Caroline Corrigan, Director, HR/Development, the Modernisation Agency, National Health Service UK.

On paper, Rolls-Royce Marine and the National Health Service (NHS), look worlds apart, but during coffee I was writing down similarities and I hope to draw those out. It was because of a conversation that we got into the ICoSS project and what I got from the Rolls Royce presentation was the feeling that this was something that could contribute to the development of our organisation and could be given ownership within the organisation. It's very good value for money so that makes it easy to bring into the organisation.

I think we're very much at the point of standing back and asking, 'What do we want to do with this exercise next?' We've done some analysis, but there are a few things in our cosmos that have changed so it's been incredibly useful listening to the journey that Rolls-Royce have undertaken so far. Although we have had a shorter lifetime in this project the list of similarities is great.

I'll just cover who we are and why we joined the ICoSS (Integration of Complex Social Systems) project and how we saw it as the melding of that project with our organisation's development. I'll cover some of the methodology on what we have undertaken so far and what we've learnt by going through the tools and techniques. I'll also go through some of the interim findings and say what we think the analysis is telling us, and where that points us as far as understanding the dilemmas and assumptions involved. Some of the actions we have taken have either been in the interests of 'quick wins' or because we knew that we didn't need to wait, but I want to consider what we think we'll be doing next and importantly, what I and the organisation are learning at this stage of the journey. At the end of this presentation there will be opportunities for questions, reflections, challenges and hopefully with the help of my Rolls-Royce and LSE colleagues, answers.

First a bit about who we are. Very simply we're an organisation within the NHS that was established in April 2001. The thing that created us was the NHS plan. This was the first time ever that the NHS had a ten year strategic plan, instigated by Alan Milburn and consisting of a simple document describing the Government's vision for the NHS and the improvement that would be brought about. It's still a sort of cornerstone and people across the NHS reflect back on it because it was the first time we had anything that described some sort of journey rather than something which changed with every election.

The Modernisation Agency has about a full time equivalent of 750 people, though there are about 1000 people associated with the organisation and we have a budget of 230 million pounds aimed at improvement for the NHS. I'll just touch on the relationship between the NHS and the Department of Health to give you a sense of the context in which we're working and I'll talk about us as a system within a system. What is it that we actually do? Well we're concerned with modernisation and improvement and I'll come on to how we do that.

There are just over a million employees in the NHS and we constitute about 1000 of those. Our efforts before 2001 and now have always been dedicated to improving services for patients. About this time the Labour manifesto included the promise to improve services, recognise the lack of investment and demonstrate improvement. That was roughly the message and starting at the bottom there is the public who inject this money as taxpayers and who can access GP surgeries and local accident and emergency (A & E) services. These services are grouped together as a

strategic health authority (SHA) and since England is divided up into 28 areas, there are 28 SHAs. These are concerned with all primary and secondary care and support. A GP surgery can be single handed and a hospital can be 4 to 8 thousand employees, so the variety in the system is enormous.

My career in the NHS over about 12 years lead to the position of director of human resources (HR) at a hospital with a population of about 5000 employees. That organisation, as part of a system employing one million, gives you a sense of the scale. Above the 28 SHAs comes the Department of Health and a minister through whom the funding flows. Each of the hospitals and some primary care trusts have their own chief executives and so are employing bodies in their own right under a framework of NHS employment.

It's the Department of Health which funds us. The money comes from the Government (maybe 60 billion pounds) and the Department of Health funnels it through the SHAs. But also there are a number of ancillary organisations ('arms-length bodies') and we are one of those. We're not a direct care provider as are GPs, care trusts and hospitals, but we are set up nationally with the responsibility of improvement for patients. There are another 44 similar organisations concerned with things such as inspections, standards, quality and so on. Some of these things are grouped up nationally and some things locally.

I hope that now gives you an idea of who we are within the system. Our work focuses on re-designing processes and roles for employees of the NHS and more and more on how we can use the benefits of technology to improve services for patients. But whatever and however we do it, we need to demonstrate the improvement. I'll just give you some examples of our work and then focus on ICoSS.

Up to the present time we have had what are called 'star rating' systems, which are basically league tables which people use for rating their local hospital and these range from zero to three star. We are the people who go in and help an organisation when there is a need for improvement. For a hospital trust that has failed in some way to meet its performance targets across a range of criteria we have a professional team of 'turnaround experts'. One of the key Government targets for example is that patients will not wait longer than four hours when they go into an A&E department. If a hospital meets that criterion it's a demonstration to us, the British public, that things are improving. We also set up Emergency Services Collaboratives to improve performance again with criteria and the performance measure is standing at 94% nudging to I think 98% across all hospital trusts within England. One of these areas of work is the Cancer Services Collaborative, and I'm going to rope in Ann Driver to tell you something about that.

Ann Driver

The Cancer Services Collaborative started in 2001 when the Modernisation Agency started and it is one of the chapters in the ten year plan funded by the policy team. There's a layer below the SHAs called the Cancer Network. There are 34 separate networks which function according to patient flow. If you have got suspected or diagnosed cancer and it is not a speciality in your area you may now cross a boundary to another area or another hospital. That's another kind of structure that the Cancer Services Collaborative has to deal with. We started the project in much the same way as Rolls-Royce by mapping the current situation. We then looked at the evidence and asked the question: 'what are the things that we need to do for cancer patients?', 'Where are the gaps and why is this service ineffective?' We constructed a

vision which fitted in with the overall cancer plan and in phase one, we pilot-tested our changes before we put it out across the NHS. The people who tested it were the people who worked in hospitals; doctors, nurses, administration staff and porters. All we did was facilitate it and help with the methodology, process mapping, how to do the analysis, capacity and demand measurement and how to look at leadership. We needed to get ownership of these ideas right from the beginning and one of the important things was that the ideas came from the staff, not us. What we aim to do is to pull an innovation up and refine it so that it can be spread.

Phase two was to take all the ideas from within nine cancer networks so we focussed on five kinds of cancer tumours that are very common in the UK and said: 'These are the things that can really make a difference to these patients and we want them rolled out across all the hospitals'. This was very centrally driven and top down, but again we needed to get ownership by going through the methodology over and over again with different organisations. However even though the strategy was the same, each trust, each SHA, each cancer network was different. There were different professional boundaries, different champions, different leaders and different attitudes. Some were very traditional, some were very entrepreneurial. Some said 'Let's do it' and others said 'You need to write a business case first'. But at the end of the day the main drive was improvement for the patient. Nobody could argue with that and nobody could argue with the evidence-based practice.

So phase two consisted of spreading the process to all the cancer networks and we are now in phase three which started in 2003 and runs to the end of 2006. This takes the process down to all the trusts, primary care, palliative care and takes into account all the other tumours that we didn't look at in phase two. So we now have localised ownership and an established service improvement need in every cancer network. Since the networks themselves now have total control we function as consultants, trouble shooters, or kick starters for a new area. Networks do monthly reports so that we can monitor what impact they are having on 'access' targets and one of the Governments drives is to ensure that referred patients are seen within 62 days and that patients get into hospitals within two weeks. One of the biggest drivers is maintaining the quality of the 'patient's journey' through the system.

Caroline

Ann has given us an example of a program that changes practice to benefit the patient and this is another process under the umbrella of the Modernisation Agency which deliberately sets out to redesign the roles of employees within the NHS. The Cancer Services Collaborative is one activity area out of 156. It is a massive component, but it is only one of the 156.

So why ICoSS? The Modernisation Agency was created in April 2001, not from a blank piece of paper because improvement was already happening in the NHS. There were already a number of people saying, 'we want to make it better' or 'why don't we group together to do it like this or at least share learning'. What in effect we did by creating the Agency in 2001 was find a home for these people and give them an umbrella organisation so that the work could be continued, be made sustainable, and spread. We also needed to take an overall view of possibilities for the future. The Agency became a home for entrepreneurs and a home for improvement that was happening, but it was also a way of saying, 'bring it here, let's make it happen for everybody and let's see how it can evolve'.

Roughly seven teams came together and each had a leader, someone who was already running their own organisation and the leaders became part of a board representing the teams. The idea was that such a federation would be able to cross fertilise the learning. However it became clear in 2002/2003 that the organisation needed change and development even if it didn't need restructuring so in September 2003 a senior management team was established from the top seventy high-fliers who we felt wanted to come together. That was when I bumped into Eve and the talk that we had made me realise that the organisation was evolving and that the co-creation of that evolution was important.

The consequence of that conversation was that the LSE team came to work with us in reflecting on the development needs of the leadership group. That was how we focussed it originally, but then came the message that the Modernisation Agency would cease to exist as from April 2005 and that any remaining work in this direction would be localised. It was not a cost cutting exercise, but it came out of a desire to ring fence the money for improvement by localising it within trusts and local hospital associations. Now phase three of our plans was always going to be the localising of our work but the 156 activity areas are at different stages of development and it means that suddenly we all have to come up to a line and dissolve ourselves by next year. There will be some sort of successor organisation, but not a large national organisation as we are today. What we thought we'd be doing with the ICoSS project has suddenly shifted from evolving the organisation to the transition of our current work and design of the new organisation. The question we have to ask now is: 'How can the same methodologies, tools and techniques help us in that journey?'

The work we have carried out so far has consisted of one-to-one interviews with the seventy senior managers but we have also carried out team interviews. Kate Hopkinson helped us with 'Landscape of the Mind' (LoM) questionnaires and we've recently picked up the Netmap tools as well. One thing that was important and someone asked about it earlier, is the question of how you get people to 'buy into' something like ICoSS and one of the key factors for us in achieving this was the 'Landscape of the Mind' questionnaire. This was particularly revealing at the time when people were told the agency would cease to exist. Kate will later describe how this tool can be used to characterise the kinds of people that exist in an organisation. There are for example, people characterised as 'warm golds'. Warm golds are people who think the most important thing is establishing a relationship. They are the sort of people who will say, 'We've got the ideas, let's just get on and put them into action' and they'll go out there and get things done. We had a lot of senior people in the organisation that were like that. They enable change to take place because they strike up a relationship and get on and do things. But there were also a lot of people who said, 'Can we please stop and reflect?' or 'Can we stop and share the learning?' These are people who were characterised as 'cool greens' and they were getting very frustrated with the warm golds. So the LoM was very useful not just as a way of understanding who people were but also constituted a way of validating the interviews and the patterns of behaviour within the organisation.

Following the interviews of those seventy managers we held workshops which enabled us to ask what the interviews were telling us, what the main assumptions were that were held by people in the organisation and what dilemmas we faced. Yasir will tell us more about NetMap in a moment but what made the process very powerful was that the several tools enabled a 'triangulation' of the data in that each approach backed the characterisation of the organisation from a different direction. It enabled us to say, 'Here it is. This is what you're saying and we can now validate it through

the workshops'. A core group was set up after the workshop to take the process forward and we have quite a few people who are well versed in complexity theory and its methodology. It's one of the features of our organisation that we will argue the toss over what the data is saying and whose theory is right. It's important that in arguing over theory we don't miss validating what the data is saying.

When it was announced that we would cease to exist the work that we thought we would be doing with the ICoSS project shifted from evolving the organisation to dealing with a transition to localised project management and the possible design of a new kind of umbrella. The question we then had to ask was, 'How can the same methodologies, tools and techniques help us in this journey?' It became urgent not only to ask the question about what we were currently, but if we were going to make the transition effective and not lose the gain of all the hard work of the last few years then we needed to understand the behaviours and patterns that existed within the organisation so that we could effect an efficient transition to localised activity and the design of a new kind of overall management. So the LoM interviews have gained a new significance in that the question is not just what change means for the organisation, but 'What does that change mean for me as far as my job is concerned?' Some of the answers now reflect this kind of concern though since the majority of the study was undertaken prior to the announcement most are a view of where we were to what we are now. We knew we weren't good at demonstrating the impact and the value of our work because although we had these wonderful 'warm gold' people running around out there and making it happen we weren't necessarily able to turn round to different audiences, Ministers or other people in the NHS, and say, 'Here is the business case that demonstrates it, or here is the value'. We're now on the cusp of creating something that will do that more rigorously for our work. We admit we need better management systems and processes. The federation works effectively but we could be duplicating. We could do things better and we could be seen to do things better, but whilst some would say restructuring is the solution, our way of working is saying that we should recognise the patterns of behaviour, and think about the process in the context of those. We agree that there is a need for clarity, though we can never have ultimate clarity in terms of the role of the Department of Health versus the role of the NHS versus the role of the Modernisation agency. In terms of capturing the learning there is often a sense that we're reinventing wheels and that we do need better knowledge systems and processes. We need to know who we are and how we work, and we should listen to what people say about how they can be more effective.

We're struggling quite a lot at the moment with what it means to be an innovation organisation. What is innovation for improvement and what should we do next? We think we're going to use the findings to inform the design of a new organisation, but why we should restrict this activity. Surely we should step outside of it and ask: 'What is it that the system requires? What do these all these million people require in order to improve things for patients?' We're thinking about 750 people, but let's not get too bound up in the design space that we occupy at present and ask what the synergy might be in designing something for a million people.

We've only been working on the project for 6 to 8 months and we've been learning about the power of language. In every sensible and sensitive organisational development, we need to examine the language that we use and say: 'Stop, I mean this by this, what do you mean?' Take the word 'process'. People tend to think 'process' in terms of structure or in terms of pattern and you have to spend a lot of time asking the question: 'What is the territory we're talking about?' As I said earlier we're an organisation that's quite happy to argue the toss over which theoretical

framework is best but if you can't bring it down to a simple question that asks, 'Why are we doing this and what is it for?' then you've lost the game.

In thinking about the NHS as a business we need to understand the value of the work we are doing. What is the cost benefit of our work in terms of the opportunities for the whole system? We're focussing on our present organisation but we need to step back and ask what the opportunity is for understanding the whole. Recently we have been using the NetMap tool and Yasir is going to tells us a little about the use of that.

Yasir

Due to certain licence restrictions on the software I cannot show it to you directly but I will give you something of an artist's impression. The idea is that you monitor e-mail traffic within the organisation for set periods of time. In practical terms it's useful to take week slots with a couple of weeks in between which gives a base line.

What the software does is produce a visual display to show e-mail traffic between individuals or teams. This can be in terms of a specific program or project and a visual display is produced to show connections in a number of different ways, usually as lines between an array of blocks representing individuals or teams. Lines are thickened depending on how much traffic is going on between particular blocks. Because this can be carried out for traffic between teams or between individuals within teams you begin to see patterns emerging. Job titles or particular roles can be used instead of people's names to preserve anonymity.

What the method also does is map emergent groups so if some people suddenly begin to work together patterns emerge which are not part of the organisational structure per se. You can also identify are what I call 'kingpins' who are individuals (shown as nodes) that hold an emergent group together such that if you take the person out the group separates.

You can also see communication hubs within the organisation, either by team or individual and these are identified either by the number of connections they make i.e. the number of reciprocal e-mails that happen or by the number of teams they communicate with. From that, information conduits can also be distinguished. You might see for example that certain teams or individuals are the only channel of communication and that's important.

The way in which we conducted the analysis was that we took out all e-mails that were to more than ten people and we only mapped those e-mails that were reciprocal or two way traffic. That refined our results to communication rather than dissemination. Details of this tool which was developed in Australia can be obtained from the LSE complexity project team.

Caroline:

Thanks Yasir. I want just to say that the key thing about it is that it is another way of seeing the patterns in the organisation and for us that's a way of determining what we want to build upon and how we want to operate. It may be that we can design the new organisation based on that or the transition of our work. But it's one of a number of tools not the final piece of the jigsaw.

Terry: Was that done for the Modernisation agency or for the whole of the NHS?

Caroline: Just for the Modernisation Agency.

Yasir: But it's scaleable.

Eve: One thing I must emphasise is that we don't look at content or even the subject of the e-mail because there are a lot of ethical issues with that. We only register the fact that there has been an exchange.

Questioner 1: I think this is fascinating though of course some people use e-mail more than others. Some people will just walk over to a desk.

Yasir: Yes, but that also comes up if you know that there is a team who happen to share an office and suddenly you find a big hole in the flow. There are factors that you can add in. The other thing is that e-mail communication isn't necessarily a good thing. So this is just one tool and it can't be the sole or central focus of the analysis.

Les: And you triangulate it with the other tools. So you can sit down with a group of individuals and interview them and you can pick up the idea that they would rather pick up the phone or walk down the corridor and if you look at the NetMap you can see that they have few e-mail communications so one thing supports the other.

Questioner2: Isn't this just a scientific way of telling you that the 'old grape vine' is alive and kicking? You've got formal lines of communication.

Yasir: Yes but it's more powerful than that. When you're trying to provide arguments and build business cases and reach people who need the analysis from it you have some additional clout. Some people were saying earlier that there are people that are intuitive and those that need to actually visualise what is happening in the organisation. This does it smartly and gets the message across.

Questioner3: It seems very useful but how do you get over the 'Big Brother' aspect because in a real life situation people will worry about what you might really be looking at.

Caroline: I couldn't agree more and in our case where present organisation is going to cease and something new is to be created, some people would look at the NetMap tool and say: 'You're just deciding who's going to be in the new organisation. This is a new kind of selection process. You have to be this colour with this kind of communication skill'and so on. I think we have to keep reinforcing and demonstrating what we are using the data for and continue to show that we are not using it for any other purpose than what we set out to do.

Yasir: There are two ways of approaching this. One is where you get written consent from everyone involved before the exercise but because of time limitations we made it anonymous in the sense that you can't map any individual to a particular node. I gave the assurance to my IT team that it was an analysis tool that didn't identify individuals and was not part of any recruitment process that we would be going through.

Les: We went through a similar thing in industry with the unions and we have a policy within the company which says we monitor e-mail traffic, not for content but to know how big the network and the file server needs to be. On NetMap you can record telephone traffic as well as long as you put the telephone numbers but we didn't have any problems.

Eve: It is a matter of trust and we have to make the ethical aspect clear. We cannot do this kind of work if we do not.

Questioner3: And are people convinced? If I was going through reorganisation or I found out that the organisation was going to cease to exist next year it would be very destabilising. Even if I was asked to sign up to it, I might sign up because I daren't do otherwise, because I would then be labelled obstructive.

Caroline: I do think that the acceptance lies in convincing people what you are going to do with it and to demonstrate what you do with it.

Terry: Transparency.

Questioner 5: I've just read an article or newsletter where someone said sending an e-mail takes twice as long as just talking to people. I know there are some data produced by the LSE on the value of coffee bars and face-to-face contact. In this there is not only a simultaneous transmission of body language etc., but you put yourself in a loop where you're privileged with a certain level of trust. I think the stark contrast is that if you send someone spam e-mail, no one gives it any respect at all, whereas if you put yourself out for a face-to-face meeting, a different kind of transaction takes place. That seems to be a limitation and you seem to be in the position of someone who hasn't cracked the codes, but know there's radio traffic going on across the Atlantic. I can see there's some use, but it's not capturing any of the quality and I feel slightly troubled by it.

Yasir: As Caroline said, it must be seen within the context of the other tools.

Questioner 5: We were talking about working within the Rolls Royce matrix and going from it to a cube. You almost seem to be lost in phase space with the Modernisation Agency being atomised. If the queen bee has gone what is going to happen to the rest of the hive? What will be left and what will be lost in that process?

Caroline: Our intention is not to lose anything because it's not a cost cutting drive. We at the NHS will fail if as a result of localising our work in this way we do not continue to make improvement even better as a result of this phase. With that as our sole purpose and being clear about that as our journey we are in the middle of asking: 'What does our work look like?' Every single one of the activity areas including the Cancer Collaborative is a highly successful area so we have to ask: 'What does the work look like in transition?' 'How is it that we would recognise these people localised and their budget localised in the NHS?' Some of our work is already structured in this way and looks like that. You're merely shifting the name on the contract of employment. But there is the psychological contract which is broken and perhaps that's the territory that we're dealing with.

Questioner5: You've got a kind of centre of excellence at the moment. If you atomise that then what happens?

Caroline: We're asking what the pattern of the organisation is at the moment, but people come together whether the name 'Agency' is above them or not. They come together because the work pulls them as opposed to them being pushed. You don't need to be an employing agency to be an improver of the NHS system. So perhaps it's about taking the titles and the boundaries off and shifting things around in the system.

Yasir: What we're doing partly, is to capture all the legacy information that we've been accumulating for the last three years in order to live beyond whatever the reorganised structure may be. We've created a hub which is a portal of innovation and improvement knowledge where groups like the Cancer Services Collaborative and others can migrate into. It's an area which is not necessarily formally tied to the organisation. It's a platform from which there is access to people globally who have an interest in improvement and innovation in the Health Service. They can find each other and you don't have to be a member of any particular organisation to participate in that.

Just to touch on a couple of your earlier comments. I agree about the limitations of e-mail. Perhaps some 11% of our communication is verbal and with e-mail you lose the nuance of pitch and intonation. When you're on the phone you loose the nuance of body language, eye contact etc. There are limitations but in an organisation it does have its use and understanding where that fits in and how you want to use it is just as important.

Questioner 6: Have you looked at patterns of change?

Caroline: No, not yet. That is an opportunity.

Questioner7: Given that you're the NHS and your first point was power of language and your third point was business impact, how many people in the NHS see themselves as part of a business, say a Rolls Royce, or though maybe you could be compared to a retail organisation, and understand that kind of language?

Caroline: Ann could perhaps answer that.

Ann: They don't but we change the language to deal with the audience if we're trying to get a particular message across and that can vary from department to department. If people understand business cases and say: 'Why do you want these resources?' we need to put a paper together to demonstrate in those terms that this is what we need to achieve the benefits for the patient. It's knowing what the logic is in the complexity and then applying the language to that logic to communicate. Sometimes I can be talking about the same thing the whole day but giving a different message. You have to understand the context and the history of the organisation when dealing with people, and that takes time.