

Securing Systems Change

Prof Becky Malby

Universal Healthcare: The Proposition



We recognise the NHS's intent to address health inequalities, alongside the reality of unequal service provision. The focus of this work is on the three areas where we propose the NHS is complicit in-service inequalities. These are:

1. **Medicalising poverty** and providing 'sticking plaster' approaches, with the best intentions, that make the problem invisible. People are turning up in Primary Care with health issues that stem from poverty with nowhere else to go.
2. **Providing services that are not accessible to all.** The Vaccination programme shows how the NHS can reach out to communities and ensure equal access, but we don't do this for many services e.g. diabetes checks.
3. **Not being frank and open about the reality of the rationing of services.** This is depicted in one of the National Voices 'I' statements – 'I am not forgotten' (National Voices 2020).

West Yorkshire
Health and Care Partnership



Sussex
Health&Care

EST 1892
LSBU

How to do this work



WE KNEW that the most important thing is to *start*, to get going. From there, the road takes surprising turns as the system reacts to what is happening, and everyone gets involved. This is a good thing as it brings new ideas, new people, and new solutions.

West Yorkshire
Health and Care Partnership



Sussex
Health&Care

EST 1892

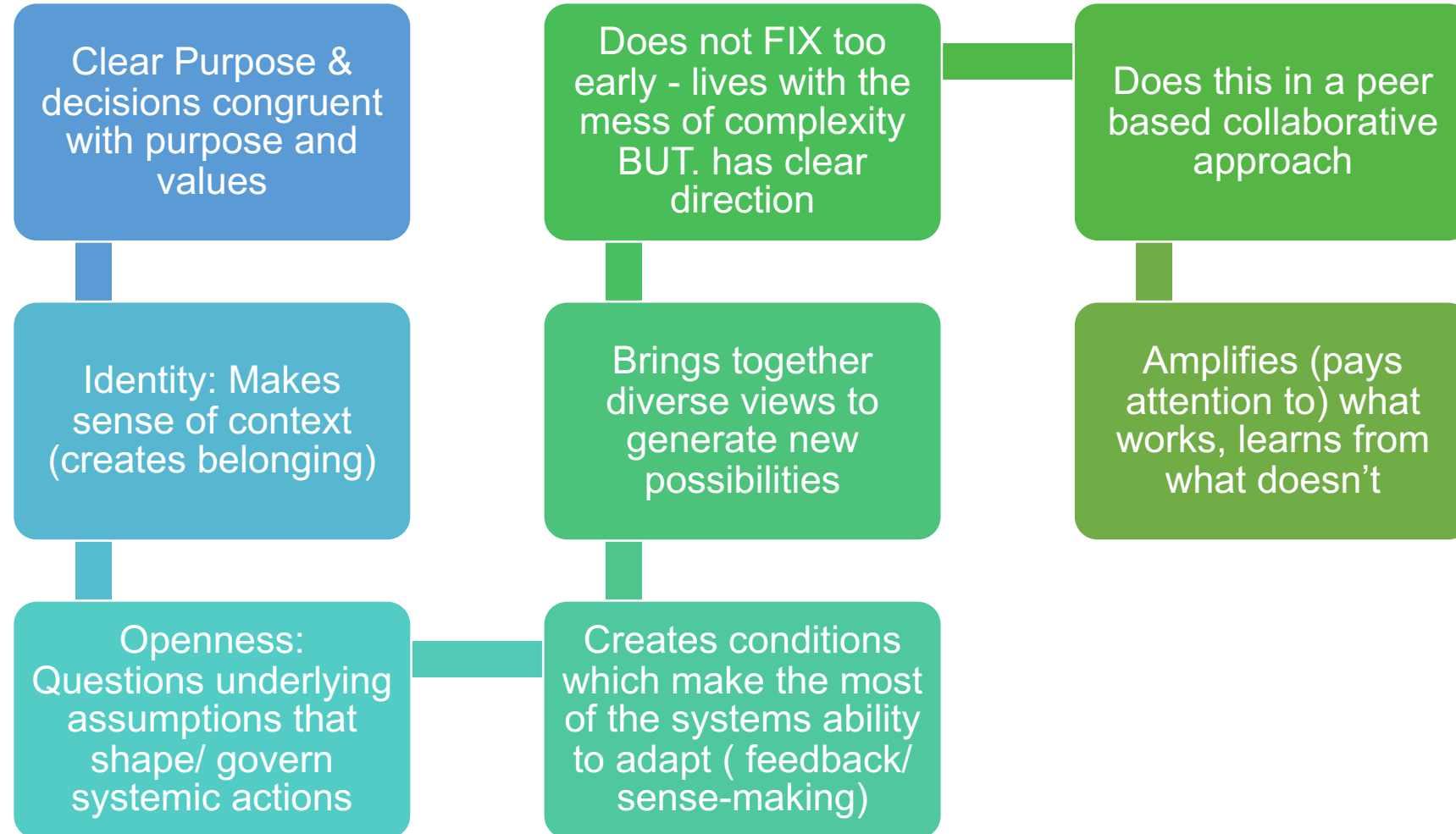
LSBU

The Ideas

Systems Leadership

“Leadership is becoming increasingly complex with a growing need to deal confidently with volatility, uncertainty, chaos and ambiguity” (Ghate et al 2013 p 4)

Key Principles in Leading Systems





“Relationships are the most important thing in a complex system. If you don’t have strong relationships, none of this works.”

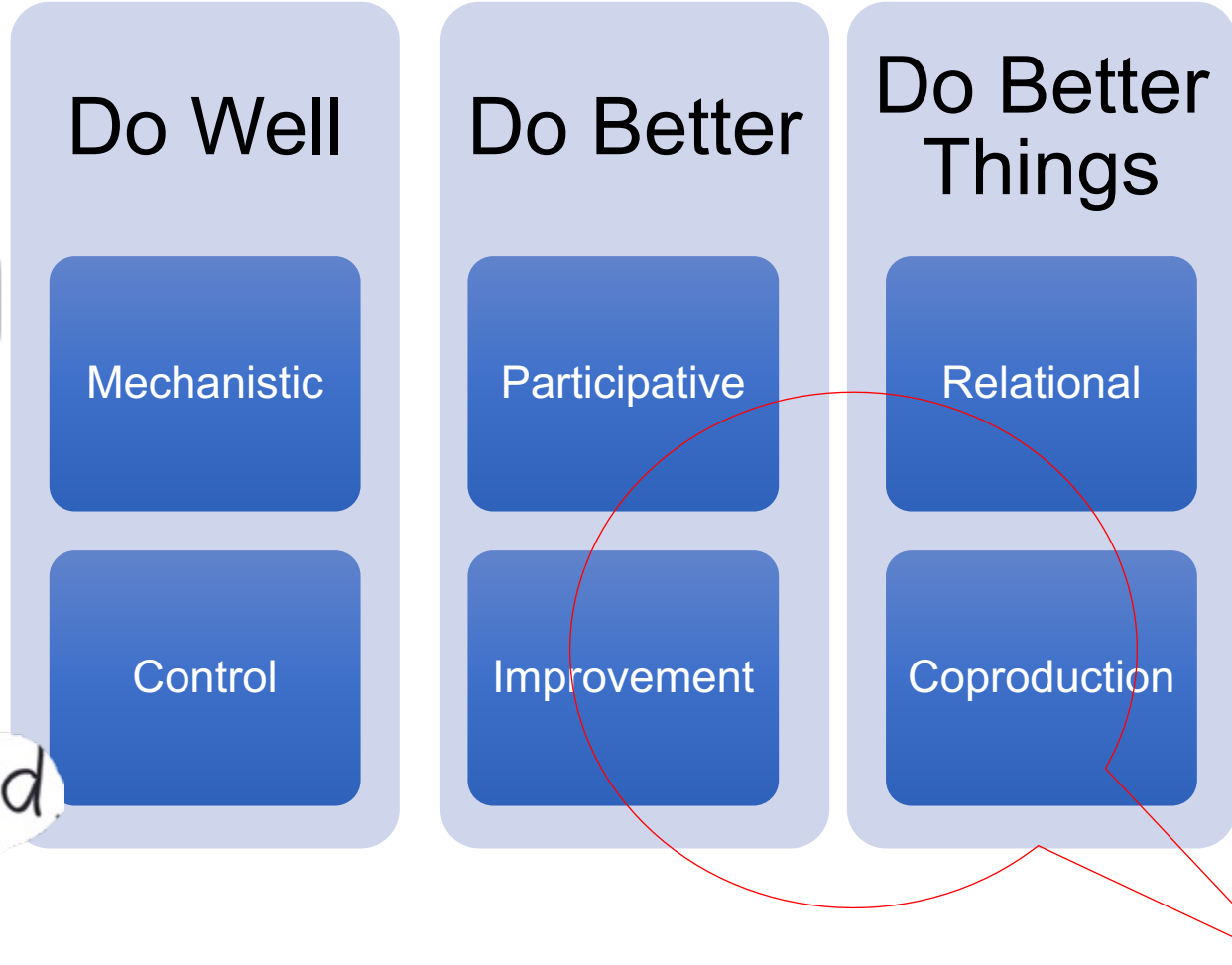
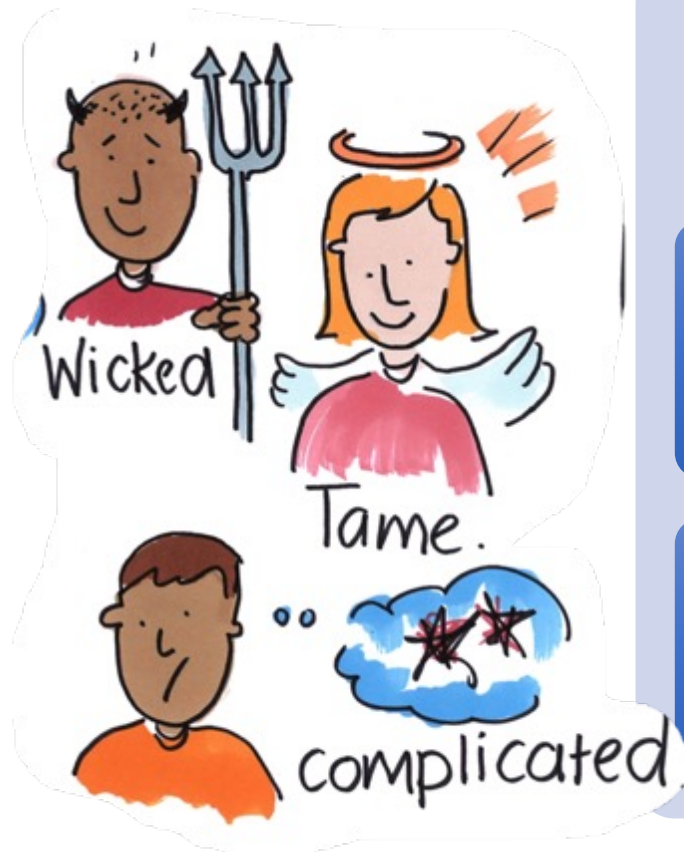
Regine, B. and Lewin, R., 2000. Leading at the edge: How leaders influence complex systems. *Emergence*, 2(2), pp.12.

How do Systems Work?

The problem



Kim Nurse Darzi 9 from the NHS England
(2014) Five Year Forward View



Adapted from Anderson-Wallace, Blantern and Boydell, (2000-2007) in Malby, R., and Anderson Wallace, M., (2016) *Networks in Healthcare: Managing complex relationships*. Emerald.

The 10 Properties of Wicked Problems

1. There is no well-defined uncontested statement of the problem.
2. There are no stopping rules, so you don't know when you have reached a solution.
3. Solutions to wicked problems are not true or false.
4. There is no immediate and no ultimate test of a solution because they generate unexpected consequences and can change the environment.
5. Every solution is a 'one shot' operation' no opportunity to learn by trial or error because it has consequences, that cannot be undone.
6. They do not have an exhaustively described set potential solutions, just many possibilities. Nor are there a well described set of possible operations that may be part of a plan.
7. They are part of a class of problems but each is essentially unique.
8. They are not self contained and don't have one root cause. They can be considered a symptom of other problems.
9. They involve many stakeholders who may have different ideas about both the nature of the problem and possible solutions
10. You will be held accountable for inevitable unintended consequences. The planner has no right to be wrong.

Systems Practice

1. What is the Question?
2. What is the System for that Question?
3. Does the system have access to itself?
4. What does the system want to do?

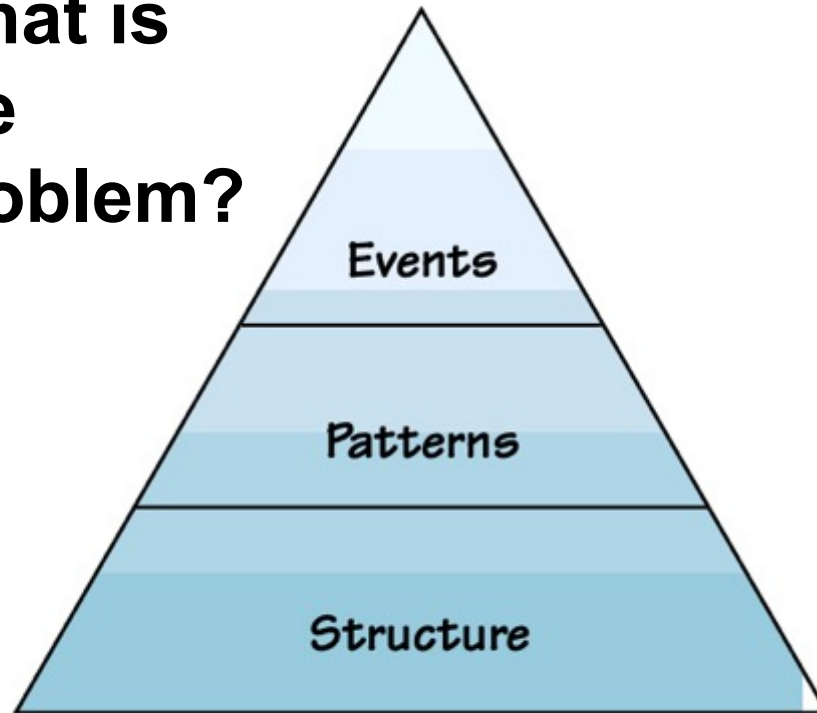
Core principles

- (a) The knowledge is in the system
- (b) Bringing the diversity of the system together generates solutions that stick

From Myron Rogers

THE ICEBERG

What is
the
problem?



Use the iceberg framework to discuss patterns and discover how different people see the same event. Ask the following questions in a group setting:

Events: What happened?

Patterns: What has been happening? What are the trends we have seen?

Structure: Why is this happening? What forces (including the underlying mental models) have created this behavior?

Goodman, M. (1997). Systems Thinking: What, Why, When, Where and how? *Systems Thinker*. Vol 8 No 2 p6-7 (provided on Moodle)

What you see determines what you do.

1. What you 'see' is shaped by your experience and the culture of your system. It shapes how you interpret situations and problems, and in turn this predicates how you choose to act. An example could be are communities that are not accessing healthcare 'hard to reach' or 'easy to ignore'. This interpretation shapes who needs to act and how.
2. What we 'see' can also be over reliant on tacit knowledge and experience, rather than data. This means we can be meeting an assumption about need rather than actual need. We found this when we explored the need for multidisciplinary teams. A national assumption about who needs MDTs was not borne out by the data.

Linear cause and effect models (the basis for most of our planning) assume that:

- The environment can be simplified enough to be modelled into a limited number of variables.
- The environment will stay constant such that the variables stay the same.
- The system will be predictable in how it reacts to these variables, no matter what the feedback loops are telling it, no matter what is going on internally.

Faucheux and Makaridakis (1979)

This leads too simple solutions that increase the problem e.g. the increasing number of people waiting in A&E

Current Solutions

- Increasing GP Appointments (assumption not enough PC appts to people go to A&E)

Which leads too

- Increased demand in PC



Rather than tackling the problems e.g.

Current Presenting Issues

- Increased complexity of need in A&E

Which leads too

- Putting senior clinicians on the front door
- Changing the skill mix
- Managing people upstream collaboratively

The evidence?

A&E breaches are related to

- Increasing acuity/ complexity
- Increased length of stay (workforce related)
- Staffing and facilities out of pace with the changes in need in A&E,
- Increase in case management within A&E

not as the dominant narrative suggests, as a result of increased numbers and poor primary care

[Wyatt, S. \(2019\) Waiting Times and Attendance Durations at English Accident and Emergency Departments. The Strategy Unit](#)



Theory U

1. Co-Initiating:

Uncover Common Intent
*Stop and Listen to Others and to
What Life Calls You to Do*

2. Co-Sensing:

Observe, Observe, Observe
*Connect with Diverse People and Places
to Sense the System from the Whole*

3. Presencing

Connect to the Source of Inspiration and Will
Go to the Place of Silence and Allow the Inner Knowing to Emerge

5. Co-Evolving:

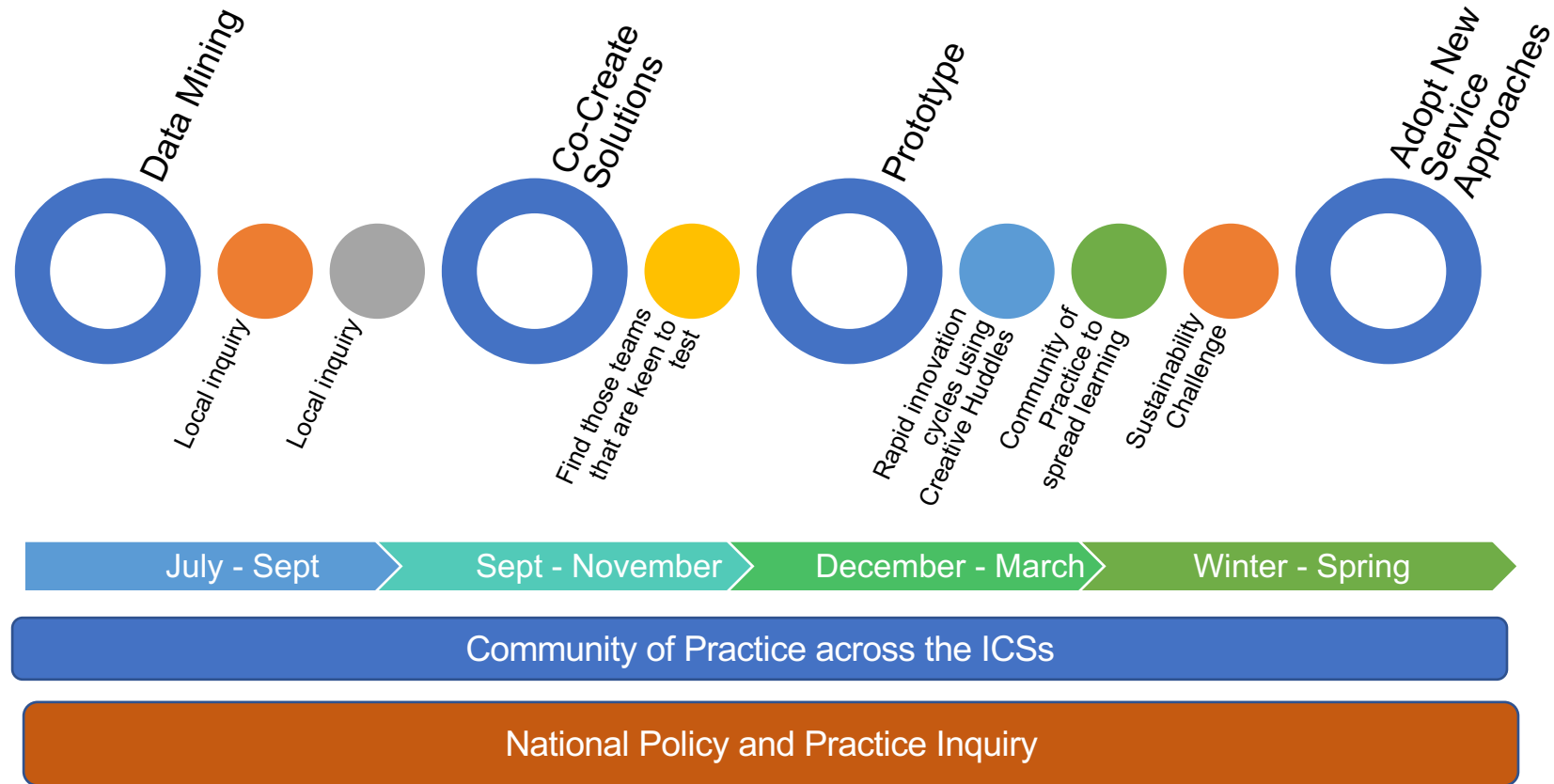
Institutionalize the New
*in Practices by Linking Micro,
Meso, Macro Change*

4. Co-Creating:

Prototype the New
*in Living Examples,
to Explore the Future by Doing*

The Practice

Universal Healthcare ICS Lab



West Yorkshire
Health and Care Partnership



Sussex
Health&Care

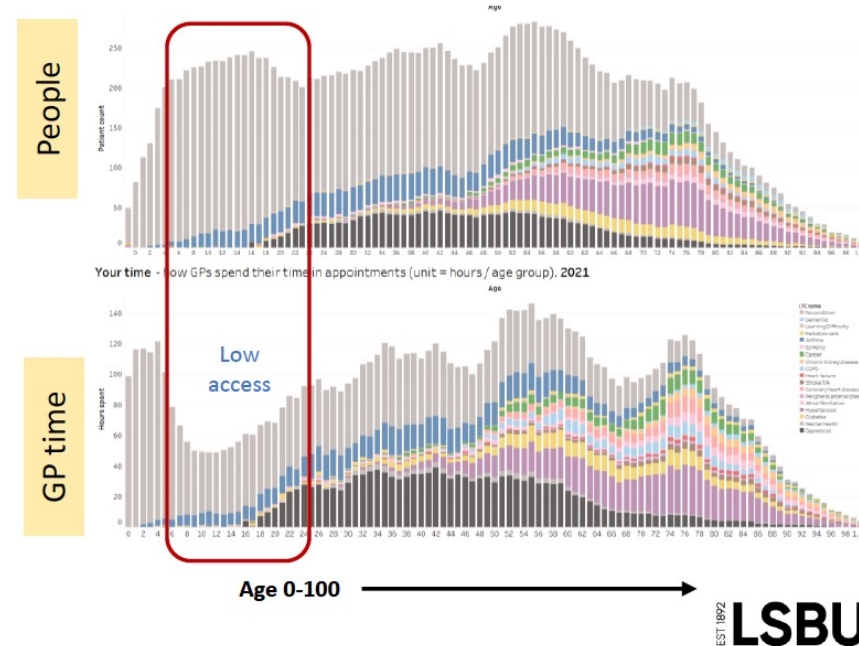
EST 1892
LSBU

Data Mining to check assumptions

C5

In the current system young people access Primary Care to a much lower degree.

Data example: young people access primary care much less



A1

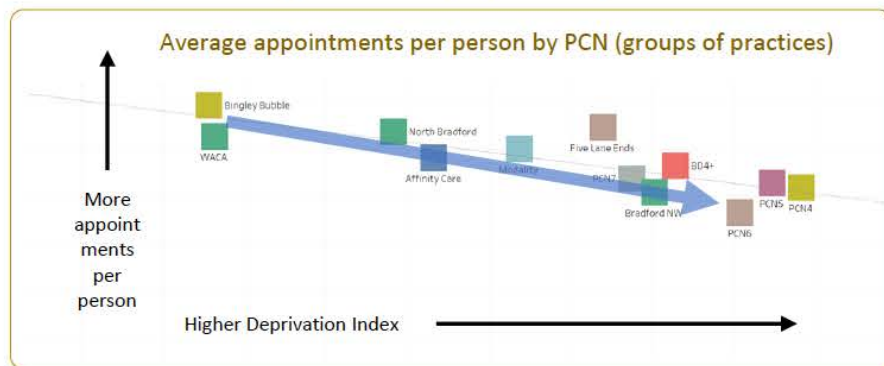
There is both unequal and different care for poorer people

The primary care we provide is fundamentally different in poorer areas.

For a poor population who may have huge challenges in their lives, primary care is:

- (a) harder to access (fewer appointments)
- (b) And less preventative (lower screening levels, less planned admissions).

Data example : fewer appts available per person in poorer areas



A2

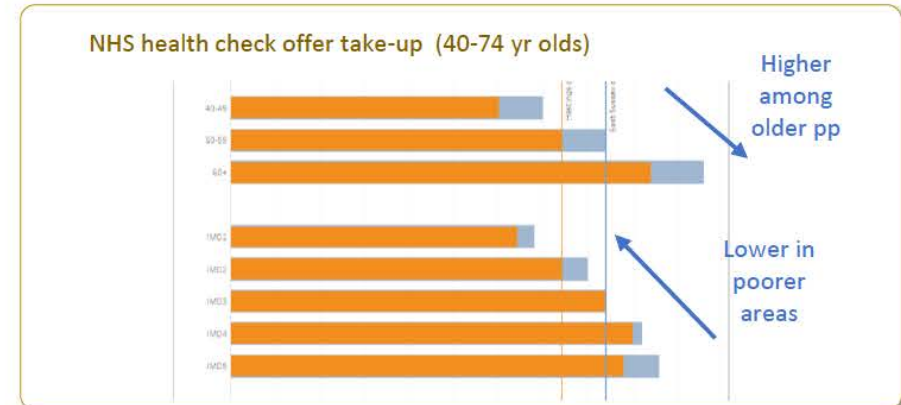
A flat offer is unequal

Equal inputs produce unequal outputs. Counterintuitively the same offer to everyone generates more inequality.

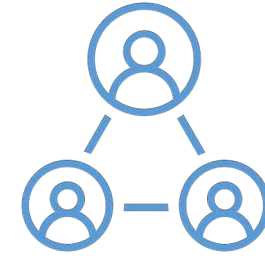
“Fair” is not fair

Data example: NHS health checks demonstrate this. A common offer made to all aged 40-74 shows produces markedly different take-up rates by age, gender, ethnicity and poverty/deprivation.

Data example : different take-up rates for a common offer



Getting the System in the Room – the Design Team



The Design Team needs to reflect the system we are working with, be passionate about the work, be well connected in the place, and have the power to invite people to the workshops. Being interested in the work is not enough, design team members need to be committed to the work of universal healthcare.

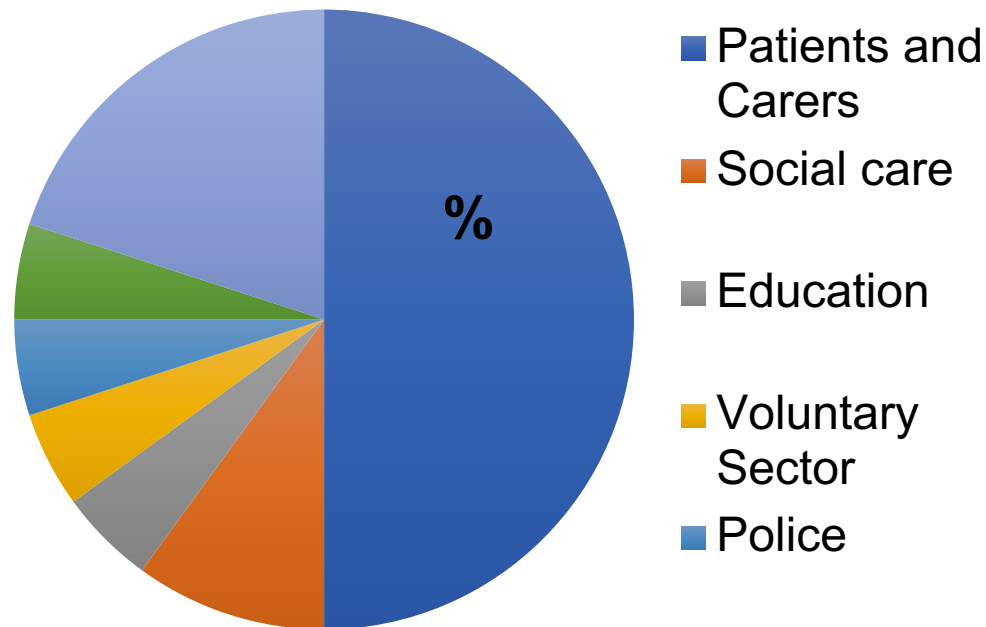
The Design Team is a small group of 6-8 people from each ICS place who

- (a) are committed to the concept of Universal Healthcare
- (b) come from diverse experiences and are therefore, as a whole group, well connected across the place (the local system Lab)
- (c) are curious about how to design systems change, and are willing to learn and facilitate new approaches
- (d) are dedicated to developing the relationships necessary to support this work

With thanks to our Design Teams who committed time to build relationships to invite people to the work, and who contributed throughout

What is the System for that Question?

Who 'takes part' in the system? Who has a say in what happens?
What is the % of their participation in this system?
It could look like this:





Workshop Design



Incubation & Construction Workshops – the groundwork for effective prototypes



Workshop 1: Observe

Myron's Maxims

- People own what they help create ¹
At the heart of co-creation. You can never direct, only disturb.
- Real change happens in real work.
Change is embodied in what we do and how we do it
- The people who do the work do the change.
Those who do – know how to do.
- Connect the system to more of itself
Release the intelligence of the group. Connections create healthier systems.
- Start anywhere, follow it everywhere
Begin with what matters and engage with what shows up.
- The process we use to get to the future is the future we get
The way we work together today creates the way we'll work together tomorrow.

© Myron Rogers. Criteria for Systemic Design and Radical Co-Creation

EST 1892
LSBU

¹Attributed to Kurt Lewin and Margaret Mead, et al



WHAT WE HOPE FOR...

RATIONING-CYP...



MEDICALISING POVERTY



The conditions where people can have a good life



"Put money where it's most needed" "Put G.P.s in areas of most need"



RATIONING-CYP



MEDICALISING POVERTY



PRIMARY CARE





Only then can I really be heard.

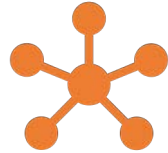


Prototyping



Initiative Teams Prototype

Weekly cycles of testing and review
Monthly Peer review of developments
Evaluation of impact



Build Network

Connect the initiative prototypes to learn together



Check and Challenge

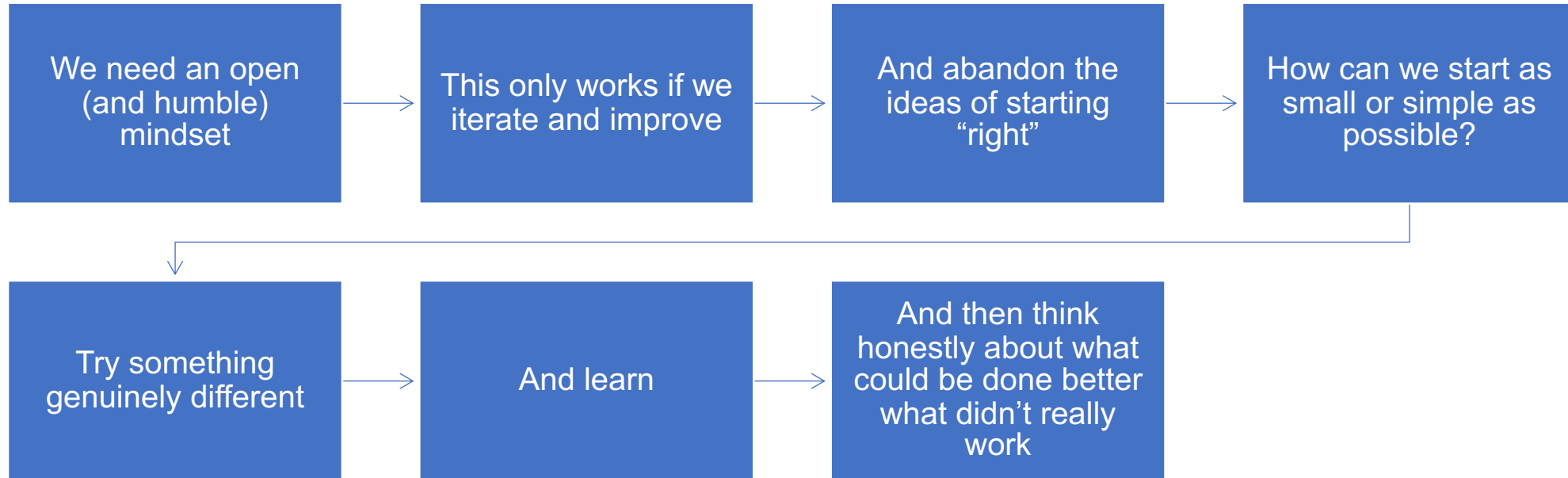
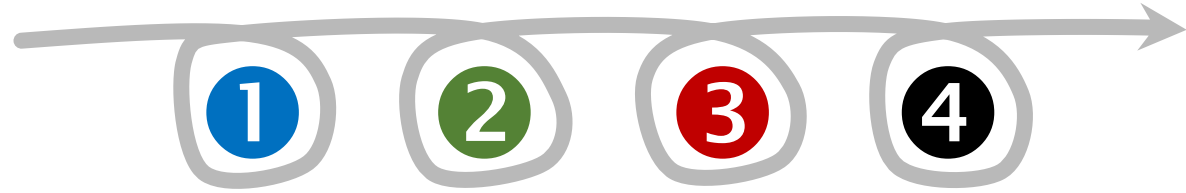
Build the Business Case
ICS scrutiny against Lab objectives,
ICS strategy and Prototype sustainability

Prototyping is:

- Trying it out before you adopt
- Rehearsing for the Future
- De-risking your idea
- Its an experiment to see if your ideas actually work in practice
- Failing fast, failing forward; a stepping stone to success.



A learning prototype

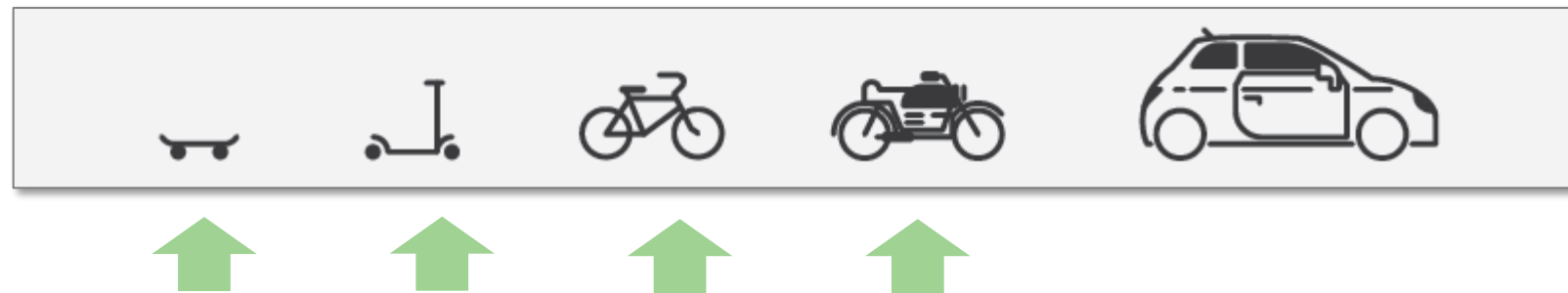


Prototyping is practical

Rather than try to build the ultimate solution ...



... we create and learn from practical solutions first



Prototype Sponsors/ Mentors



Our Prototype

THE INTENTION:

One sentence with no long words

THE CAUSE

What's the problem we are trying to solve?

ASSUMPTIONS

What's assumptions are we making?

PATIENT VIEWPOINT

What's this perspective from the view of the public?
Do you need to get more input?

DATA

What do you know? What have you got? What do we need? How will we know that it's working?

ELSEWHERE

Can we look elsewhere / Anything similar? Where can we learn from?

WHO ELSE?

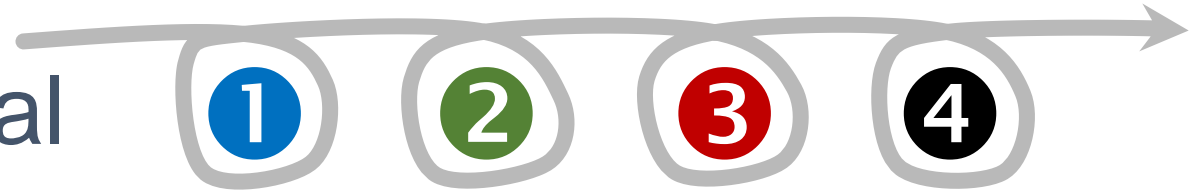
Who do we need to bring in to help? What other voices do we need to hear?



VERSION 1.0?

Our small experiment. What's the smallest first iteration of this?
How will we iterate and learn, and improve and repeat? What will we change?
How will we know if it's a success?

What to expect from the initial test cycles 1/5:



- Testing suggests a learning cycle.
- The testing is not to prove a finished model. It is to develop the new model.
- Due to the complexity and ambition of these changes (these are what are called ‘Wicked’ problems) it is impossible to get the new models ‘right’ before they are tested.
- The test cycles are where the models are truly developed and refined. Essentially learning by doing – otherwise everything is based on assumption and limited by the vey system conditions we are trying to avoid.
- The test cycle is based on creating a ‘double loop’ learning cycle. Where there is a feedback loop back into the frontline team AND also into the system to remove system blockages.
- This is different to the usual ‘single loop’ cycle where a model is worked up before test, and the test is about judging if the new model works, usually through some form of evaluation or outcome measurement.
- For this to work, the testing needs to be modest in terms of demand / case load. The intention is to generate learning and make design changes to the model, rather than shift demand from existing services.

Medicalising poverty	Access	Rationing
Designing a pro-active appointment system for high intensity users	Providing general practice in the voluntary sector to meet the health needs of people with drug and alcohol dependency who are not accessing services, and helping them transition into mainstream NHS.	Designing Children and Young People Friendly Practices
Finding ways to inform the community of what's available in the voluntary sector (Health fair)	Provide 'no wrong door' access to service users	Teaching English to support health to non-English speakers
Securing referrals from primary care to Fuel Poverty service	Accessing translation services and prescription services	
Providing activities that keep people healthy (Active)		

'Growing our own NHS professional staff locally'. Creating a path into healthcare for local people.

NHS to support Voluntary Sector to be a partner – funding and coordination

Fair Funding for Primary Care

Sustainability Check & Challenge

This next stage is to 'check and challenge' the proposals as they are developing in terms of their potential to be adopted, and to spread. Each group working on a solution has the opportunity to pitch their idea and solutions to leaders in the health system, for advice, support and adoption.

Check and Challenge Panel Questions

Use the Lennox Sustainability Questions (Lennox et al 2017) to review the proposal.

Lennox, L., Doyle, C., Reed, J.E. and Bell, D., (2017). What makes a sustainability tool valuable, practical and useful in real-world healthcare practice? A mixed-methods study on the development of the Long Term Success Tool in Northwest London. *BMJ open*, 7(9), p.e014417.

Criteria	Explanation	Is this criteria met?
1. Commitment to the improvement	To reflect on both own personal commitment to the initiative and impression	
2. Involvement	Reflect on who has been involved and who may need to be engaged further for the initiative to achieve long-term success. Asks about personal involvement and contribution and explores the involvement of patients, carers and members of the public who are impacted by the changes being made	
3. Skills and capabilities of those involved	Explores whether the staff and other people delivering the change have the skills to do so successfully and whether training of new members of the team has been planned for	
4. Leadership	Asks if there is strong leadership in place and if the leaders are approachable, available and able to garner support for the initiative	
5. Team functioning	Explores the accountability and responsibilities for the workload involved in the initiative and ask if the team is working well together	
6. Resources in place	Explores if the necessary resources such as staff time, equipment and facilities have been dedicated to the initiative	
7. Progress monitored for feedback and learning	Encourages teams to consider what systems are in place to monitor the initiative over time and how this information will be used to inform staff of further changes needed	
8. Evidence of benefits	Asks if and how the benefits of the initiative are communicated to both staff and patients over time	

9. Robust and Adaptable Processes	Reflects on the need for initiatives to be adapted to local processes and emerging needs. It also asks about the process for recording successes and failures of changes made	
10. Alignment with Organisational Culture and Priorities	Encourages teams to consider the need to align improvement initiatives to organisational strategies to gain executive buy-in and support as well as have the initiative become part of organisational policies and procedures	
11. Support for Improvement	Explores the values and beliefs held within organisations related to continuous improvement and looks at the support given to staff and patients to be involved	
12. Alignment with External Political and Financial Environment	Looks at the need for teams to be aware of the potential political and financial changes that may impact the initiative	

Lennox Sustainability Questions

1



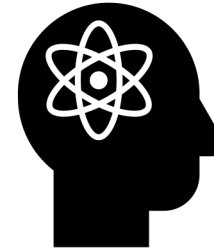
Check what is really going on with data (take an evidence-based approach to need)

2



Expand how you see the issues by diversifying who is involved in interpreting what is happening and why.

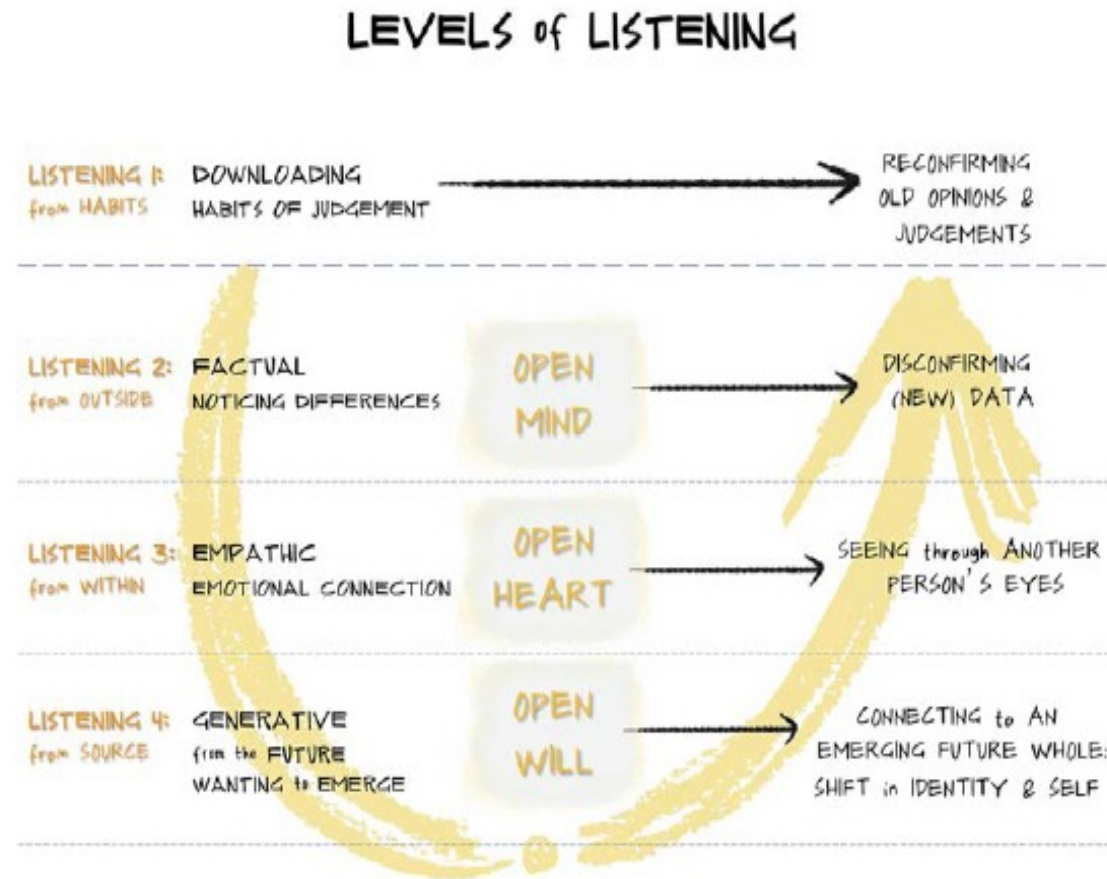
3



Changing your thinking (how you see the issue) will provide more options for what you can do together

LEVELS OF LISTENING

One of the core ideas of Theory U is that form follows attention or consciousness. We can change reality by changing the inner place from which we operate. The first step in understanding the impact of attention on reality is to look at our own individual practice of listening. The image below introduces four levels of listening, representing four distinct places from where our listening can originate.



A heads up on 'spread':

The spread of these new models is not simply to be an organic process. It is a set of very deliberate steps predominantly at system level.

Spread will also be reliant on the alignment and development of new payment (incentive), clinical and financial governance, referral and IT and structures.

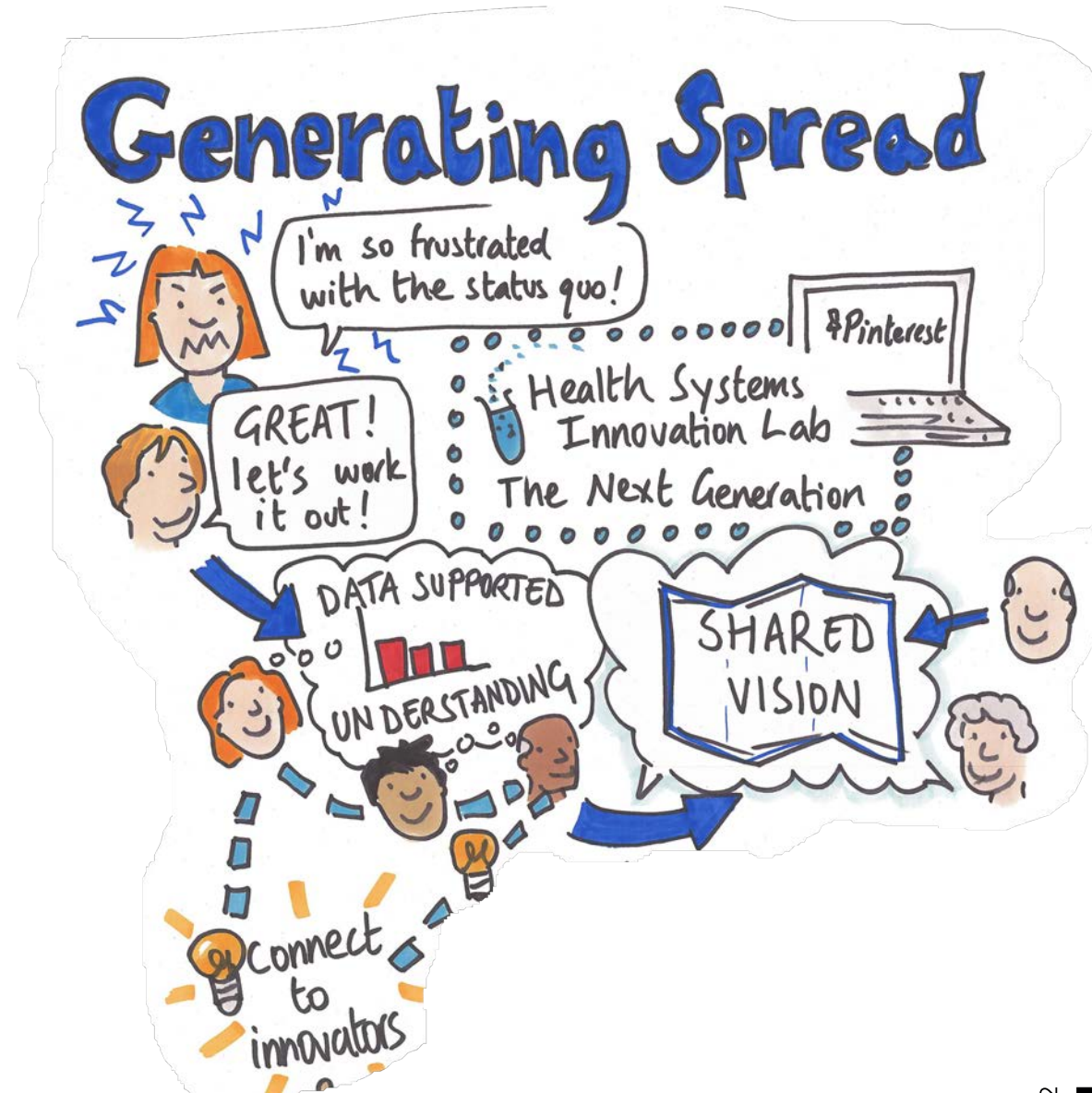
So spread will not be dependent on teams or individuals embracing a new model, but rather on the system's ability to move to a new model.

This is not simply a product of project management resource, or transformation governance, but it will be a product of how well parts of the system can share of risk, and can let go of traditional roles and power.

The true system leaders need to be actively involved in the learning from the new model, and the reasoning why the model is as it is.

It is essential that system leader engagement is present throughout.

- You need to be frustrated enough with the status quo
- You have to have the capacity to adapt
- You have to diversify who is involved
- You have to give up power at the top



Lessons Learnt on the Process



- The one thing that ‘holds’ the NHS in the mode to innovate/ address these issues is having the community as partners in the inquiry and solution finding. Starting matters – local people have to be involved from the outset.
- Systems leadership is key, paying attention to the emerging ideas and solutions, and supporting people testing these out. People in the ‘middle’ are not confident in leading change without this support.
- Be non-judgmental and honest about the relationships in our system and inquire together about how things are now. Check your assumptions are based on evidence. Welcome people into the work.

The Old World Bites Back.
What to watch out for.

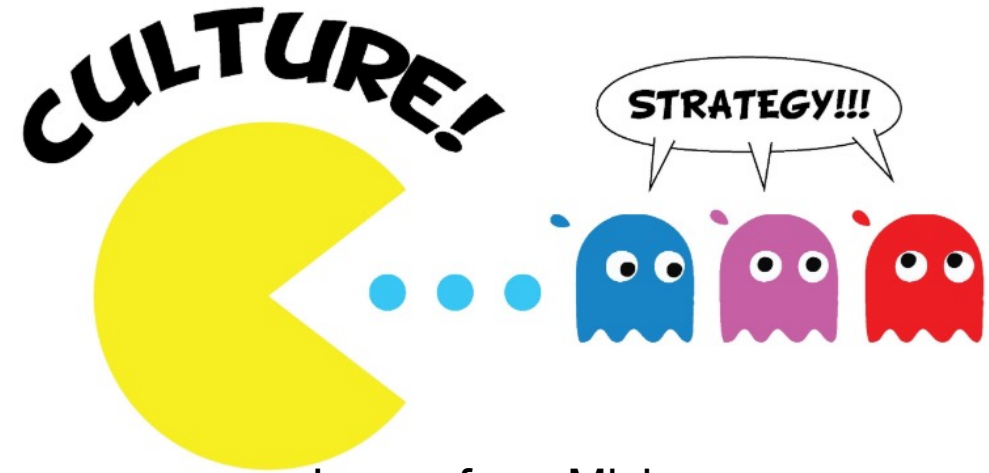


Image from Misbo.com



Resources

Easy Reads

Easy Read Books:

1. Scharmer, O. (2018). *The essentials of Theory U: Core principles and applications*. Berrett-Koehler Publishers
2. Malby R, Fischer , M (2006) *Tools for Change. An invitation to dance*. Kingsham Press
3. Wheatley, M., (2006). *Leadership and the new science: Discovering order in a chaotic world*. 3rd Ed. Berrett-Koehler Publishers

Easy Read Articles

Senge, P., Hamilton, H., Kania, J. (2015) The Dawn of Systems Leadership Stanford Social Innovation Review

https://ssir.org/articles/entry/the_dawn_of_system_leadership

Kim, D (1999) Introduction to Systems Thinking. Pegasus Communications Inc

<https://thesystemsthinker.com/introduction-to-systems-thinking/>

Grint, K., (2010). Wicked problems and clumsy solutions: the role of leadership. In *The new public leadership challenge* (pp. 169-186). Palgrave Macmillan, London.

<http://leadershipforchange.org.uk/wp-content/uploads/Keith-Grint-Wicked-Problems-handout.pdf>

References and Reading

<https://beckymalby.wordpress.com/2016/08/03/doing-systems-leadership/>

<https://beckymalby.wordpress.com/2019/04/24/leading-networks-top-tips/>

Abercrombie, R, Harries E, and Wharton, R (2015) *Systems Change. A guide to what it is and how to do it*. NPC

Drucker, P. (1977) *Management*, London: Pan

Ghate, D., Lewis, J. and Welbourn D. (2013). *Systems Leadership: Exceptional leadership for exceptional times*. Synthesis Paper. Virtual Staff College, Nottingham.

Goodman, M. (1997). Systems Thinking: What, Why, When, Where and how? *Systems Thinker*. Vol 8 No 2 p6-7

Hulke, S., Walsh, N., Powell, M., Ham, C., Alderwick, H. (2017) Leading across the health and care system. Lessons from experience. The Kings Fund

Randle A. (2016). *Systems Change in Public Services: A discussion paper*. Collaborate.

Malby B (2016) Doing Systems Leadership
<https://beckymalby.wordpress.com/2016/08/03/doing-systems-leadership/>

Malby B., and Fischer M. (2006) *Tools for Change, An invitation to dance*. Kingsham Press

Malby, R. and Anderson-Wallace, M., (2016). *Networks in Healthcare. Managing Complex Relationships*. Emerald

Senge, P., Kleiner, A., Roberts, C., Ross, R., Roth, G., Smith, B. and Guman, E.C., 1999. The dance of change: The challenges to sustaining momentum in learning organizations.