

CHAPTER 6

ACTIVE
Work Together

Let me tell you about Andy. A great nurse with a huge amount of experience in A/E, Andy has a passion for pain – or, rather, for managing it. I worked with Andy in a private hospital for women and children. Pain was particularly difficult to manage there, as the needs of women in childbirth and of children are, of course, completely different. Andy, though, had volunteered to take on the role of Pain Specialist Nurse. His job was to improve pain management in the hospital.

When I started working with him, Andy was struggling with his role. He knew that good pain management depended on a large number of factors: the anaesthetist, the ward staff, the pharmacists and the clinical leaders all needed to approach the problem together and to do so in a co-ordinated way. He had lots of support, but wasn't getting any results.

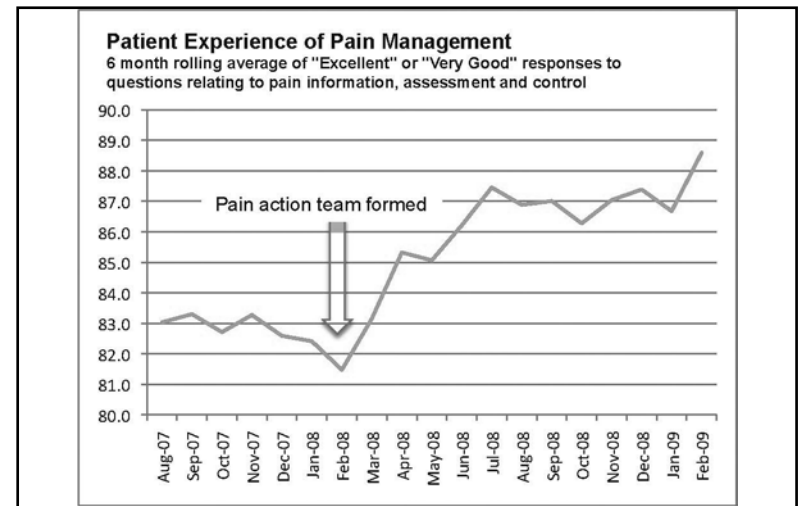
The solution was to create a pain management Action Team – a group of motivated staff from different departments and different levels of the organisation: a ward sister, a recovery nurse from theatre, an anaesthetist, an admitting clinician, even a member of the business office. The team met every week; its exact membership varied over the months, but that didn't matter. Andy was able to use the group to create the momentum that had initially been lacking.

First, the team reviewed and, where necessary, modified the procedures and protocols around pain management, which they then reviewed with the clinical management committee. They then set about changing how expectations were set with patients, how pain was assessed and how it was managed. They organised training for every patient-facing member of staff so that everyone knew how to assess and treat pain effectively.

The other crucial thing they did was to set themselves targets for improvement. I continually stress how numbers provide an opportunity for people to learn and a yardstick by which they can measure their progress. It won't come as a surprise to realise that this is a necessary part of running a successful Action Team. Discussing a problem without measuring progress lacks bite,

and people soon drift away. It is important that everyone involved knows that progress will be measured - and how that will be done.

In Andy's case, the hospital used existing feedback on patients' subjective memory of pain as the yardstick – although they put in place proper pain scores for each patient as well. As you can see from the graph, they made a huge impact.



What Andy had hit upon was that in order to tackle a particular problem, he needed three things: a very specific plan of action, collaboration across the organisation and a measurable result.

ACTION VS RESENTMENT

The 2009 swine flu epidemic provided me with an interesting comparison of the approaches made by two hospitals. Both hospitals experienced a doubling of attendances at A/E by worried and anxious patients and their families.

In Hospital B, not known for its collaborative approach, the flood of swine-flu victims was seen as a burden, purely as extra work. Senior staff used email

HOW ORGANISATIONS LEARN

One of the things that Andy learned is that the so-called 'cascade' system doesn't work. It relies on training the leaders, leaving them to train their deputies, who then train their teams and so on. Most organisations will rely on this – usually for reasons of cost, or a misplaced sense of increasing speed of delivery. But it rarely works. The chain of cascade breaks, thanks to holidays, lack of time or just a lack of motivation to train the next level properly. In Andy's case the lack of training of front-line staff meant that the necessary changes to pain management simply didn't happen.

The fact is – and this is very important in any attempt to change the culture of an organisation – that everyone needs to be dipped in the same stuff. Everyone needs to be trained the same way. This has implications for what we discuss in this chapter (how to hold effective meetings and the importance of team leadership) but it is also crucial to the discussion of leadership in Chapter 8, induction in Chapter 9 and process in Chapter 10.

to give instructions on when and how to judge the necessity for prescribing the anti-viral drugs. This, and other advice, was passed down the line, where staff quickly came to resent what they saw as unnecessary extra work undertaken with little support and even less forethought. Little, apart from the workload, actually changed.

In Hospital A, by contrast, the hospital set up a team to deal with the problem, which they called the Swine Flu Emergency Committee. (Personally I don't like the word committee, as it seems too inactive, but no matter.) The team consisted of representatives from all the areas affected, such as A&E, medical nursing, wards, pharmacy and security. The team met every day and tried to solve the problem creatively. They set up a separate swine flu reception, with a patient questionnaire. They changed the traffic flow through the hospital and created a new waiting area. They employed some GPs specifically to deal with the extra patients. After the main surge had passed, which took several days, an email was sent by the COO to every member of staff involved,

congratulating and thanking everyone for their contributions. Staff were, needless to say, encouraged.

Was this better leadership or just extra resources? Undoubtedly it was both – along with great management and confident decision-making. The point is that the team approach tackled the problem head on, spread the load and made decisions more consistent and more visible. This is a superb example of an active organisation.

WHAT IS AN ACTIVE ORGANISATION?

An **active organisation** uses, wherever possible, TEAMS rather than individuals to make decisions.

An **active organisation** is INNOVATIVE – thinking up new, often simple solutions to persistent problems as well as thinking up imaginative ways of tackling new issues.

An **active organisation** is COLLABORATIVE – it tends to use teams that draw their members from many parts of the organisation and from many levels ('cross-functional'), rather than 'functional' teams, the members of which all come from one area or one level.

An **active organisation** is INCLUSIVE – it encourages staff to come up with their own solutions rather than waiting for their boss or others to solve things for them.

An **active organisation** DELIVERS simple solutions to persistent problems.

WHAT'S THE BENEFIT OF ACTION?

Action Teams can solve problems that are not solvable using traditional line management structures. Think about the pain management problem. Everyone is involved in the solution (ward staff, pharmacists, doctors). They don't all report to the same person.

Teams not only outperform but also outlast individuals. When someone in a hierarchy goes on vacation or becomes ill or moves, then the initiatives that they are responsible for will wither or die completely. A team – if well formed and well led – will persist through a fair amount of change and potential

disruption.

Implementation is also much easier, because decisions have come from within the team rather than from on high. And more people know and ‘own’ the decisions – which makes it much easier to both disseminate and argue the case for any change: ‘My boss tells me that...’ is much less powerful an argument than ‘We all decided that...’

WHAT HAPPENS IF AN ORGANISATION IS NOT ACTIVE?

In an organisation that is not active, there is a reliance on ‘command and control’, where one person is at the head of all orders and actions. This approach is typical of many healthcare organisations, which traditionally have a hierarchical structure.

However, in most organisations, this structure tends to disenfranchise and disempower people. The result is a ‘them’ and ‘us’ attitude, with staff complaining about their superiors – ‘them’ – as if they weren’t all part of a team. Similarly, people will be quick to explain why ‘it’s not my fault’ and give reasons why things ‘will never change round here’ and that ‘it’s always been like that.’ They feel detached from the organisation and its problems, and feel that these problems can’t ever be solved, least of all by them.

Also, where an organisation lacks Action Teams, any problem is seen as a failure of the command and control system, rather than an opportunity for people to get together in a team and start problem-solving. So the first reaction to a problem in an ‘inactive’ organisation is to try to identify the person or department who ‘failed’. It can be very unhealthy.

WHY DON'T WE HAVE ACTION IN OUR HEALTHCARE ORGANISATIONS?

It doesn’t sound very difficult, does it? Use teams to implement stuff. People get together, choose a target and then change the way things happen... Well, anyone who has worked in any large organisation will understand that this

is the very definition of hard, as I discussed in Chapter 4.

There are a number of reasons why an organisation is not active:

1. HIERARCHY IS THE PRINCIPAL WAY OF MAKING DECISIONS

We tend to view organisations as organograms – with people ‘reporting’ to other people. This military-style system is useful in some areas, but for complex and wide-ranging changes that cross different departments, it’s not appropriate. A hierarchical system believes that ‘individuals get stuff done’ rather than ‘teams outperform individuals’. But we know this isn’t so.

2. NO VALUE IS PLACED ON NON-CLINICAL TIME

‘Improvement time’, i.e. time spent off the ward, working out how to improve the organisation, is not valued or even made possible. The pressures of operational targets override the need for thinking time. Time away from the ward or the clinic needs to be recognised and protected - which means that people need to be covered. Given the pressure on rotas, this is often difficult. But it’s a leadership issue. It is essential to have a ward leader who understands the importance of a junior member of staff being away from the ward at an Action Team meeting. Senior leaders need to understand this and promote Action Teams and ensure that time off the ward is protected.

3. JUNIOR STAFF ARE NOT PROPERLY INVOLVED

Action Teams work only if there is a cross-section of people available. Junior staff usually know most about how things actually happen on the ward and in the clinic and need to be able to share this knowledge. Improvement teams need to nurture and develop these people – they are an invaluable asset but often lack confidence.

4. LACK OF A MEASURABLE RESULT

Organisations fail to understand the importance of giving people a way of measuring their progress and therefore tasks are unclear and unfocused.

5. MEETING INCONTINENCE

Finally – and probably most importantly – the problem with Action Teams is often the meetings. I can't count the number of times I have heard even senior leaders say: 'Oh my God, not another meeting! Why can't we just do something instead of talking about it?' That prompts the question 'What's so wrong with your meetings?' and I always get the same response: 'We talk and talk and nothing happens. Meetings over-run. No one turns up, or it's cancelled. It's a nightmare!'

The problem is, this is often true. I call it Meeting Incontinence (which implies incompetence and something altogether more unpleasant). It's an inability to hold a meeting together. One of my managers in a consulting firm once said that as an implementation consultancy, we probably spent about 50% of our time teaching people how to have good meetings. It's a skill that is badly taught, and usually not taught at all and it's a real problem. If you're going down the Action Team route, then you need everyone in the team, not just the team leader, to understand how a team meeting should work.

HOW CAN WE CREATE ACTION IN OUR HEALTHCARE ORGANISATIONS?

If you do only one thing to make your organisation more active, teach your staff how to hold effective meetings.

If you ask almost anyone in business - in fact almost anyone at all - whether they enjoy meetings they will probably squirm. If you encourage them to hold more meetings, rather than fewer, you'll end up with substantial resistance. I know. I've tried it.

The reason that people hate meetings is that meetings tend to be incontinent - or perhaps more charitably 'ineffective'. Incontinent meetings run on for hours, people go off at tangents, dominate, pontificate, answer their mobile phones, arrive late, leave early... and then the whole thing just peters out.

But – most dishearteningly – people meet and talk without the benefit of numbers and without any targets. Some conversations may not benefit from such a numerical perspective: coaching and counselling, for instance. But

most business-related or clinically related conversations should be numbers-based.

When I refer a patient to an on-call physician, I will discuss the patient's history and symptoms, but what the other person needs to know most of all is the numbers: temperature, blood pressure, heart rate. Similarly, there is no point having a meeting about, for instance, patient satisfaction or waiting times, without having some statistics to hand.

So, in any organisation it is essential to teach people how to have effective meetings – and, preferably, more of them. It is essential also for team leaders to learn how to focus a meeting, so that something actually gets done. As suggested above, you'll find that this is always about studying the numbers, which gives the meeting direction and a sense of achievement. You should be asking, where are we numerically, and where do we want to get to?

You also need to teach people how to *attend* meetings – in other words, how to be a useful and effective attendee. Everyone is responsible for meeting continence – not just the team leader.

When I train healthcare teams – or any team, in fact - I encourage them to use meeting effectiveness checklists, which allow teams to assess the meeting according to their own criteria, such as whether the meeting started and ended on time and whether conversations kept to the point. I train people how to focus a meeting on the numbers and I insist that all meetings use action logs, which record people's verbal commitments and can be reviewed at the beginning of the next meeting. With such training and tools, meetings can become continent and from there they can become effective. They may even become popular.

SUPPORTING ACTION – OTHER THINGS THAT YOU WILL NEED TO DO

Organisations have to learn the difficult task of managing by using teams, rather than individuals. It may be difficult at first because there may be a preference for using the more traditional 'command and control' mechanism. Initially, using teams will be more inefficient. However, it's worth the effort.

As people become more confident and more competent at running meetings, ideas and projects persist for longer. As a senior leader, this is what you need to do:

1. Select a series of important topics that need cross-functional solutions.
2. Appoint for each topic an Action Team leader. Allow them to select a group of like-minded and enthusiastic people to help them.
3. Train all of them in Meeting Effectiveness.
4. Protect their time away from their day jobs.
5. Ensure that each team has one and ONLY one target to deliver, and make that target clear and measurable. Make sure they have a clear plan of how to deliver this target. This may mean that their plan involves putting measurement systems in place.
6. Ask the team to present their plan to the senior management team initially and then every three months to report on their progress.

It is hard to ignore the effect that a good Action Team can have, when you read the swine flu and pain management examples above. But this kind of collaborative behaviour and decisive action occur far too rarely. If you can make such action an integral part of your organisation, it will be a key part of your transformation.