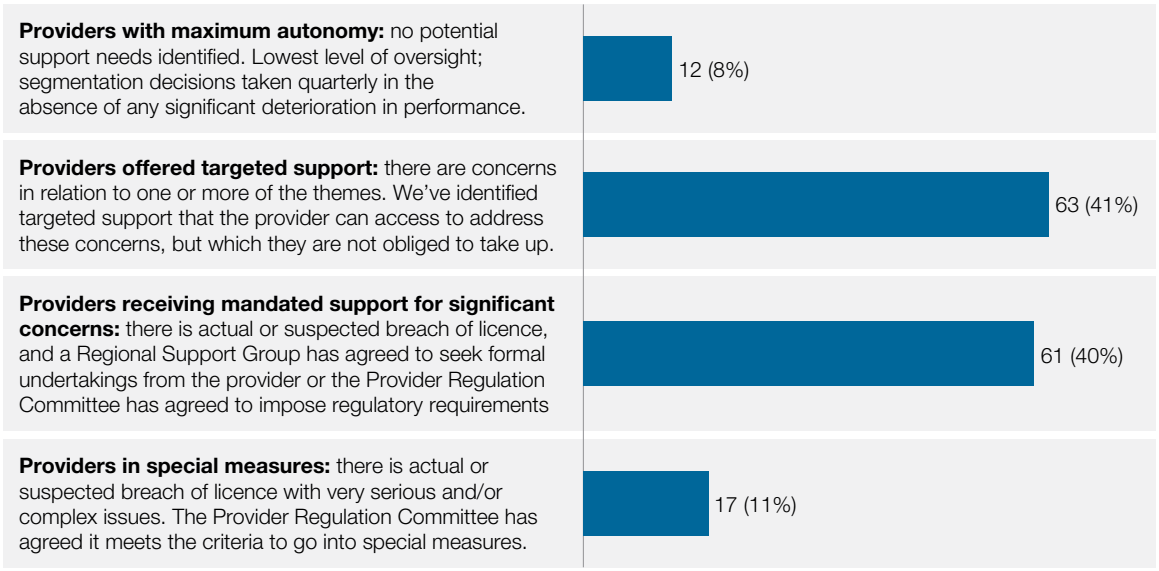
1. Signal a genuine commitment to transformation from the top

The most important starting point of a transformation, and the best predictor of success, is having a **chief executive and other senior leaders** who recognise that only a new approach will dramatically and sustainably improve the hospital's performance. Leadership from other executives, including the medical and nursing directors, is essential to signal to the clinical staff the organisation's level of commitment to tackling long-standing problems and frustrations and, ideally, to hearing a similar appetite for change from the staff. For example, at one hospital facing severe challenges with A&E performance, the chief

EXHIBIT 1 **National Health Service Improvement (NHSI) provider segmentation**

Single oversight framework: provider segmentation for acute, acute teaching, and specialist trusts

Number of trusts by NHSI provider segment, July 2017



Source: NHSI data extracted July 17 2017, https://improvement.nhs.uk/resources/single-over-sight-framework-segmentation.

executive became much more visible in walking the floors, including at night, to gain first-hand experience of the issues and to engage directly with staff to understand their perspectives.

2. Articulate a clear and compelling change story

Simply communicating the need to close a financial gap or address a specific set of concerns raised by the regulator is not going to provoke a meaningful response from staff who may already feel stretched to the point of exhaustion. The leadership team will need to prioritise time to **describe their long-term aspiration** (horizon 3), test and refine it with their staff, and ensure that the hospital board is aligned. From our experience, this would typically involve the chief executive writing a first draft within two weeks of a recovery programme starting, getting feedback and input from the senior management team, refining the draft, and then sharing it with staff through a series of briefings and a multitude of other channels—whatever works best for the organisation. Over time, the message should be retold and reinforced throughout the organisation so that every member of the staff has heard it (even if not always from the chief executive directly) and understands how they can contribute to moving towards the aspiration. Most successful stories not only address the future vision but also outline the benefits for patients, staff, the organisation, and the broader society.

3. Increase the rate of metabolism of the organisation

Once leaders have clearly communicated the change story, they may be tempted to delegate responsibility to a steering committee or programme management office (PMO) charged with providing periodic updates. Our experience is that it pays to put in place a different kind of infrastructure whose role is to **minimise reporting and focus instead on rapid decision-making** based on weekly, in-person conversations with those leading initiatives to ensure that they are on track to deliver and, if not, that any obstacles are tackled. This kind of transformation office (TO), overseen by a chief transformation officer (CTO), has three main benefits relative to most PMOs:

- Increased pace through a rigorous and efficient meeting schedule—this provides the drumbeat for improvement, building momentum and energy early on, and creating a sense of belief that change will really happen.

- Greater transparency across the whole organisation, all divisions, and all improvement initiatives. This goes beyond a typical PMO-style tracking in which data is absorbed but often not widely shared. Instead, initiative-level metrics (both process and outcomes measures) are analysed and shared at least weekly, and progress of every initiative is measured against agreed milestones and goals. Done right, this will be a foundation for the clinical, operational, and financial transparency required in horizons 2 and 3.

- Clearer accountability by assigning ownership of initiatives to teams and specific individuals to design and deliver them. The TO's accountability is to challenge and coach the teams and individuals to deliver the initiatives—for example, by asking "What can *you* do to ensure this is delivered?" and "What help do you need?"

Our experience is that staff welcome a process that adds value by increasing pace, transparency, and accountability in a way that feels different from their previous experience with a PMO.

4. Install a CTO who acts with the authority of the chief executive

Managing a recovery programme or an organisation-wide transformation is a demanding, full-time, executive-level job. It needs to be filled by someone with the authority to push the organisation to its full potential.

The CTO (or equivalent role) is effectively an additional executive team member whose job is to challenge, question, cajole, and provide praise and recognition to steer the organisation and individuals to think and act differently by asking "What will it take to do this?" rather than detailing the reasons why things have not happened. Accordingly, the CTO must have a team with the experience, discipline, energy, and skills necessary to provide targeted support to the major initiatives, each with a specific owner and a detailed, evidence-based implementation plan. Above all, the CTO must constantly push for decisions to create a palpable sense of progress.

Many PMOs are strong on processes but unable or unwilling to challenge senior leaders, including the executive team, which can lead to an increase in reporting and complexity rather than a change in tempo. The right CTO can sometimes come from within the organisation, but typically does not—at least to start with. The CTO must be dynamic, respected, unafraid of confrontation, and willing to challenge the status quo. This is a difficult role to ask someone from within the hospital to play, given concerns about protecting their legacy, securing their next role, or avoiding long-standing internal political tensions. In some cases, we have been able to provide a CTO from our Restructuring Practice, typically someone with a background as an executive in similar situations.

5. Understand the full improvement potential—nothing is "off the table"

Most targets result from negotiations between leaders and line managers; this approach often leads to "sandbagging", where people will commit only to a level of improvement they are sure they can deliver. To counter this tendency, leaders should demand a clear, fact-based analysis of the hospital's full improvement potential. For example, the maximum theoretical capacity of an operating theatre can be considered as 7 days per week, 12 or more hours per day, rather than the utilisation measures many trusts currently use, which often assume that operating theatres will be used only 5 days per week, 8 hours per day, and that a number of planned cancellations will occur each day. Thus, while many hospitals may think they have a high level of in-session productivity (perhaps 85%), the denominator

they are using is typically 30 to 35 hours per week (5 * 8 – planned cancelled sessions). Using the full potential of 84 hours (7 * 12) would reveal a much greater utilisation improvement opportunity. Our Restructuring Practice has found in its work across industries that the impact achieved is, on average, two to three times more than the organisation's ingoing estimates of potential. This approach can often feel scary in the beginning but ultimately allows the trust to explore a full set of opportunities and possibilities.

6. Address the mind-sets and behaviours that hold the organisation back

Many organisations perform below their full potential not because of structural disadvantages—e.g., an expensive PFI (private finance initiative) or shortage of staff and equipment—but because of a deficit in leadership, capabilities, and misaligned incentives at many levels. The present period of restricted funding puts a premium on strong leadership and creativity in coming up with alternative ways of doing things, as well as the ability to make the changes in behaviour that these new ways of working typically depend on. The transformation will only achieve its full potential if these issues are addressed early on and explicitly, rather than focusing exclusively on processes and performance metrics. Common mind-sets we encounter include:

- Prioritising the "tribe" (local unit) over the "nation" (the hospital as a whole)
- Being too proud to ask for help
- Focusing on "firefighting" and "busy" work
- Confusing authority delegation with "management by committee"
- Being embarrassed to reveal too big an improvement potential
- Blaming external factors as the reason why change is not possible

A well-designed recovery phase can bring about a shift to a mind-set of setting and owning high aspirations, and a willingness to confront long-standing issues and collaborate across organisational boundaries. For example, having the TO role model decision-focused meeting and having top executives review their diaries to better prioritise their time can act as strong signals across the organisation.

7. Frontline staff must co-develop the solutions if they are going to own them

Frontline staff are not only those who are best placed to solve specific problems but also the only people who can make this change happen—or block it. To promote engagement and change, the TO team should work closely with frontline staff to develop a prioritised portfolio of initiatives based on the areas of opportunity identified in the diagnostic across all domains (that is, quality, productivity, finance, and people), and help them follow a logical, step-by-step approach to develop their plan to implement changes.

Each initiative requires a clear description of the scope, a prioritised set of initiatives or actions, an implementation plan, expected impact, risk assessment and mitigation plan, and independent quality impact assessment, all of which must be approval by finance, HR, and the hospital board. The result of this process is a robust transformation plan that combines short- and long-term initiatives to achieve measurable financial and operational goals, instead of a long list of ideas with rough estimates of financial savings against them.

We have found that creating a common currency for the maturity of initiatives has enormous value for frontline staff as well as the hospital board. In our work supporting financial recovery, we introduce a framework with six levels of maturity:

- L0, an initial idea
- L1, a worked-up idea with an estimated annual impact
- L2, a plan supported by a proper evidence base and risk assessment
- L3, a detailed, implementation-ready plan

- L4, changes are being implemented as described in the plan
- L5, validating the financial (or other) impact through the formal reporting mechanisms

We also bring an online reporting tool which creates transparency and provides real-time information on the progress of every initiative against this framework.

8. Be open to innovating *everywhere*, especially in clinical operations

A relatively low proportion of traditional CIPs (cost improvement programmes) challenge or change clinical practices. As the Carter Review[13] and GIRFT (Getting it Right First Time) programme[14] have shown, too often clinical practices, supply selection and use, and patient outcomes vary enormously across specialties, teams, and individuals. Against this background, we have seen constructive challenges to clinical practices produce major improvements in quality of care and financial performance (e.g., in staffing patterns across similar wards, use of diagnostic tests across clinical teams, and clinical time as a proportion of job plans within a specialty). Hence, we believe strongly in having clinical professionals—doctors, nurses, midwives, physiotherapists, pharmacists, and so on—on the transformation teams, engaging in dialogue with frontline staff, and sharing their understanding of the sources of clinical variation, so the transformation effort can address critical issues effectively.

To ensure parity and legitimately challenge clinical operations, the entire organisation must be open for transformation—there are no sacred cows. Staff are often quick to point out how much of their own time is wasted, which suggests there is room for improvement in every area of the hospital, and so all clinical and non-clinical areas require scrutiny. Doing this is not easy. We are all too aware of how recent service changes or established ways of working can provide grounds for exemption (e.g., "Orthopaedic prosthetics have recently been rationalised so we can't go there again", "Nursing staffing levels have been signed off to meet national standards"). Yet the magnitude of the challenge requires exploring everything, and we have found the best results come from a willingness to leave no stone unturned.

Furthermore, the most successful organisations are open-minded as to what form the solution might take—for example, in the role that patients can play in their own care; rethinking who does what amongst ward-based staff to make full use of the team's skills; and using technology. Reaping the rewards of innovation requires decision-makers to judge when to push for a more innovative solution rather than pursuing an incremental approach to refine the existing way of working. We have also found it helpful to challenge the tendency to spend months trying to develop a perfect, risk-free solution before agreeing to change anything, and instead to adopt the mind-set and methodology (borrowed from software development) of agreeing on a "minimum viable product" in one to two weeks and then testing and refining it.

Of course, some of the biggest headaches for hospitals can't be solved by the organisation alone: re-admissions, delayed transfers of care, and growth in demand for emergency care, to name just a few. Instead hospitals must work with their health and social care partners to optimise for the patient and the whole system before the hospital can benefit. We have seen effective examples of acute hospitals creating on-site nursing home wards, providing more direct access to specialist consultants (such as a directory of services with mobile numbers), or collaborating with GPs at the front door to help deliver more system-wide impact.

9. Build capabilities and incentives to sustain the transformation

Sustainable long-term impact on clinical and financial performance requires a broad team that includes clinicians, managers, frontline staff, and hospital executives. Every member of this team needs the capabilities to fulfil their

role and ensure that initiatives deliver the impact identified, improving productivity and quality of care. A recovery programme can be the ideal moment to make an honest assessment of the skills gap the organisation faces and to put in place a structured programme of capability building designed to support performance improvement (e.g., practical training in how to have a difficult but constructive feedback discussion).

The formal incentives and informal consequences in hospitals are often not aligned with the need for

Case study: Central Manchester University Hospitals NHS Foundation Trust discovers the full potential of rapid recovery

The Central Manchester University Hospitals NHS Foundation Trust (CMFT) is one of the United Kingdom's largest acute trusts, with 1,200 beds, more than 12,000 employees, and revenue of more than £950 million. In FY 2016/17, CMFT was facing a particularly tough challenge: it would have a £65 million underlying deficit unless significant improvements were made.

To address this financial challenge, CMFT initiated an internal recovery/turnaround programme. The intense recovery regimen included:

- **Setting out the internal turnaround challenge to leaders and engaging all staff** through leadership briefings (delivered through January 2016) and video clips that all staff could access. These explained the scale of the challenge and the core areas of focus for returning to financial sustainability. Strong emphasis on the benefits to patients and support for staff was positioned as the "golden thread" in the turnaround communications programme.

- **Using the NHSI FIP programme to "turbo-boost" the focus and pace of the internal turnaround programme**, after leaders realised that momentum had been insufficient in late February/March 2016. The intensive, externally resourced nature of the FIP programme concentrated greater attention week after week on driving plans through to delivery and ensuring that tangible changes to operating practice were pushed "over the line" and embedded into the organisation.

- **Persistent challenge to progress at all levels**, including executive colleagues, divisional leadership teams, and those in charge of key corporate work-streams. The goal was to instill the discipline that delivery progress was only recognisable if it was reported to the hospital board; the report had to clearly link the results achieved on related items of income or cost.

This effort delivered benefits on a number of fronts:

- **Improved CMFT financial performance** from a do-nothing deficit of £80 million for 2016/17 to a year-end position of £56.6 million surplus (including £20.5 million core STF (sustainability and transformation fund) and £29.7 million additional STF), over-achieving the 2016/17 Control Total by £22 million at the end of the financial year.

- **Ensured a transformed climate for financial delivery**, drawing in part on the disciplines of the internal turnaround approach but also on improved clinical leadership and senior finance capabilities, supported by a wider organisational development programme.

change. The formal incentives do not have to be financial; however, it is crucially important that individual staff members and teams understand what good looks like, routinely participate in effective performance dialogues, and are offered recognition and rewards that are meaningful to and valued by them. We find that there are often issues in all three of these areas—roles are unclear or undefined; feedback is infrequent, unstructured, and not constructive; and good work does not get the recognition it deserves (or the staff feel that there is a fixed amount of credit to go round, which can inhibit collaboration).

10. Make time and space to reflect on the learning as a leadership community

In several recovery programmes we have supported, we have worked with the executive team to design and facilitate whole-day events for the top 100 leaders in the hospital. The purpose of these events is to help leaders reflect on the impact of some of the changes described in this article and decide how they want to take the transformation forward so they can embed some of the changes in their managerial model and enable the changes to become business as usual. By bringing in speakers from other sectors (such as the military and sport) to share lessons on leadership, we have provoked discussions on how the leadership model and behaviours may need to change to support a culture of improvement.

We also use our Organisational Health Index tool to measure culture and management practices, creating a fact-base to help leaders make important judgments on how to change how the hospital is managed and move it towards being an agile organisation. Our global database of findings suggests that key management practices associated with agility are role clarity, top-down innovation, and the ability to capture external ideas.

For an example of what a rapid recovery can achieve, see the case study "Central Manchester University Hospitals NHS Foundation Trust discovers the full potential of rapid recovery".

Beyond recovery

As a hospital moves out of the recovery phase—most likely by undertaking some genuinely transformational initiatives (e.g., rethinking the outpatients model, digitising the maternity pathway), the focus shifts from the immediate short-term goals towards long-term aspirations. This shift involves a fundamental change in the operating model, including clinical pathways. Reaping the rewards of innovation requires that leadership prioritise innovation and try out new practices without waiting for consensus to build (e.g., through rapid prototyping of changes).

Accessing this level of creativity and innovation will be difficult if the recovery phase has been painful or has left staff feeling exhausted or demoralised. This is why the recovery phase must be executed with one eye on the longer-term aspiration, making small trade-offs in short-term performance to enable longer-term transformation.

Done well, we believe that the recovery phase can be used as a catalyst—or a jolt—to move the hospital towards a more agile operating model and culture, one based on distributed leadership, with some of the practices put in place during recovery becoming the platform to build on. In many respects, this harks back to the toolkit and practices of service line management, which we helped to develop some years ago. Perhaps what was missing back then was the sense of urgency and the case for change, as well as the awareness of how profound the shift in culture and mind-sets must be to delegate decision-making authority to the service level.

In our view, the stakes are now very high—morale and goodwill are eroding, and they will be difficult to rebuild. So, there is now an urgent need to escape the turnaround trap and to provide staff with light at the end of the tunnel by building elements of horizons 2 (clinical and operational transformation) and 3 (continuous improvement and organisational agility) in the recovery phase.

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