

BEYOND REORGANISATION

The Practice and Reality of
Organisation Development
in the NHS

From Alder Hey to NHS England —
how shadows and learning
make or break change

MICHAEL WASH

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*The Practice and Reality of Organisation Development in
the NHS*

**From Alder Hey to NHS England — how shadows and learning make or
break change**

Culture changes when leaders change first.

*Through self-awareness, openness and trust, leaders create the conditions in
which others can speak, learn and lead.*

Beyond Reorganisation

The Practice and Reality of Organisation Development in the NHS

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This book is based in part on an earlier work on Organisation Development in the NHS first written in 2003 and has been substantially revised and updated for the contemporary NHS.

The experiences and examples in this book are used to illustrate Organisation Development principles. Where individuals or organisations are identifiable, material is based on the author's experience and/or publicly available information. Some examples have been anonymised.

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A Personal Note from the Author

I want to acknowledge and thank the many senior leaders, clinicians, managers and staff within the NHS with whom I have worked over the years. I have learned a great deal from them — from what worked, from what did not, from the pressures they faced and from the courage some showed in trying to make their organisations better.

Many of the insights in this book were shaped through those relationships and experiences. They were not developed from theory alone, but through working alongside people attempting to lead complex organisations in circumstances that were rarely straightforward.

Had the principles in this book been understood, taken seriously and acted upon by those in senior leadership positions, I believe some of the failures that later required major public inquiries might have been recognised and addressed much earlier.

The argument running through these pages is practical as well as philosophical. It is about the behaviours and disciplines that make organisations safer: listening when people raise concerns, remaining curious when something does not fit, understanding the effect of leadership behaviour, making the undiscussable discussable, involving patients and staff

in understanding problems, challenging assumptions, developing leadership at every level and creating a culture in which learning leads to action.

These are not abstract ideals. They are preventative skills.

My hope is that future NHS leaders will take them to heart and use them before warning signs become crises. If leaders learn how to create organisations in which people can speak openly, question safely, learn continuously and act on what they discover, then some of the circumstances that have led to inquiries such as Thirlwall may be recognised and corrected long before patients, families and staff suffer the consequences.

The greatest tribute to those harmed by past failures would be to develop a health service whose leaders possess the insight, courage and practical skills to prevent the same organisational failures from happening again.

That would be a worthwhile legacy for everything I have learned from the NHS over the past forty years.

Michael Wash

Some propositions within this book include

Culture changes when leaders change first.

A leader who cannot learn cannot lead a learning organisation.

Patient safety depends upon the NHS being able to listen — especially when it does not like what it hears.

What remains undiscussable cannot be improved.

The shadows in an organisation can do real harm when uncomfortable truths are left there.

Restructuring an organisation does not necessarily develop it.

You cannot impose ownership of change.

Culture change cannot be bought off the shelf.

The behaviour of leaders is a powerful communication system in an organisation.

You cannot develop an organisation without its leaders experiencing development in parallel.

From a Staff Perspective — August 2026, when asked how the NHS feels right now – here are some responses:

Repeated restructuring dismantles organisational knowledge faster than new structures can replace it.

Change without evidence, purpose and meaningful involvement risks creating disruption rather than improvement.

Patient experience should be treated as evidence, not simply as feedback collected after decisions have been made.

Before an organisation can discuss the undiscussable, it must first be willing to think the unthinkable.

An organisation that repeatedly changes without learning from previous change is unlikely to achieve lasting improvement.

Uncertainty damages trust when major change is not communicated openly, directly and compassionately.

Sustainable improvement depends upon senior leaders being genuinely invested in learning from patients and staff.

Synopsis

The Thirlwall Inquiry, published in September 2026, brings critical issues of Organisation Development into sharp focus. After examining culture across the NHS, Lady Justice Thirlwall concluded that simply describing the culture we want is not enough:

“It is behaviours that need to change.”

She also questioned why, after repeated calls for cultural improvement, so little appeared to change in practice.

That goes to the heart of this book.

Culture changes when leaders change first.

My proposition is that sustainable culture change begins with leaders who are prepared to examine themselves: how they behave, how they exercise power, how they respond to challenge and what impact they have on the people around them. Leaders need to be open to learning themselves before they can credibly ask others to learn and change.

Through self-awareness, openness and developing a trust environment, they can create the conditions in which other people are able to speak honestly, challenge assumptions, learn from mistakes and exercise leadership themselves. Leadership can then begin to develop at every level rather than remaining something associated only with position or hierarchy.

This is also where the hidden life of the organisation matters. Every organisation has a Shadow Side: conversations that take place outside the meeting, uncomfortable truths that are avoided, informal power, defensive routines and matters that people know about but struggle to discuss. Healthy organisations do not eliminate these shadows. They lighten them. They create sufficient trust and courage for the undiscussable to become discussable and, importantly, for something useful to happen as a result.

Thirlwall reinforces why this matters. 'Speaking up mechanisms' alone are insufficient if the surrounding leadership and culture do not enable concerns to be heard and acted upon. The Inquiry heard evidence that in organisations without the right senior culture, formal speaking-up arrangements can become little more than a box-ticking exercise.

Beyond Reorganisation therefore argues that genuine Organisation Development cannot be delivered through another standard change programme. Every organisation has its own history, relationships, pressures, strengths and shadows. Change has to be diagnostically informed and designed around that particular organisation.

It must, however, be visibly led from the top.

Senior leaders have disproportionate influence over culture because people watch what they do far more closely than what they say. If leaders ask for openness but become defensive when challenged, staff notice. If they promote learning but cannot acknowledge their own mistakes, staff notice that too. If they expect others to change while regarding themselves as outside the change process, the programme has already contradicted its own message.

The task of leadership is therefore not to impose a new culture upon an organisation. It is to model and facilitate the conditions in which a different culture can develop.

That means becoming more self-aware, remaining curious, inviting feedback, listening to patients and staff, making difficult conversations possible, developing leadership throughout the organisation and continually asking whether what we are doing is genuinely making care safer and better.

The NHS does not need another reorganisation to teach it how to reorganise.

It needs leaders capable of learning how to change themselves. This process and how it encourages openness throughout the organisation is the manner of development explained in this book.

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1. Why I Have Returned to This Book

When I first wrote about Organisation Development in the NHS in 2003, the service was already in the middle of another substantial period of structural and managerial change. Primary Care Trusts were taking on new responsibilities, Strategic Health Authorities had replaced the previous Health Authorities, new arrangements for involving patients and the public were being established, Foundation Trusts were emerging and Payment by Results was beginning to alter the way money moved through the system. Alongside all of this came an increasingly strong emphasis on targets, performance and accountability.

I was not watching these developments from a distance. I was working among them.

By then I had worked with a number of major NHS organisations on change and development, including five large hospitals, and was designing and facilitating a series of conferences bringing together senior people from specialist children's hospitals across the UK. We called this a confederation, although it was never intended to become another organisation. Its purpose was much simpler: to give people space to make sense of what was happening around them, to learn from one another, to understand emerging performance and payment systems and, importantly, to think about Organisation Development rather than simply respond to the latest organisational change.

At around the same time I was Chair of the York and Selby Patient and Public Involvement Forum. This gave me a rather different view of the NHS. I could see organisational change through the eyes of managers trying to implement it, but also through the experience of patients and members of the public trying to understand what those changes actually meant for their care.

What interested me then was not primarily the creation of new organisations, reporting lines or management arrangements. It was what happened underneath them. If the structure changed, did relationships change with it? Did communication improve? Did people understand their responsibilities more clearly? Did professional boundaries become easier to cross? Did patients experience better coordination? Did leaders become better at listening and learning? Most importantly, were NHS organisations becoming more capable of improving themselves, or simply more experienced at reorganising themselves?

Those questions became the basis of the original book.

More than twenty years later, I have found myself returning to them because they seem as relevant today as they did then. The names of organisations have changed repeatedly and the language of improvement has developed considerably, but many of the organisational difficulties are surprisingly recognisable. We still struggle with boundaries between services, with information not passed on or becoming distorted, with learning that remains trapped without sharing in parts of organisations and with the perennial question of how those leading large and complex systems can remain connected to the experience of patients and the staff providing their care.

The publication of the Thirlwall Inquiry report in September 2026 brought many of these questions into particularly sharp focus. The Inquiry was necessarily concerned with the events at the Countess of Chester Hospital and with understanding why babies were not protected when concerns were being raised. But its significance extends much further than one hospital. Its terms of reference deliberately examined culture, management, governance, the response to concerns, the effectiveness of NHS structures and whether lessons from previous inquiries had actually been absorbed into wider NHS practice.

There is something deeply uncomfortable in that last question. The NHS has investigated serious failures before. Recommendations have been made before. Policies, procedures and reporting systems have been changed before. Yet Thirlwall has once again required us to examine how an organisation responds when people raise concerns, how information travels, how professional and managerial authority interact and how those with responsibility recognise when something is seriously wrong.

The Government's immediate response was significant because it did not describe the answer simply in terms of another procedure. It described the issue as one of leadership and responsibility, stressing that safeguarding belongs to boards, managers, professionals and staff throughout the NHS, and that concerns have to be heard and acted upon.

That brings us very close to the central concern of Organisation Development.

The quality of an organisation cannot finally be secured through its structure alone. It depends upon what happens between people: whether they are curious, whether they listen, whether they question, whether difficult information can be interpreted objectively, whether authority can be challenged appropriately and whether learning changes what happens next.

2. Why This Book Now

I retired from large-scale consultancy in 2015, but I did not stop observing, using or experiencing the NHS. Since then my involvement has continued in different ways, through service governance, patient advocacy, mental-health improvement networks and, inevitably as one gets older, through increasing contact with health services personally and through the experiences of family and friends.

That has provided a rather different vantage point from the one I occupied when the original book was written.

When you are working as an OD consultant it is possible, despite your best intentions, to see the organisation through the problems you have been invited to help solve. When you encounter the same system as a patient or relative, things look different. The organisation chart disappears. What matters is whether the person in front of you knows what happened at the previous appointment, whether the hospital has communicated with the GP, whether medication information is correct, whether one specialist knows what another has recommended and whether anybody appears to understand the whole journey rather than their particular part of it.

Over recent years I have experienced, both directly and through people close to me, care moving across different parts of the NHS in ways that were sometimes impressive and compassionate but at other times fragmented, poorly coordinated and unnecessarily confusing. I have seen information fail to be updated or inaccessible, having to rely on the patient to keep relaying the same information many times, professionals working from different records, investigations repeated because results of prior tests not available, uncertainty over what medication the patient is on and occasions when failures of communication or coordination could potentially have caused harm.

None of this leads me to the conclusion that the NHS is failing everywhere or that those working within it do not care. My experience has usually been quite the opposite. I continue to encounter people working extraordinarily hard, often under considerable pressure, who want to provide good care and who are frequently frustrated by the systems within which they have to provide it. That distinction matters because many organisational problems are not caused by people who do not care; they occur when good people are required to work within systems that make good work unnecessarily difficult. This was one of the realisations that brought me back to Organisation Development.

I began asking myself whether the principles we were advocating more than twenty years ago had genuinely become embedded within the NHS. Had we become better at understanding the status and effectiveness of what we have before trying to change them? Had patient experience moved from consultation at the edge of decision-making to becoming part of the evidence upon which decisions are based? Had we become better at redesigning care around the journey of the patient rather than around organisational boundaries and convenience? Had our understanding of leadership moved sufficiently beyond position and hierarchy? Had we learned how to create cultures in which people can challenge what is happening without having to calculate the personal consequences first?

And perhaps the most difficult question of all, had the NHS become better at learning? To what extent was learning a core process of how everyone worked?

Thirlwall makes that question impossible to avoid. One of the issues explicitly considered by the Inquiry was whether recommendations arising from previous NHS inquiries had actually been implemented and, where they had, what effect they had produced. The Nursing and Midwifery Council's response to the Inquiry was revealing in this respect. In acknowledging its own failures, it said that it should have been more proactive, should have challenged the information it was receiving and should have shown greater professional curiosity.

I find the phrase professional curiosity particularly important because it applies far beyond professional regulation. Organisations need curiosity too: people prepared to ask why something does not quite make sense, whether an apparently isolated incident may be part of a pattern, why an accepted way of working persists and whether the explanation being offered really fits the evidence. Without that curiosity, organisations can become very efficient at explaining why things are as they are; Organisation Development should help them ask if that is right and fit for what's needed today?

This book is therefore not an attempt to reproduce an Organisation Development text from 2003, nor is it an argument that the NHS was somehow better twenty years ago. Much has changed for the better. Our understanding of patient safety, human factors, quality improvement,

psychological safety, systems thinking and the importance of patient involvement has developed substantially.

But new terminology does not necessarily mean that old organisational problems have disappeared.

My purpose has been to return to the principles that shaped my work, examine them against what we know today and ask what remains useful. Some ideas have needed substantial revision. Others have become, if anything, more relevant. Throughout the book I have tried to combine the experience of the past with contemporary evidence and with the lessons being offered, sometimes painfully, by the NHS of today.

I am not suggesting that Organisation Development contains some undiscovered answer to all of the problems facing the health service. It does not. The NHS is operating within severe financial, workforce, demographic and political pressures that no organisational technique can simply remove.

OD can remind us that structures and relationships are not the same thing; that culture cannot be reorganised by decree; that data and lived experience both matter; that authority and knowledge do not always sit in the same place; that improvement depends upon the people closest to the work being able to influence it; and that organisations learn only when experience results in something being done differently.

That is why the title **Beyond Reorganisation** feels even more appropriate now than it did when I began revisiting this work.

The NHS has never been short of reorganisation.

The more difficult task is developing organisations capable of learning from what happens to them and, through that learning, becoming better at what they are there to do.

3. Finding Your Way Through This Book

This book can be read from beginning to end, and there is a deliberate progression through it. We begin by considering what Organisation Development actually means, move through purpose and organisational diagnosis into patient pathways and structures, and then examine connectedness, organisational shadows, leadership, culture and learning.

But I am conscious that many people who may find the book useful will not have the luxury of reading it sequentially.

Managers rarely begin their working day thinking, *Today I need to understand Organisation Development.*

The questions below may help you find the part that is most immediately relevant.

Why have we reorganised again but the underlying problems are still here?

Chapter 1 – What is Organisation Development — and Why Does the NHS Still Need It? This establishes the distinction between changing structures and developing the organisation itself.

Everyone knows our values, so why doesn't the organisation always behave according to them?

Chapter 2 – Purpose, Vision, Mission and Values — Knowing What We Are Here For. This considers the gap between declared values and the choices people make when those values are tested.

Something isn't working, but are we sure we understand the real problem?

Chapter 3 – Understanding the Organisation and Its World — Diagnosis Before Action. Start here before commissioning another solution, restructuring a service or launching another improvement programme.

Why is the patient's journey so complicated when every individual service seems to be doing its job?

Chapter 4 – Following the Patient — Process Redesign and the Flow of Care. This looks beyond individual departments to what happens across the whole journey of care.

Should we restructure, merge, remove a management layer or change responsibilities?

Chapter 5 – Making Structures Work — Mergers, Boundaries, Hierarchy and Organisational Change. This asks whether structure is really the problem and what may be lost as well as gained when structures change.

Why do quality, workforce, finance, improvement and clinical governance seem to operate in separate worlds?

Chapter 6 – Connectedness — Bringing People, Performance and Quality Together. This explores how specialist expertise can remain specialist without allowing responsibility to become fragmented.

People seem to know something is wrong, so why isn't anybody talking about it?

Chapter 7 – Lightening the Shadows — Making the Undiscussable Discussable. This explores power, silence, psychological safety and the capacity first to see and think about uncomfortable possibilities before they can be discussed.

How do I lead improvement without making everybody dependent upon me?

Chapter 8 – Leading Continuous Improvement — The Facilitative Leader with Vision. This examines leadership as something exercised throughout an organisation rather than residing only in senior positions.

We have managed the change programme, but why hasn't the culture changed with it?

Chapter 9 – Beyond Change Management — Leading Culture Change. This considers why behavioural and cultural change takes longer than implementing a project plan or a new structure.

Why do we keep encountering problems that previous inquiries, reviews and improvement programmes were supposed to have solved?

Chapter 10 – The Learning Organisation. This brings the book together around perhaps its most important question: what enables experience, evidence, patient voice and failure genuinely to change what an organisation does?

These chapters are not separate techniques. They overlap and complexities of interaction require patience, listening and learning from each other.

A problem that first appears to be about structure may turn out to be about relationships. A performance problem may reveal a problem of purpose. A patient-safety concern may also expose hierarchy, communication, culture and the ability of people to speak openly. What appears to be resistance to change may tell us something about the way the change was conceived or led.

Thirlwall demonstrates this particularly starkly. It would be possible to look at the Inquiry separately through the lenses of patient safety, speaking up, governance, regulation, leadership or accountability. Yet the organisational lesson comes from seeing how these things interacted. Culture affected communication; hierarchy influenced whose concerns carried weight; governance affected what became visible; leadership influenced what happened when concerns were raised; and the wider system also had opportunities to question more deeply what it was being told.

When organisations get into difficulty, the temptation is to identify the defective component and repair it. Sometimes that is exactly what is required. But the more persistent problems usually ask something harder of us. How did it become defective in the first place and what has its impact been on the rest of the organisation?

You can therefore enter the book wherever your present question takes you.

About the Author

Michael Wash has spent more than three decades working with people and organisations facing change, with a professional background spanning nursing, psychology, counselling, teaching, leadership and Organisation Development. He has applied this experience across the health sector and many commercial, manufacturing and service sectors.

His NHS work has included senior Organisation Development and consultancy roles across major hospitals and health organisations, including Leeds Teaching Hospitals NHS Trust, Alder Hey Children's Hospital,

Aintree, the Royal Liverpool and Broadgreen University Hospitals, Huddersfield Hospital Trust, Renfrewshire and Inverclyde PCT and Caithness and Sutherland Scottish health service. He also worked with the Confederation of Specialist Children's Hospitals UK, helping organisations make sense of NHS reform, share good practice and develop approaches to improvement.

In the late 1990s, as Organisation Development Director in Leeds, he led *Achievement through Cooperation*, a major culture and organisational improvement programme during the period preceding the creation of Leeds Teaching Hospitals NHS Trust. At Alder Hey as an independent OD consultant he helped develop and implement *Excellence through Learning*, an organisation-wide programme which received national recognition in 2006, winning both the Organisational Learning category and the overall Excellence in Human Resource Management Award.

He has also served as a Non-Executive Director of Selby and York Primary Care Trust, Chair of the York and Selby Patient and Public Involvement Forum, and a Trustee Director of The Retreat Hospital in York with responsibility for clinical governance.

His qualifications include RMN, RGN, RCNT, RNT, Certificate of Education, a Postgraduate Diploma in Humanistic Psychology and a master's degree in business and economics from the University of Leeds.

What This Book Is — and Who It Is For

This is not an academic textbook, a history of NHS reform or another prescriptive methodology for managing change. It is a practitioner's book, drawing on experience, organisational stories, established thinking about Organisation Development and the realities facing the NHS today.

It is written for people trying to make organisations work better: Board members and senior leaders, Organisation Development and improvement practitioners, clinical leaders, managers, students, and those leading teams and services. You do not need to have Organisation Development in your job title to practise it.

Indeed, one of the arguments running through this book is that Organisation Development cannot be left to an OD department or a small group of senior managers or project leaders. Leadership and responsibility for improvement exist at every level. The following questions may be asked in a ward, a clinical team, a service, a whole Trust or around a Board table:

What is really happening here? What are we not discussing? What impact are we having on our patients? What are we learning? What could we do differently?

The book can be read from beginning to end, but individual chapters can equally be used to stimulate discussion within a team, leadership group or Board. The questions, exercises and practical tools are intended to help people stop, think and apply the ideas to their own circumstances. They are prompts for reflection and action, not another organisational checklist.

More than twenty years separate the first version of this book from this one. During that time NHS organisations have been created, merged, renamed, reorganised and abolished. New structures will undoubtedly follow.

The names on the organisation chart will continue to change.

The challenge of developing the organisation behind the chart remains.

What is Organisation Development — and is it fully understood throughout the NHS?

When I first wrote this guide in 2003, the NHS was a very different organisation from the one we know today. Many of the organisations I had worked with no longer exist under the same names. New structures have been created, others abolished, responsibilities transferred and boundaries redrawn. More than twenty years later, that process continues.

Yet when I returned to the ten Organisation Development challenges I identified in the original edition, I was struck not by how outdated they had become, but by how familiar many of them still sounded. I wrote then about the need to reduce bureaucracy and hierarchy, move decisions closer to patients, involve staff in shaping their working environment, create more seamless health and social care, develop open systems of accountability and learning, and build organisations capable of continuous improvement. We have made progress in many of these areas, but few could reasonably claim that we have solved them.

That raises an important question:

Why, after so much structural change, do so many of the underlying organisational challenges remain?

Part of the answer, I believe, lies in confusing **reorganisation with Organisation Development**.

Changing organisational boundaries, reporting arrangements, management structures or job titles can sometimes be necessary. But changing a structure does not necessarily change the relationships between people. It does not automatically create trust, improve communication, remove professional barriers, make people feel safe to speak up or ensure that everyone understands the purpose they are trying to achieve.

Organisation Development concerns itself with those things.

At its simplest, I still define OD much as I did in 2003:

Organisation Development is the process of bringing improvement activities together and aligning them with the purpose, priorities and desired future of an organisation.

It begins by understanding where we are now, being sufficiently clear about where we want to go, and then making thoughtful interventions that help people, systems and services move in that direction.

But I would add something today that I perhaps did not emphasise sufficiently then: **Organisation Development is ultimately about leadership – leadership at every level. Creating the environment where initiative taking at the service of improvement by anyone is recognised as part of the culture.**

That belief has run through much of my professional life. In *Psychiatric Nursing Skills — A Patient-Centred Approach*, written with Graham Dexter in the 1980s, we argued for moving away from a predominantly medical and task-oriented model towards one that paid much greater attention to the person, the relationship and the skills of those providing care. Many years later, in *54 Ways to Work With Change*, (MWA Publications 2026) my focus was on another aspect of the same human experience: why people resist change and how we might work with that resistance rather than simply push against it. Organisation Development brings these concerns together at organisational level. It asks how we create the conditions in which people can work with each other in a creative, learning and supportive capacity.

Structures, strategies, technology and money all matter, but none of them changes an organisation by itself. Change happens through the decisions people make, the conversations they have, the behaviours leaders model, the relationships between professions and organisations, and the degree to which people feel able to question, learn and improve.

In healthcare we continuously check and ask **does any of this ultimately make things better for the patient and the communities we serve?**

Diagnosis Before Intervention

One of the mistakes made in Organisation Development is to assume that the same intervention will work everywhere. It will not. An organisation facing severe financial pressure does not need the same immediate response as one recovering from a serious patient-safety failure, while a newly merged service faces different challenges from a mature organisation trying to improve an already good service.

The first task of OD is therefore **diagnosis**. We need to understand what is really happening, what is working and what is getting in the way. That means paying attention to what people are experiencing, what the data is telling us, what patients and communities are saying, and what may not yet be appearing in formal reports. All of this leads to an important diagnostic question: **what does this organisation need now?**

My experience of working with NHS organisations has repeatedly reinforced this. Sometimes the immediate need has been greater clarity of direction.

Sometimes it has been rebuilding trust. Sometimes it has been getting people from previously separate organisations to work together. At other times the problem has been much more basic: financial reality, poor communication, weak leadership or a culture in which difficult issues were simply not being discussed.

The following examples are therefore not prescriptions. They illustrate the relationship between **organisational condition and appropriate intervention**.

Possible Organisational States — and What OD Might Contribute

Possible organisational state	Possible OD response
A new organisation, service or partnership is being created	Clarify purpose, values and intended outcomes. Bring key partners together early. Establish how decisions will be made and how patients, staff and communities will influence development. Build relationships before structures become entrenched.
Services are being reorganised, consolidated or moved between organisations	Maintain clarity about why the change is being made and what improvement patients should experience. Communicate honestly, including where answers are not yet known. Identify critical skills and services that must not be lost during transition. Give people opportunities to shape the new arrangements rather than simply announcing them.
An organisation is under severe financial or productivity pressure	Establish a shared understanding of the reality rather than allowing finance to become somebody else's problem. Examine where resources genuinely add value and where duplication, delay or failure activity exists. Protect quality and patient safety while making difficult choices. Engage clinical and operational staff in redesign rather than imposing savings without understanding their consequences.
The organisation has experienced serious failure, regulatory intervention or loss of public confidence	Acknowledge what has happened openly. Listen to patients, families and staff. Avoid defending the organisation before understanding what went wrong. Create sufficient psychological safety for uncomfortable information to surface and ensure that learning results in changed behaviour and systems rather than another action plan that gradually disappears.
Two or more organisations or services are merging	Recognise that bringing structures together does not automatically bring people together. Understand the histories and strengths of each organisation. Surface differences in culture, professional identity and ways of working. Create a new shared purpose rather than expecting one organisation simply to absorb another.

Possible organisational state	Possible OD response
An integrated care partnership or system is struggling across organisational boundaries	Shift attention from individual organisational interests towards the needs of the population. Examine where incentives, accountability, professional boundaries and information systems encourage silo behaviour. Build relationships between leaders and frontline teams across health, social care, local government and the voluntary sector.
Staff morale is poor and recruitment or retention is becoming difficult	Listen before launching another wellbeing initiative. Explore workload, leadership behaviour, autonomy, recognition, fairness, psychological safety and people's ability to deliver the standard of care they believe patients deserve. Involve staff directly in redesigning their working environment.
The organisation is introducing major digital change or artificial intelligence	Begin with the service problem rather than the technology. Involve the people who will use the system and the patients affected by it. Examine consequences for roles, skills, accountability and relationships. Test whether the technology removes unnecessary work or simply automates an inefficient process.
Performance is reasonable but the organisation wants to become substantially better	Strengthen continuous improvement, reinforce the importance of ambition and guard against complacency. Develop leadership at every level, encourage experimentation and make learning visible. Benchmark intelligently, learn from patients and other organisations, and create mechanisms through which good ideas can spread.
The organisation repeatedly solves the same problems and makes the same mistakes.	Look beneath individual incidents. Examine assumptions, culture, incentives and organisational defensive routines. Move beyond correcting each occurrence towards understanding what it is about the way the organisation works that allows the problem to keep returning.

That final situation is particularly important. If the same waiting-list problem, staffing problem, communication failure or safety issue keeps returning despite repeated attempts to solve it, we may be treating symptoms rather than understanding what continues to create the problem. The distinction between correcting a problem and questioning the assumptions and systems producing it is something we will return to later when considering organisational learning.

Intervention is Not the Same as Organisation Development

It is tempting to call almost any improvement initiative, OD. A restructure, leadership programme, staff survey, digital implementation or even a culture-change programme may contribute to Organisation Development, but none is necessarily OD in itself.

They become part of Organisation Development when they are **diagnostically informed, connected to organisational purpose, aligned with other development activity and followed through to determine whether they have actually improved the organisation.**

Over the years I have been involved in organisational change in NHS organisations ranging from teaching hospitals and specialist children's services to primary care, regional organisations and mental health services. The circumstances were always different. What worked in one organisation could not simply be lifted and transplanted into another because the context, history, personalities, professional relationships and pressures were different.

Effective OD therefore requires **curiosity before certainty**. It requires sufficient confidence to bring experience and expertise to a problem, but sufficient humility to recognise that we do not yet fully understand it.

Leadership at Every Level

One of the principles I have held throughout my work in Organisation Development is that leadership should not be confined to people with management titles. Leadership can be exercised by anyone who notices something that could be improved and has the confidence, permission and support to do something about it.

The role of formal leaders is therefore not simply to make good decisions themselves. It is also to create an environment in which other people are encouraged to think, question, suggest and act. Some of the most useful improvements can begin with apparently insignificant observations made by people close to the work.

A group of domestic assistants working on a ward in a community psychiatric unit for older people once reviewed their work schedule with the help of a facilitator. One of their routines involved collecting the water jugs beside each patient's bed and replacing them with fresh water three times a day. They noticed that most of the jugs when collected were still almost full. Much of their time was therefore being spent pouring away water and replacing it with fresh water that patients were not drinking.

Someone asked whether this was really the best way of ensuring that patients had enough to drink.

When the issue was discussed with the nursing staff, the conversation changed. Instead of concentrating on whether the water had been replaced according to routine, people began asking whether the patients were actually drinking enough. The result was a change in the way patients were encouraged and supported to drink, while the domestic staff reduced unnecessary work and wasted less water.

There was nothing dramatic about the intervention, but it illustrates something fundamental about Organisation Development: **the people closest to the work often see things that senior managers cannot.**

The challenge is to create an organisation in which people can ask, *Why do we do it this way?* and expect the question to be taken seriously.

Imagine the cumulative effect if staff throughout an organisation routinely worked together to identify improvements in their own working environment and methods, using simple techniques such as observation, discussion, brainstorming and problem solving, with managers responding with interest rather than defensiveness. Some ideas would make only a small difference. Others might improve safety, save considerable time, reduce waste or transform a patient's experience. Taken together, those changes can become a culture of continuous improvement.

That is what I mean by **leadership at every level.**

Twelve Questions for Organisational Health

Organisation Development can quickly become complicated. Models, strategies, structures and improvement programmes all have their place, but sometimes a more useful starting point is to ask a small number of good questions.

In the first edition of this book I suggested ten questions that a Chief Executive should be able to answer. I still believe in that approach, although today I would direct the questions to all team leaders. They are offered here as prompts for honest discussion. They are simple and basic but sometimes useful to revisit and check to what extent is everyone working from a common base understanding.

1. Are we clear about why we exist and what we are trying to achieve?

People need to understand the purpose and direction of their organisation or service beyond targets and activity figures, and to see how their own work contributes to better care and better health. A strategy understood only by the Board is not an organisational strategy.

2. Are patients, families and communities genuinely influencing the way services are designed?

Patient focus should mean more than collecting satisfaction data. Their experience needs to be heard early enough to influence decisions, rather than being sought after most of the important decisions have already been made.

3. Do the people working here feel valued and able to contribute?

Staff need to understand the importance of their own contribution and see their knowledge and experience used when services are changed. An organisation cannot reasonably expect initiative and enthusiasm from people who believe their contribution is neither noticed nor valued.

4. Are we designing care around the needs of patients — or around the convenience of organisations?

Duplication, delay, repeated assessment, unnecessary investigations and conflicting information are often much more apparent when viewed across the whole patient journey. What appears efficient from within one department can look very different from the patient's perspective.

5. Do our structures help people do the right thing?

Organisation charts tell us who reports to whom. They tell us much less about how work actually gets done. Boundaries, hierarchies and professional territories should support rather than inhibit patient care, and people need to be able to work across them when the patient's needs require it.

6. Are we working as one system where patients need us to?

Healthcare increasingly depends upon relationships between hospitals, primary care, community services, social care, local authorities, voluntary organisations and many others. The important test is whether our behaviour supports partnership or whether organisational interests repeatedly pull us back into silos.

7. Is it safe to say that something is wrong?

Staff need to be able to challenge assumptions, question senior colleagues, report mistakes and raise uncomfortable information without fearing inappropriate personal consequences. Patients and families need that opportunity too. An organisation cannot learn unless it genuinely listens.

8. Are we creating the conditions in which people can do good work?

This goes well beyond wellbeing initiatives. Workload, resources, autonomy, leadership, opportunities to develop and people's ability to provide the quality of care they believe patients deserve all contribute to their experience of work. When morale is poor, we need to understand the working conditions producing it rather than simply trying to improve people's resilience. An employee assistance programme is no substitute for a supportive working environment.

9. Are we creating leadership at every level?

People throughout the organisation should be encouraged to use their initiative, question unnecessary routines and suggest improvements. That requires confidence and capability to improve services, make decisions, challenge appropriately and take responsibility. It also requires senior leaders to model the behaviours they ask of everyone else.

10. Are technology and data helping us provide better care?

Digital systems, automation and artificial intelligence create enormous opportunities, but technology should serve care rather than become an end in itself. The important considerations are whether it solves a real problem, makes work easier rather than digitising unnecessary bureaucracy, and gives the people using it a meaningful voice in its design and implementation.

11. Do we learn — particularly when things go wrong?

Correcting a problem is not necessarily the same as learning from it. When the same problem returns repeatedly, we need to be prepared to question the assumptions, systems and behaviours that continue to reproduce it. A learning organisation becomes better not simply at solving problems, but at understanding why particular problems keep being created.

12. Are all our improvement activities pulling in the same direction?

An NHS organisation may simultaneously have programmes concerned with workforce, finance, quality, digital transformation, patient safety, leadership, productivity, equality and service redesign. The question is whether they reinforce one another or whether we have created separate improvement industries, each with its own language, meetings, measures and priorities. One of the central purposes of Organisation Development is to make those connections visible and keep development aligned with organisational purpose.

A Continuing Process

Few organisations could answer all twelve questions positively all the time, nor should that be the objective. Organisational health is not a status that is finally achieved. Circumstances change, people change, communities change and new pressures emerge. Yesterday's successful solution can become tomorrow's obstacle.

The value of these questions lies in keeping an organisation curious about itself and noticing where a gap is developing between what it says it wants to be and what patients, staff and communities are actually experiencing.

I explore the concept of organisational health more fully in *The Healthy Organisation* (MWA Publications). Within the NHS it takes on particular

significance because organisational health is not simply associated with better organisational performance. Ultimately, it affects the experience, safety and quality of care received by patients.

The NHS will continue to change. Structures will come and go, technology will develop, financial and workforce pressures will alter, public expectations will evolve and new policies will replace old ones. We cannot know precisely what the NHS will look like twenty years from now any more than I could have predicted today's NHS when writing the original guide in 2003. (although the demographics, increasing costs, and the need for significant investment in social services were all seen as significant challenges then too)

What we can be much more certain about is the continuing need to create organisations in which people understand their purpose, work well together, feel able to contribute and learn, and continually find better ways of serving patients and communities. All achieved in the context of an ageing population, increased cost of provision and a continual cry for increasing investment.

That was the purpose of Organisation Development when I first wrote this guide in 2003.

It remains its purpose today.

Vision, Mission and Values — Knowing What We Are Here For and what we are trying to achieve.

The words *vision*, *mission*, and *values* have become so familiar in organisational life that we sometimes use them without stopping to consider what they mean. I have been involved in many discussions where considerable energy has gone into deciding whether a particular sentence should be called a vision or a mission. There is some value in clarity, but the label is not the important part. What matters is whether these things help people understand why the organisation exists, where it is going and what principles should guide the journey.

I find a simple distinction useful. **Mission** describes what we are here to do, for whom and to what standard. **Vision** provides a picture of what we are trying to become. **Values** express what we believe matters and how those beliefs should influence behaviour and decisions.

These ideas inevitably overlap, but they perform different functions. An organisation can have a worthy vision but little sense of moving in that direction. It can have a beautifully written mission that bears little relationship to the reality experienced by patients and staff. It can proclaim admirable values that disappear as soon as difficult choices have to be made.

For Organisation Development, therefore, the test is not primarily the quality of the words. It is whether those words influence organisational life.

Vision — Expressing a desired future.

In the original edition of this book, I described vision as an aspirational, and often inspirational, description of what an organisation will be like in the future, usually three to five years ahead. It may describe what will have been achieved, what the working environment will feel like, how patients, staff and other stakeholders will perceive the organisation and what reputation it hopes to have.

I still find that definition useful because the word *vision* contains its own clue. We should be able to **see something**.

At the time of writing, NHS England — the national body responsible for leading and overseeing the NHS in England — describes its vision as:

High quality healthcare for all.

It also sets out its own organisational mission in terms of driving safe and high-quality care, supporting NHS staff with the training, data and tools they need, and delivering value for taxpayers while supporting population health.

Against the definition above, however, I would question whether *High quality healthcare for all* is a vision. It tells us a great deal about the aspiration, but rather less about the future it intends to create. A vision should help us picture what patients might experience differently, how staff might be working differently and what we might see several years from now that we do not see today.

This is not a criticism of the aspiration. It simply illustrates how easily vision, purpose and mission become blurred.

The Government's current 10 Year Health Plan gives a much clearer picture of a desired future through three major shifts: **hospital to community, analogue to digital and sickness to prevention.**

Now we can begin to see something. We can imagine more care taking place close to people's homes rather than requiring a hospital visit. We can picture patients having greater control over appointments and information. We can imagine services intervening earlier rather than waiting until illness has progressed sufficiently to require treatment.

For those ambitions to be achieved, all aspects of OD will need to be coherent and linked so turning an attractive description of the future into the lived experience of patients and staff is precisely where Organisation Development enters the picture.

Designing “Visions” requires an element of prediction in the light of the forces of change.

Vision building cannot simply be an exercise in asking a group of people what sort of organisation they would like to work in. A credible vision has to be informed by what is happening around us.

Some of the forces acting upon the NHS can be anticipated with reasonable confidence. The population is ageing. Demand is changing. Health inequalities remain substantial. Workforce supply and expectations will alter. Scientific developments will continue. Digital systems, artificial intelligence and genomics will influence diagnosis, treatment and the organisation of work. Climate and environmental pressures will affect estates and services. Public expectations will evolve, while political decisions will continue to alter structures, priorities and accountability.

Other events will surprise us. Few organisational strategies written in 2019 anticipated what COVID-19 would demand of the NHS only months later.

Prediction does not therefore mean pretending that we can forecast the future accurately. It means developing what I have sometimes called organisational **antennae**: remaining sufficiently aware of the environment to notice what may affect us, challenge our assumptions and prepare intelligently.

The useful question is not whether we can predict the future. It is whether we are paying sufficient attention to what is changing around us that would be foolish to ignore.

An organisation that neglects those forces risks constructing a vision based on wishful thinking ignoring the realities of the forces of change that will mould services in the future. An organisation responding only to immediate pressures can spend its life reacting without ever deciding where it wants to go. Organisations can shape the future if they are well informed and prepared – they do not need to be reactive to predictable surprises if they can foresee the possibilities ahead.

Good strategy holds these two things together: **realism about the environment and imagination about the future.**

When I first wrote this guide, I drew substantially upon Professor Gerard Egan's work, particularly *Adding Value*, to frame a number of strategic questions. The language can be updated, but I continue to find the framework useful because it prevents vision from becoming an isolated exercise.

Vision is only one component of strategy. Leaders also need clarity about values and mission, the services they provide, what the organisation needs to be particularly good at, the environment in which it operates, the people and groups whose cooperation matters, and the resources upon which success depends.

In today's NHS I would express that framework like this:

Strategic area	The issue to understand
Values	The beliefs that should influence behaviour and decisions, particularly when choices are difficult.
Mission	What we do, for whom, across what scope and to what standard.
Services	Whether the services provided make sense together and deliver value from the patient's perspective.
Core capability	What we must be particularly good at if we are to fulfil our purpose and future ambitions.
Environment	The political, economic, social, technological, legal and environmental forces likely to affect us.

Strategic area	The issue to understand
Stakeholders	Whose knowledge, cooperation, experience or support is necessary for success.
Critical resources	The people, skills, finance, buildings, technology, information and partnerships needed now and in the future.
Outcomes	How we will know that health, quality, experience and the use of resources have genuinely improved.

The value of such a framework is not that every organisation should spend months producing perfect answers. Its value is that the questions offer connections and a shared meaning of what strategy is.

A vision of moving care into the community, for example, has consequences for buildings, staff, skills, information systems, partnerships, finance and professional roles. A commitment to prevention changes what success might mean and which organisations need to work together. A commitment to digital care raises questions about access, inclusion, professional practice, patient choice, trust and accountability.

The strategic task is to see these connections rather than allowing separate programmes to develop independently.

As I wrote in 2003:

Having strategy is one thing — getting it into the guts of the organisation is another!

I would still put it that way.

A strategy sitting on a Board portal is not yet an organisational strategy. It becomes real through decisions, priorities, conversations, resource allocation and thousands of behaviours throughout the organisation.

Consider the shift from hospital to community. At national level it is readily understandable. The 10-Year Health Plan envisages more integrated care being available within local communities, organised less around institutional boundaries and more around people's needs.

Now imagine what that means for an individual patient.

A service previously provided in hospital moves closer to home. Different professionals may become involved, information has to move with the patient, equipment may need to be available somewhere new, and staff may require different skills. Accountability can cross organisational boundaries,

finance may need to follow responsibility, and community facilities may find themselves undertaking work once concentrated within the hospital.

The patient should not need to understand all this machinery. They should simply have the information, guidance and support to navigate the changes and experience care that feels coherent.

This is where strategic ambition becomes Organisation Development.

The same principle applies to digital transformation. Installing technology can be relatively straightforward compared with redesigning the work impacted by it. A sophisticated new system that still requires a patient to repeat the same information to several professionals is not necessarily an improvement.

The measure should not simply be whether the system has been implemented. It should be whether care has become better.

This distinction is reflected in the Government's 2026 ten-year capital plan for health and social care, which explicitly describes digital capability as **“not an end in itself”** but an enabler of wider reform.

A vision does not become reality because senior leaders announce it. It becomes real when people throughout the organisation understand it, are excited by its ambition and want to be part of the future it describes.

There is no single correct process for vision building. I would, however, preserve one of the central principles from the original edition: involve people sufficiently that the vision becomes understood and owned rather than simply issued.

Today I would extend that involvement considerably beyond the management team. Frontline staff, patients, carers, communities and partner organisations may each see aspects of the service that senior leaders do not.

That does not mean several thousand people should collectively edit every sentence of a vision statement. Leadership still requires choices and direction. But there is a considerable difference between asking people to approve a future already designed for them and involving them in imagining what a better future could be.

A useful starting point is the present. Before imagining what, the organisation might become, understand what it is like now — not simply what its strategies, dashboards and reports say it is like.

Then move forward three years.

Imagine arriving at work and discovering that the organisation has been remarkably successful. Walk through it in your mind. Perhaps the building looks much the same; perhaps it does not. Listen to the conversations and watch what happens when a patient arrives. Observe how different professions speak to one another and how information moves. See what happens when somebody notices a problem and suggests an improvement.

Listen to what patients are saying about their experience and what staff are proud of. Notice what has become easier and what frustrating routines have disappeared. Above all, pay attention to **what it feels like to be there**.

This imaginative stage matters. In my experience, somebody will usually introduce reality rather quickly with, “*Yes, but...*” There is certainly a place for practicality, resources and constraints, but not too soon. People occasionally need permission to picture something better before explaining why it cannot happen.

Once that future becomes sufficiently visible, the conversation naturally moves towards strategy. Which parts of the picture matter most? What would have to change to make them possible? What must be protected because it already works well? What could we begin doing differently now?

Values — What Matters When Things Become Difficult?

As people describe the organisation they want to create, strongly held beliefs usually begin to emerge. These are values.

In the original text I described values as beliefs sufficiently important to influence attitude and behaviour. I also distinguished several ways in which values can operate within a vision. There were **principle objectives**, clarifying broad aims and the nature of the work; **social values**, concerned with the needs of the community served; a wider **value system**, consisting of the interconnected beliefs underpinning the organisation; and what I called the **ultimate value**, the fundamental belief sitting beneath everything else.

The terminology may sound a little different today, but I think the distinctions remain useful.

A health service organisation may have broad purpose values concerned with health and care. It will have social values around fairness, inclusion, access and obligations to its community. It will have behavioural values describing how people should treat patients and one another. Beneath all these may sit something more fundamental: a belief about the intrinsic worth of the person being cared for.

This is where values stop being an exercise in selecting attractive words.

In the original vision-building work I used three deceptively simple questions: *What do we believe in? What is really important to us? What will we not compromise?*

It is the last of these that often reveals the most. This uncompromising value can also be a helpful criterion when deciding a difficult decision or evaluating use of resources or direction.

Healthcare has no shortage of powerful words: *patient centred, compassionate, respectful, inclusive, open, collaborative*. They can sound impressive on a wall, but unless they can be translated into behaviour, they amount to little more than decoration.

A patient does not experience an organisation's values by reading them on its website. They experience them when somebody listens with empathy, when information is explained, when professionals communicate with each other, when concerns are taken seriously and when somebody accepts responsibility rather than sending the problem elsewhere.

For the organisation, a missing telephone call or delayed conversation may be one incident among thousands. For the person waiting for news about a diagnosis, frightened about what it might mean and uncertain about what happens next, the same failure may dominate their entire experience.

This creates an important distinction between **espoused values** and **experienced values**.

An organisation can say that it puts patients first while requiring patients repeatedly to chase information. It can say that it values compassion while organising work in ways that leave staff little opportunity to demonstrate it. It can talk about partnership while budgets or professional boundaries repeatedly draw people back into organisational silos.

When these discrepancies persist, patients and staff notice. Values can then become not a source of pride but a source of cynicism.

From an OD perspective, however, the gap between the stated value and the experienced value is not merely a discrepancy. **It is diagnostic information.**

Patient Centred

Patient-centred care has been a continuing theme throughout my professional life. Dr Graham Dexter and I placed it explicitly at the centre of *Psychiatric Nursing Skills — A Patient Centred Approach*, written at a time when much psychiatric nursing practice remained heavily influenced by medical and task-oriented models. For me, patient-centredness begins not

with an organisational process but with the quality of the encounter between people.

A short passage from *Quaker Faith & Practice* expresses something I have long believed:

“Careful listening is fundamental to helping each other.”

The passage goes on to make the point that listening does more than uncover somebody’s needs; it can itself become part of ‘meeting’ them.

That has direct relevance to healthcare.

Listening is not simply a technique for collecting information before the professional moves on to the apparently more important business of diagnosis or treatment. Being listened to — particularly when frightened, uncertain or vulnerable — can itself be fundamental to the caring process.

The same Quaker passage also expresses the value of plain speaking. Healthcare requires both careful listening and honest (plain) speaking in a language that can be understood. Patients and families need to feel able to express what worries them. Staff need to be able to say when something is wrong. Junior colleagues sometimes need to question those with greater authority. Leaders need to communicate difficult realities without hiding behind organisational language, while all of us need to be capable of hearing something uncomfortable without immediately becoming defensive.

Careful listening without honest speaking can leave important things unsaid. Plain speaking without careful listening can become insensitive or confrontational creating defensiveness and shadows. (see Chapter 7)

Values in Current NHS Practice

There are contemporary examples of organisations attempting to make the connection between values and observable behaviour explicit.

Leeds Teaching Hospitals refreshed its values in July 2026 after a Trust-wide conversation with staff. Its four values are now **Responsible, Open and Honest, One Team and Kind**. What interests me is not simply the choice of words but the attempt to explain their behavioural meaning. *Open and Honest*, for example, includes sharing information, listening to feedback and speaking up so that the organisation can learn and improve. *One Team* is described in terms of working across teams and putting patients at the heart of what people do.

That movement from **value to behaviour** is the important part.

A useful organisational exercise is therefore surprisingly simple. Take one publicly stated value and look at it in three places: what the managers say, what people actually do, and what patients or general staff experience. Where these align, the value has life. Where they do not, the discrepancy deserves attention.

Mission

Vision asks us to look forward. Mission brings us back to what we are here to do now.

My original definition was deliberately uncomplicated. A mission should indicate **what we do, who we do it for, the scope of our work and the standard to which we intend to do it.**

I included three examples in 2003. A Community Trust I was working with said:

“We work in partnership to deliver continuously improving primary and community health services for the people of Renfrewshire and Inverclyde.”

A children’s hospital described its mission as ‘providing comprehensive, high-quality child health services while integrating hospital and community care in a family-centred, friendly and safe environment’. A specialist neurosciences unit used a considerably longer statement about ‘providing the best available care, improving care over time and using specialist skills effectively.’ Its references to purchasing organisations and contract values clearly locate it in the NHS of its period.

Looking at these statements more than twenty years later is interesting because the organisational structures have changed while much of the language of aspiration has not. Partnership, continuous improvement, hospital and community integration, family-centred care, quality and safety remain familiar ambitions.

Alder Hey’s current Vision 2030, for example, looks towards **“a healthier, happier and fairer future”** in which every child and young person can achieve their full potential. It connects that future with patient and family experience, staff, innovation, collaboration and inequality. Leeds Teaching Hospitals describes its vision around high-quality specialist and integrated care.

Some organisations call these statements visions, others, purposes or aspirations. I would not become trapped in prolonged semantic debate. The more useful test is whether somebody working there understands **why we exist, what we are trying to achieve and how their own work contributes.**

That brings me to a story I have carried with me for many years.

Cutting Stone or Building a Cathedral?

Walking towards York Minster one day, I heard the unmistakable sound of chisels striking stone from a nearby stonemason's yard. The gates were open, so I wandered inside.

Two people were working on similar pieces of stone. I approached the first and asked what he was doing.

His reply was abrupt.

“What does it look like? I'm cutting this stone.”

I moved on and asked the second stonemason exactly the same question. He stopped working and looked towards the Minster. There was a smile and a sense of pride when he answered:

“I am helping to rebuild the most beautiful cathedral in the world.”

Both people were cutting stone. Only one described the work in terms of its larger purpose.

I have told that story all over the world and I know it is repeated by many (using their own ‘Cathedral’ to embellish familiarity) trying to make the same point as it says more about organisational purpose than many carefully drafted mission statements.

Imagine asking somebody cleaning a hospital ward what they are doing. *I'm cleaning this floor* is a perfectly accurate answer. But there is another way of understanding the same work: *I'm helping to protect these patients from infection.*

Someone working in appointments may quite reasonably say, *I'm booking people into clinics.* But they may also be helping someone who is frightened get to the right professional as quickly as possible.

The second description does not diminish the task. It enlarges it by connecting **what I do with why it matters.** Connection and having purpose and meaning influences behaviour.

If I understand the purpose behind my task, I am in a stronger position to notice when the task has become disconnected from that purpose. The domestic assistant who sees almost-full water jugs being replaced three times a day can ask whether replacing water is really the objective, or whether

ensuring patients drink enough is the purpose. A receptionist who repeatedly speaks to anxious patients confused by the same letter can suggest changing the letter. A porter who regularly has to search for wheelchairs can ask if we are using and storing them correctly?

Purpose therefore links directly with the principle introduced in Chapter 1: **leadership at every level**.

People do not need a senior title to notice that something could be better. They need an environment in which noticing, questioning and improving are welcomed.

Getting Strategy Into the Guts of the Organisation

Vision, mission and values do not create change because the words are impressive. Their value lies in what they enable people to see, understand and do.

Vision should provide a sufficiently compelling picture of the future. Mission should keep us connected with the work that matters today. Values should influence how we behave while pursuing both. Strategy connects those things with services, people, resources, partnerships, capability and the forces of change.

Eventually, however, all of them have to drive change and improvement and be connected to the realities of organisational life.

There is little point describing ourselves as patient centred if patients do not experience involvement, listening and care based on insightful understanding of need, physical, psychological and social. There is also little value in claiming that staff matter if they do not feel listened to. Integrated care remains an aspiration rather than a reality if organisational boundaries continue to dominate the patient's journey. And a vision has little practical value if somebody doing an everyday job cannot see any connection between that vision and what they do on a day to day basis.

For Reflection and Discussion

Vision: Imagine your service three to five years from now at its best. Describe what a patient would notice, what somebody working there would notice and what you would be proud to be known for.

Forces of change: Identify the three external developments most likely to influence that future and consider whether current strategy is preparing for them or mainly responding to today's pressures.

Values: Choose one publicly stated organisational value. Identify the behaviours that should make it visible, then compare them with what patients and staff actually experience.

Mission and purpose: Take one routine activity within your service and follow the question *Why do we do this?* until you reach the patient, family or community benefit it is intended to provide. i.e. all activity within the health system should have a health care improvement outcome connected to it.

Current NHS direction: Take one of the three national shifts — hospital to community, analogue to digital or sickness to prevention. Imagine it has genuinely been achieved in your area. Describe what has become better for patients, what staff are doing differently and what the organisation has been able to stop doing.

Understanding the Organisation and Its World — Diagnosis Before Action

Organisations can become remarkably absorbed in themselves. Meetings, targets, budgets, performance reports and operational pressures consume attention. In large healthcare establishments this is understandable.

But an organisation that continually looks inward eventually loses touch with the world it exists to serve.

I have always thought of good organisations as having **antennae**. They are constantly picking up signals from the environment around them: changes in the population, what patients are experiencing, what staff are saying, what new technology is on the horizon, what is happening in our suppliers and related services and what political or economic decisions may change the context in which they operate.

Some signals are loud. Others are weak. Part of the OD task is to notice them before they create urgent reactivity, diverting unplanned time and resource.

In the original edition of this book I described the importance of having antennae reaching into the health, social and wider environment and feeding that intelligence into strategic decision-making. I coupled this with an equally important internal diagnostic: understanding the organisation itself, including staff perceptions, organisational strengths and weaknesses, and whether stated values were actually being reflected in practice.

Good diagnosis requires us to look in two directions at the same time: **outwards, at what is changing around us, and inwards, at what is really happening within us.**

In Chapter 2 I argued that designing a vision requires an element of prediction in the light of the forces of change. This chapter takes that idea a stage further.

Prediction does not mean pretending that we know exactly what will happen. It means becoming sufficiently alert to what is happening around us that we are not repeatedly surprised by developments that were already visible.

One of the simplest ways of doing this remains PESTLE analysis: looking systematically at **Political, Economic, Social, Technological, Legal and Environmental** influences. PESTLE is not particularly sophisticated, and that is part of its usefulness. It obliges people to look beyond the boundaries of their own organisation.

The particular forces affecting the NHS have changed considerably since I first used the framework in 2003, although some have simply become more important.

PESTLE lens	Examples of forces affecting the NHS today
Political	NHS reform, national priorities, changing structures and accountabilities, devolution, public expectations and political scrutiny
Economic	Constrained public finances, productivity pressures, workforce costs, capital investment, medicines and technology costs, and the financial position of social care
Social	An ageing population, long-term conditions, mental health need, health inequalities, population diversity and changing expectations of access and involvement
Technological	Artificial intelligence, electronic patient records, genomics, virtual care, remote monitoring, automation, cybersecurity and digital exclusion
Legal and regulatory	Professional regulation, patient-safety requirements, equality duties, data protection, transparency and accountability
Environmental	Climate-related health risks, sustainability, energy use, estates, waste, resilience and the NHS Net Zero agenda

In the original edition I wrote about the impact of the internet, e-learning, increasingly sophisticated technology and information sharing. Those issues seem relatively modest beside the questions now raised by artificial intelligence, digitally supported care and the increasing ability to connect information across systems.

Likewise, I wrote in 2003 about an ageing population, socio-economic circumstances and growing public expectations. None of those concerns has disappeared.

The purpose of PESTLE is to ask: **what is changing that could materially affect the organisation we are trying to create?**

A useful discussion then goes beyond identifying individual forces and considers how they interact. An ageing population, for example, is not simply a social trend. It has implications for workforce, finance, buildings, community provision, technology and social care. Artificial intelligence is not simply a technological issue. It raises questions about professional roles, ethics, accountability, trust, inequalities, skills and the relationship between clinician and patient. Financial constraint is not simply an economic issue. It can affect staff morale, access, waiting times, innovation and the ability to move resources between hospital and community services.

Some organisational information arrives with a flashing light attached. A major financial deficit is difficult to ignore. A serious patient-safety incident

immediately commands attention. A regulatory intervention creates its own urgency.

Other signals are easier to dismiss. Staff turnover rises gradually. There are a few more complaints about communication. An experienced clinician's mortality rates increase. Sickness absence begins to increase. A service maintains its targets, but only because staff routinely stay late. Patients begin finding informal ways around a system because the formal route is too difficult.

Individually, these may mean very little. Together, they may be telling us that disease is not confined to the patient and the organisation itself needs urgent care.

One of the difficulties in large organisations is that weak signals are often distributed. Human Resources sees the turnover. A service manager sees the overtime. Patient Experience sees the complaints. Finance sees the rising costs. Frontline staff experience the workarounds. No single person necessarily sees enough of the big picture to recognise the pattern.

Effective OD creates ways of bringing those signals together.

Looking Inwards — Understanding the Organisation We Actually Have

External intelligence tells us something about the world in which we operate. It does not tell us whether our organisation is capable of responding to it. For that, we have to look inwards.

In the original edition I suggested beginning with familiar ideas such as strengths, weaknesses, opportunities and threats, while stressing that organisational diagnosis needed to go considerably beyond financial indicators, waiting times and numbers of episodes of care. I argued that the quality of the working environment, staff attitudes, communication and whether organisational values were being put into practice were equally important.

I think that argument is even stronger today.

The NHS has access to vastly more data than it did in 2003. The challenge is no longer simply obtaining information. It is understanding what the information means.

SWOT

SWOT analysis has become so familiar that it can sometimes feel almost ritualistic. A group of senior managers sits around a table, identifies several strengths and weaknesses, fills four boxes and moves on.

The framework itself is not the problem. The question is **whose view of the organisation is being represented.**

A Board may regard communication as one of the organisation's strengths, while frontline staff see it as one of its greatest weaknesses. Patients may have a third view and a neighbouring organisation a fourth.

The temptation is to reconcile those differences quickly. I would resist it.

The differences are information.

A more useful SWOT can therefore be developed from several perspectives. Ask leaders, frontline staff, patients, carers and partners what they believe the organisation does particularly well and where it struggles. Then put the answers alongside one another.

Agreement tells us something. Disagreement may tell us even more. A substantial difference between an organisation's self-image and the experience of the people who work with it, work within it or receive its services can be extremely valuable diagnostic information.

The NHS Is Not Short of Measures

When I wrote the first edition, I referred to frameworks such as the **European Foundation for Quality Management — EFQM — model** and **Investors in People**. Their particular language belongs to that period, but the purpose behind them remains relevant. They provided standards against which organisations could assess themselves and, importantly, compare themselves with others.

The NHS now has much richer forms of benchmarking. The **Model Health System** allows NHS leaders and clinicians to compare quality, productivity and responsiveness with similar organisations and identify variation that may warrant further investigation. The annual **NHS Staff Survey** provides another substantial source of organisational intelligence, with results available nationally, regionally and at organisational level and opportunities for comparison between organisations. The **Care Quality Commission** provides an important external perspective through its assessment and wider analysis of quality, access, workforce, people's experience and inequalities. The **NHS Oversight Framework** adds national performance metrics and assessments of leadership and organisational capability.

Most organisations will add their own dashboards, scorecards, targets and local measures. There is enormous value in all of this.

But there is also a problem with comprehensive measurement systems.

External standards and benchmarking can provide valuable comparators. They can reveal that an organisation's performance differs markedly from comparable services, expose variation that has gradually become accepted as normal, give Boards an independent reference point and make performance more transparent to patients and the public.

The problem begins when **achieving the rating becomes more important than achieving the purpose behind it.**

I have encountered organisations and consultancies that became remarkably skilled at designing quality systems capable of satisfying an external assessment. Policies were written, procedures documented, evidence collected and audit trails made immaculate. The organisation could demonstrate that the required quality system existed.

The same danger exists in healthcare. A dashboard may turn green because a target has been achieved, and that tells us something useful. But it does not necessarily tell us what a patient experienced, whether staff achieved the target through sustainable effort or exhaustion, or whether another part of the system deteriorated as a consequence. Nor does it tell us whether people have simply become very good at managing the measure.

There is an important distinction:

Compliance asks whether we can demonstrate that the required standard has been met. Improvement asks whether something worthwhile has actually become better.

The two should reinforce each other, but they are not the same thing.

Contemporary NHS oversight increasingly attempts to look beyond individual delivery metrics towards organisational capability, including leadership, governance, use of data, partnership working and the ability to sustain improvement. That matters because **a metric is a signal. It is not a diagnosis.**

It is understandable that a red indicator attracts immediate attention. The danger is that the first organisational response becomes, *How do we get this back to green?*

A better starting point is **why is it red?** What is happening beneath the number? What are patients and staff experiencing? Is this a temporary

fluctuation or part of a pattern? Does the metric accurately represent the issue? And what might we inadvertently miss if we concentrate too narrowly on this one result?

Green requires curiosity too. An organisation can display a reassuring dashboard while significant problems are developing elsewhere. Average waiting times may conceal a particular part of the population experiencing much poorer access. Patient feedback may be positive overall while one group consistently reports something very different. Performance can remain strong because exhausted staff are compensating for inadequate systems.

A good organisational diagnosis rarely relies upon one source of evidence. I would normally want to bring together **performance data, comparative data, patient experience, staff experience, observation and conversation.**

Suppose a service is achieving most of its formal targets and the dashboard looks healthy. At the same time, staff-survey results are deteriorating, and patients increasingly complain that they cannot obtain information.

Which picture is correct? Possibly all of them.

Staff may be maintaining performance through increasing personal effort. The process that achieves the target may be creating a poor experience somewhere else. Or the formal measures may simply not capture what matters most to the patient.

When different sources of information disagree, we should not regard that as an inconvenience to be tidied away. **The disagreement itself may be diagnostically important.**

From Data to Understanding

The modern NHS produces extraordinary quantities of information. Comparative performance, staff experience, patient experience, incidents, complaints, workforce information, finance and regulatory assessments can all be made available to leaders with a speed that would have been unimaginable when I first wrote this book.

Yet more data does not automatically produce more understanding.

A number on a screen acquires meaning only when somebody interprets it. A fall in staff morale may be visible in a survey score, but understanding why it has fallen may require sitting with staff and listening. A rise in complaints may appear on a dashboard, but reading the complaints may reveal that the issue is not the clinical treatment itself but uncertainty, communication or the sense that nobody has taken responsibility. A performance problem may

appear to belong to one department, while following the patient's journey reveals that its causes lie several stages earlier.

The progression therefore needs to be:

data → information → conversation → understanding → action → review and learning

The conversation in the middle matters. Without it, organisations can become extraordinarily efficient at producing dashboards about problems they do not really understand.

The Staff Survey — Listening or Merely Measuring?

The NHS Staff Survey gives organisations an unusually rich opportunity to understand what it feels like to work in the NHS. But its value is not created when people complete it. Its value is created by what happens afterwards.

I made much the same point in 2003. Staff surveys can become powerful vehicles for engaging people in continuous improvement, but their design, interpretation and follow-through determine whether staff see any value in participating.

If people repeatedly identify the same problem and nothing visible follows, the survey may gradually teach them something unintended: **that being asked is not the same as being heard.**

The opposite is also true. When teams receive their results, discuss them openly, identify one or two things within their influence and then report back on what has changed, measurement becomes part of OD rather than an annual administrative exercise.

Patient Experience — Beyond Satisfaction

The same caution applies to patient data. A satisfaction score can be useful, but it can also be superficial.

Patients frequently judge care in ways that do not fit neatly into organisational categories. They remember whether somebody seemed to care, whether they understood what was happening, whether professionals appeared to communicate with one another and whether they felt safe and taken seriously. A patient can rate the clinical treatment highly while describing the overall experience as frightening because nobody explained what would happen next.

For this reason, qualitative evidence — stories, complaints, compliments, interviews and observations — should sit beside formal quantitative

measures. One patient's experience should not automatically be treated as representative of thousands, but neither should it be dismissed because it is only one experience. Sometimes an individual story exposes a process problem that aggregated data has hidden.

There is another reason to look beneath headline figures. An average describes something about a population, but it does not tell us whether everybody within that population is having the same experience.

Current NHS approaches increasingly require attention to population health and inequalities, while regulatory evidence continues to identify substantial variation in access and experience between different groups and communities.

An average waiting time may look acceptable while one group waits considerably longer. An overall positive experience score can conceal a population whose experience is consistently poor. A successful digital service may work extremely well for many people while making access harder for those with limited digital confidence, language barriers or particular disabilities.

There is a danger that sophisticated information systems make leaders feel they understand an organisation without actually spending much time experiencing it outside of the Board room.

Some things are best discovered by being present.

Walk through an outpatient department when it is busy and spend some time in the waiting area. Follow a patient pathway. Sit in A and E for half an hour. Listen to a handover. Watch how staff find information and notice the unofficial workarounds experienced people use to keep the service functioning. Talk to somebody doing a job that rarely gets any recognition.

This is not a substitute for formal data. It is another source of intelligence.

The people closest to the work frequently know where a process fails because they spend their lives compensating for it. Indeed, their workarounds may be hiding the weakness from senior management. **A system can appear to work because good people continually rescue it.**

Diagnosis Requires Psychological Safety

There is a further difficulty. Organisations can only diagnose what people are prepared to reveal.

If staff believe that raising a concern will be regarded as negativity, they quickly learn to remain silent. If managers believe that acknowledging a problem will damage their reputation, information becomes softened as it

travels upwards. If Boards reward reassuring information and react badly to unwelcome news, they should not be surprised when everything eventually appears satisfactory.

Organisational diagnosis therefore depends upon something we will explore much more fully later in this book: **psychological safety and the ability to discuss the undiscussable**.

A healthy diagnostic culture does not celebrate failure but welcomes and turns it into a learning platform.

From Diagnosis to Action

Diagnosis is not an end in itself. There is little value in repeatedly analysing an organisation without eventually deciding what to do but acting too quickly can be equally dangerous.

A recurring problem is often related to the speed with which organisations move from symptom to solution. Quick fixes can produce short term results with long term failure. Poor staff morale produces a wellbeing programme. A communication problem produces a newsletter. A leadership problem produces leadership training. Long waits produce another performance meeting.

Sometimes those interventions are exactly right. Sometimes they treat the visible symptom while leaving the underlying cause untouched.

The discipline of OD is to ask whether we understand enough before intervening. If morale is poor because people are exhausted by an unworkable process, a wellbeing programme will not repair the process. If communication is poor because leaders avoid difficult conversations, another newsletter will not create openness. If waiting times are rising because several parts of a pathway no longer fit together, another meeting about the waiting-time number may simply consume more of the time needed to understand the pathway.

Good diagnosis should therefore produce a clearer sense of priority. Not everything can be improved simultaneously. The task is to identify the few things which, if addressed well, would have the greatest positive effect on patients, staff and organisational performance.

Then intervene. Measure what happens. Listen to the people affected. Review the consequences and learn from them. Be prepared to discover that the original diagnosis was incomplete.

For Reflection and Discussion

Use these questions as a practical review rather than a checklist to complete mechanically.

Look outward. Identify three forces outside your organisation that could significantly affect your service during the next three to five years. Consider whether they are already reflected in your current strategy.

Look inward. Compare what your performance information says with what staff and patients are saying. Notice where the stories reinforce one another and where they differ.

Choose one green indicator. Ask what might still be hidden beneath the reassuring result.

Choose one red indicator. Resist the immediate urge to fix the number. Spend some time understanding the system that produced it.

Identify a weakness. What concern, pattern or workaround is currently related to this weakness and what can we learn from this?

Most organisational problems do not appear without warning. Before a serious incident there may have been smaller incidents, concerns or near misses. Before a workforce crisis there may have been resignations, sickness absence, strained relationships and increasingly cynical conversations. Before a patient complaint there may have been several opportunities when somebody could have listened. Before financial failure there may have been months of workarounds and assumptions. Before a service becomes obsolete, changes in population, technology or public expectation may have been visible for years.

Good diagnosis is therefore not simply an exercise undertaken before a major change programme. It is part of the way a healthy organisation lives.

It keeps looking outwards and inwards. It compares what was intended with what people are actually experiencing. It uses standards without becoming enslaved by them and respects data without mistaking numbers for understanding.

Most importantly, it remains curious when something does not fit.

Healthy organisations keep their antennae switched on.

Following the Patient — Process Redesign and the Flow of Care

Healthcare organisations are largely organised into departments, professions, specialties and services. Patients are not. A patient experiences a journey, and that distinction lies at the heart of process redesign.

A hospital may contain excellent departments staffed by highly committed and competent people, yet the journey between those departments can still be slow, confusing, repetitive and frustrating. Each part of the organisation may perform its own task reasonably well while nobody has sufficient sight of the whole process.

I made this point in the original edition of this book. Streamlining, seamless care, one-stop services and process re-engineering were different attempts to achieve essentially the same objective: delivering care more effectively and efficiently by understanding the process from the perspective of the person receiving it.

The terminology has changed over the years. The principle has not.

Follow the patient. See what actually happens. Then ask whether we could design it better.

Following One Patient

Consider the following recent patient journey from August 2026.

A woman develops tingling in her arm and face. She is understandably concerned about what the symptoms might mean but is also reluctant to attend an emergency department because of the recent experience of her sister waiting 9 hours to be seen. Instead, she waits for an urgent GP appointment later that day.

The GP suspects a transient ischaemic attack, or TIA, and is also concerned about significantly raised blood pressure. She is referred urgently to the emergency stroke service, where she is assessed by a consultant, given aspirin and started on antiplatelet treatment and medication to reduce her blood pressure. She is then referred onwards for specialist outpatient assessment.

Several days later, another consultant is less certain that the symptoms represent a TIA and considers migraine as an alternative explanation. The antiplatelet treatment continues and an MRI scan is arranged for several weeks later.

The symptoms, however, persist and become more troubling.

The patient contacts the stroke ward directly and is advised to attend the emergency department, telling staff that she has already been in contact with the stroke service. She does so, but for approximately two hours nothing appears to happen. Increasingly concerned, she telephones the stroke ward herself from the emergency department. Within around twenty minutes she is assessed and undergoes a CT scan.

Admission is advised.

She then waits approximately seven hours in the emergency department before being transferred to a medical assessment area. Several hours later she moves again, this time to a general medical ward. During much of this journey she does not know what is happening, why she is waiting or what is expected to happen next.

An MRI is eventually carried out late on a Friday. The next stage of her care depends upon the result, but specialist reporting is not immediately available over the weekend. She therefore remains in hospital, apparently requiring no active treatment, while waiting for information that will determine what happens next.

By Monday afternoon, after repeated requests for clarification, she is reviewed by a neurologist and discharged for outpatient follow-up.

But the journey reveals other problems.

Medication is changed at different points without the patient always understanding what has changed or why. The medication information available to pharmacy on the ward does not appear to correspond fully with the medication the patient understands herself to be taking. At discharge, further clarification is required and an important blood-pressure medicine is missing from the discharge documentation.

At one stage a cannula is inserted before the MRI. The patient is left uncertain whether it is needed for the scan, inserted as a precaution or simply reflects one part of the system not knowing exactly what another part intends. It is not used and leaves severe bruising.

She also undergoes an ECG, then another. When she is later asked to undergo a third, she questions why it is necessary and is told that the previous results are not available on the record being used.

There may have been legitimate clinical reasons for repeating some investigations, and nothing in this account establishes that any individual practitioner acted improperly. That is not the point of the example.

The point is what the patient experienced: prolonged uncertainty, repeated waiting, fragmented information, changes in medication that were not always explained, and several moments when she herself had to carry information between parts of the system. Throughout this journey poor communication and uncertainty contributed to high anxiety and concern.

Follow the entire journey and a different question emerges:

The Patient Experiences the Whole System

This example illustrates something fundamental about healthcare organisations.

The patient does not experience primary care, stroke services, emergency medicine, radiology, medical assessment, pharmacy, bed management and neurology as separate organisational entities. She experiences **her care**.

The organisation, however, often manages those elements separately. That creates the possibility that every department can explain its own actions while the overall patient experience remains fragmented.

The emergency department may be waiting for a bed. The ward may be waiting for an investigation. The clinician may be waiting for a result. Pharmacy may be waiting for accurate medication information. Radiology may be waiting for specialist reporting. Another service may not even know that something already completed elsewhere is now being repeated.

Everybody is busy. Everybody may be working hard. And the patient is waiting.

This is why process redesign has to cross organisational and professional boundaries.

Get the Whole Process Into the Room

Some of the most powerful improvement work I have facilitated in the NHS has begun very simply: **bring together the people who collectively make a process happen**.

I have used this approach to examine admission and discharge, blood taking through to laboratory testing and results, outpatient appointment systems, operating-theatre utilisation and other patient pathways.

The starting point is not necessarily a sophisticated computer system. A large sheet of paper, a wall, marker pens and self-sticking notes can be remarkably effective.

The important thing is who is standing around them.

Take something apparently straightforward such as a blood test. From the patient's perspective, it may feel like one event. Organisationally, it can involve a clinician requesting the test, somebody taking the blood, correct identification and labelling, transport to pathology, laboratory reception, analysis, validation, transmission of the result, somebody noticing the result, clinical interpretation and finally communication or action.

Each part may work perfectly well in isolation. Between those parts there can still be waiting, duplication, unnecessary movement, missing information and opportunities for failure.

Something interesting happens when the people responsible for the different stages stand around the same process map. Many begin to see the **whole process rather than simply their own contribution to it.**

A pathology department may discover why clinicians repeatedly telephone for results. Clinicians may discover why apparently straightforward requests create problems for laboratory staff. Reception teams may explain why appointments are repeatedly rearranged. Theatre staff may uncover why expensive operating capacity is being lost and the under-utilised capacity elsewhere.

Nobody necessarily designed these problems.

A procedure is introduced to solve one problem. An additional check is added after an incident. A form is created because two systems do not communicate. Someone begins making a telephone call because the electronic notification is unreliable. Another person keeps a separate spreadsheet because the official system does not provide what the team needs.

Years later, all of this may simply have become *the way we do things around here.*

Process redesign makes it visible.

Map What Actually Happens

One of the first rules I would apply is:

Do not begin by mapping what the policy says should happen. Map what actually happens.

The facilitator may begin simply: a patient arrives; what happens next?

Someone describes the first stage, then the next, then the next. Sooner or later somebody usually says, *“Well, that’s what is supposed to happen, but actually...”*

That word — **actually** — can be extremely valuable.

It may reveal the workaround that keeps the service functioning, an unnecessary clinical step, repeated data entry, or unnecessary duplication of communication. It may show that the process described in a policy bears only a passing resemblance to the process experienced by staff and patients.

The purpose is not to catch people out. It is to understand the system well enough to improve it.

That requires an open, learning and non-blaming environment. People need to be able to admit that the formal process is not always the real process, that an approval no longer makes sense, that information is being entered twice, or that the safest way to get something done is to telephone somebody they happen to know.

Those statements are not necessarily evidence of poor performance. They are diagnostic information.

Four Flows Through One Journey

Traditional process mapping tends to concentrate on activity: what happens first, second and third.

In healthcare I think we need to look at at least four flows simultaneously.

A process may flow well in one dimension and badly in another. The patient may have reached the ward while the relevant information has not. A test may have been completed but the person able to interpret it is unavailable. A clinical decision may have been made but not communicated to pharmacy. A discharge may be clinically appropriate but still depend upon transport, community support, medication or social care.

The four flows therefore interact.

Those four flows are the patient, the work, the information and the decisions.

The repeatedly requested ECG example earlier illustrates this particularly clearly. A test has been completed, but if the result is not readily visible to the next professional who needs it, the work may be repeated.

Digital technology should have transformed many of these problems, and to some extent it has.

But digitising healthcare does not automatically integrate healthcare.

Different electronic systems may still fail to communicate effectively. Information can exist somewhere in the NHS without being readily accessible to the professional who needs it at that moment. Medication records may differ. Tests can be repeated because previous results cannot be located. Patients may repeatedly be asked to provide information they have already given.

A live, accurate and accessible shared patient record therefore has enormous potential value. But the important issue is not whether all the data is technically stored somewhere. The test is whether relevant, reliable and current information is available to the right person at the right time.

Patients will, of course, remain important sources of information about themselves. Listening to them is essential.

But there is something fundamentally wrong when the safest way to maintain continuity is for the patient or relative to remember which professional did what, which investigation has already been completed, which medication was stopped and what another department said would happen next.

Technology should reduce that burden, not merely digitise the fragmentation.

Finding Failure Activity

In the original chapter I wrote that following a patient through the process would expose what I called **failure activities**. These included poor communication, assumptions, rigid routines, unnecessary transportation, duplication, lost information, inflexible use of facilities, inappropriate skill mix and poor forward planning.

I would still use the term, but with an important qualification.

A failure activity is not necessarily somebody failing. It is activity that consumes time or resources without adding sufficient value to the patient's care.

Repeatedly collecting information already available, re-entering data into another system, searching for lost information, moving patients unnecessarily, chasing results, correcting preventable errors or keeping a

patient in a bed because a process has not been completed or a test result analysed, are all examples.

None of these automatically tells us where the fault lies. That is precisely why we map the process rather than blame the person.

Necessary Waiting and Avoidable Waiting

Not all waiting in healthcare is waste.

Some investigations take time. Patients sometimes require observation. Clinical priorities change. Emergency services must respond according to urgency. Specialist expertise cannot always be available instantly.

That is **necessary waiting**.

Other waiting exists because information has not arrived, nobody knows who should make the next decision, a process only operates during certain hours, medication is not ready, a bed has not been released or one service is waiting for another without the other knowing that it is being waited for.

That is potentially **avoidable waiting**. For the patient, both simply feel like waiting. For the organisation, understanding the difference is crucial.

Ten hours may appear on a performance dashboard as elapsed time. For the person lying on a trolley wondering whether they have had a stroke, whether their symptoms are getting worse and whether anybody knows what is happening, those ten hours are experienced very differently.

This is particularly important when considering emergency care.

It is tempting to describe poor flow through an emergency department as an “A&E problem”, but the emergency department may simply be where a wider system problem becomes visible.

A patient arriving by ambulance may subsequently depend upon emergency assessment, diagnostics, specialist review, pharmacy, bed management, ward capacity, discharge arrangements, transport, community services and sometimes social care. If patients cannot leave hospital safely, beds do not become available. If beds do not become available, patients cannot move out of emergency departments. If emergency departments cannot receive patients efficiently, ambulance handovers may be delayed.

The visible queue is therefore not necessarily where the underlying problem originates.

This leads to another important process-redesign principle:

You cannot successfully redesign an end-to-end process by involving only the people who own one part of it.

If the process crosses organisational boundaries, the redesign needs to cross them too.

For a complex admission-to-discharge pathway, that may mean involving emergency medicine, medical and surgical services, diagnostics, pharmacy, bed management, discharge teams, ambulance services, primary care, community services and social care. Not everybody needs to attend every meeting, but every significant part of the process needs to be understood.

Put the Patient in the Room

In the original edition I stressed the importance of involving the “users” of a process, by which I meant the staff actually operating it. Also, the users of the end product of the service, i.e. the patient.

We need the people doing the work and the people experiencing the work.

Patients and carers can see things that professionals have stopped noticing. Professionals may understand why a patient has to report to one place, wait, move somewhere else, repeat information and then wait again.

The patient may simply ask, *Why?*

Professional familiarity can make an unnecessarily complicated process appear normal. The patient’s lack of familiarity can expose its absurdity.

This does not mean patients can determine every aspect of a clinical process. Technical, safety and professional requirements may not be immediately obvious to somebody outside the system.

It means their experience is evidence.

Process redesign that claims to be patient-centred should therefore find some meaningful way of including the patient.

Redesign the Work Before Redesigning the Jobs

Process redesign can also create anxiety.

When people map a process honestly, somebody may discover that a task they have performed for years adds little value. Work may be duplicated.

Technology may have removed the original reason for a particular role within the process.

I acknowledged this difficulty in the original edition. When people begin to see that part of their contribution may be causing delay rather than adding value, the issue has to be handled carefully.

If staff believe process redesign is simply a disguised exercise in reducing jobs, they will understandably protect their role, department and territory.

The starting principle should therefore be:

Redesign the work before redesigning the jobs.

Removing unnecessary activity can release skilled people to undertake more valuable work. Changing who performs a task can make better use of professional skills. Automation may remove repetitive administration while creating a need for more complex or relational work elsewhere.

The purpose is not to prove that somebody's job is unnecessary. It is to ask whether the organisation is making the best possible use of people's time and abilities in serving patients.

Psychological safety matters here too. Someone should be able to say, "*I don't think this step in the process adds anything anymore*", without immediately fearing that they have just argued themselves out of a job.

One of the risks in process improvement is that we take the existing process and try to make each step slightly faster. Sometimes that is appropriate.

Sometimes the more powerful question is **why does this process exist at all?**

In the original redesign method, I suggested beginning by identifying a process with persistent problems and then asking what its purpose was, how it added value and what results a redesigned system should achieve that the existing one did not. That remains an excellent starting point.

If we were designing this service today, from a blank sheet of paper and knowing what we now know, would we create the process we currently have?

Often the answer is no. Only then should we design the better process.

I also proposed four tests for a redesigned process, and I still like them.

A good process should be **robust**. If one person is absent, a system fails or demand suddenly increases, the process should not collapse. Healthcare processes need resilience as well as efficiency.

It should be **simple and transparent**. The people operating the process should be able to understand it, and the patient should be able to understand enough of it to know what is happening. Complex clinical care does not require unnecessarily complex administration.

It should be **responsive**. Information needs to reach the next person who requires it. Changes should be noticed and acted upon, and there should be some mechanism for recognising when an expected response has not occurred.

And it should be **elegant**.

That was the word I used in 2003 and I would keep it.

An elegant process achieves what is necessary with as little unnecessary complication as possible. Information is collected once and used many times. Responsibility is clear. Handovers are minimised. Technology supports rather than complicates the work.

Elegance should not be confused with simplicity at the expense of safety. The best healthcare processes can be both sophisticated and elegant.

Beware the Ripple Effect

Healthcare processes are rarely genuinely linear. Changing one part affects another.

The original chapter ended with a warning against reviewing processes purely as straight lines because feedback loops and interdependencies create what I called the **ripple effect**. That principle is even more important when care crosses organisational boundaries.

Improve one department's discharge speed without ensuring community services can absorb additional demand, and the problem has not disappeared. It has moved.

Introduce a digital appointment system that works extremely well for digitally confident patients and overall access may improve while becoming worse for others.

Reduce the time spent on one clinical task and the workload may simply reappear somewhere else.

Optimising one part of the system can therefore make the whole system worse.

A Practical Process Redesign Exercise

This section deliberately remains structured. It develops the process I used in the original edition and is intended as a tool that practitioners can actually use.

1. Choose a process worth improving

Select something that repeatedly causes difficulty, delay, duplication, complaints, frustration or unnecessary cost. Do not begin with a preferred solution. Begin with the process.

2. Define its purpose

Clarify what the process is actually trying to achieve, for whom, and what a genuinely good outcome would look like. Consider how the patient would know that it had improved.

3. Bring together the people who make the whole process happen

Include the different professions, departments and organisations involved. Bring in people close to the work, not simply their managers, and include patient or carer experience where appropriate.

If the process crosses boundaries, the people in the room must cross boundaries too.

4. Map what actually happens

Start at the patient's first contact and follow the journey. Use whatever medium helps people see it clearly: paper, self-sticking notes, whiteboard or digital process-mapping tools.

Do not tidy the process while mapping it.

Capture the reality.

5. Map the four flows

At each stage look at:

Patient — Work — Information — Decisions

Consider where each one moves, where it stops and where one flow gets ahead of another.

For a fuller description of constructing process-flow diagrams, see *Making Business Work* by Michael Wash.

6. Identify failure activity, waiting and workarounds

Look for repetition, unnecessary handovers, information entered more than once, missing information, searching and chasing, unclear responsibility, avoidable waiting, approvals that no longer add value and work that exists simply because another process is unreliable.

7. Design the better process

Now use a fresh sheet.

Do not merely repair the old map. Ask what you would design if you were starting today.

Test the new process against four criteria:

Is it robust?

Is it simple and transparent?

Is it responsive?

Is it elegant?

8. Test the ripple effects

Consider who else will be affected, what happens upstream and downstream, whether reducing work here increases it somewhere else, what new risks could be created and how the process behaves when demand rises or something fails.

9. Test it with patients and staff

Walk through the redesigned process as though you were the patient, then again from the perspective of each of the main people responsible for delivering it.

Where possible, test the redesigned process on a small scale before implementing it widely.

10. Implement, measure and learn

Decide in advance what improvement should look like.

Measure what matters, not merely what is easiest to count. That may include time, cost, safety and productivity, but also patient experience, staff experience, duplication, unnecessary movement and the reliability of information.

Then review what happens. A redesigned process is a hypothesis. Reality will tell us whether it works.

NHS improvement work continues to demonstrate the value of redesigning the whole process rather than optimising individual departments. Recent examples include redesign of theatre flow and scheduling, one-stop outpatient pathways, patient-initiated follow-up, pathology turnaround, discharge-to-assess models and new approaches to allocating work in primary care. What these examples have in common is not a particular methodology but a way of thinking: follow the patient, understand the whole process, involve the people who make it happen, identify unnecessary delay or duplication, and redesign the workaround purpose rather than around inherited organisational routines.

Following the Patient

Process redesign can sound technical. At its best it is profoundly human.

The organisational chart is not the patient's experience of healthcare. Patients experience journeys. They experience the wait between departments, the unanswered question, the repeated test, the lost result, the professional who has not received the information, the discharge that nobody has properly explained and the relief when somebody finally takes responsibility for making the whole thing make sense.

The task of process redesign is therefore not simply to make healthcare faster. It is to make the whole journey work better.

The method remains remarkably straightforward. Bring together the people who make the process happen and include the people who experience it. Put the real process where everybody can see it. Follow the patient, the work, the information and the decisions together.

Then ask, with enough curiosity and courage to hear the answer:

Why are we doing it this way — and how could we do it better?

Making Structures Work — Mergers, Boundaries, Hierarchy and Organisational Change

The NHS has been reorganised so many times that structural change has almost become part of its normal condition. New organisations are created, responsibilities are transferred, management layers are removed or reinstated, services are merged and boundaries redrawn, usually with the promise that the new arrangements will be simpler, clearer, more efficient and more responsive to patients. Some of these changes have undoubtedly been necessary and some have brought improvements. Structures do matter. They determine where authority sits, how resources are allocated, who is accountable for what and how services relate to one another.

The problem arises when changing the structure is confused with developing the organisation.

That distinction lies at the heart of this book. Organisation Development is concerned with much more than the formal arrangements shown on an organisation chart. It is concerned with the capacity of the organisation to understand itself, to learn, to create effective relationships, to use evidence intelligently, to involve the people who provide and receive its services and to adapt when circumstances change. A structural reorganisation may contribute to that process, but it cannot substitute for it.

The publication of the Thirlwall Inquiry report in September 2026 provides a painful contemporary reminder of why this distinction matters. The Inquiry was established to examine not only the events at the Countess of Chester Hospital but the organisational circumstances surrounding them, including the response to concerns, management and governance, the culture of the Trust and the effectiveness of wider NHS structures. Its significance for Organisation Development is not simply that particular procedures or reporting arrangements failed. It is that important information did not produce the organisational response it should have done. Questions of structure became inseparable from questions of leadership, relationships, professional authority, communication, responsibility and culture.

The Government's initial response was notable for describing the implications explicitly in terms of leadership and responsibility and for emphasising that concerns must be heard and acted upon at every level. This is important because it takes us beyond the assumption that patient safety can be secured by adding another procedure or another reporting mechanism.

That is why reorganisation and Organisation Development must not be treated as interchangeable.

The attraction of structural change is understandable. When something is not working, a new structure gives the appearance of decisive action. It can be described, costed, timetabled and implemented. Responsibilities can be reassigned, management posts altered, reporting arrangements changed and a date established upon which the new organisation formally comes into existence. These are tangible activities and therefore easier to demonstrate than the slower and less visible work involved in changing relationships, behaviour and culture.

Yet an organisation does not simply become different because its diagram has changed. The work still has to be done. Patients still have to move between services, information still has to travel, professional groups still have to collaborate, managers still need to make judgements and staff still need to understand what is expected of them. If the underlying relationships remain poor, communication remains unreliable, professional or organisational territory continues to be defended and staff remain reluctant to challenge decisions made above them, the same difficulties can continue within the new structure.

What is lost when structures change?

There is another aspect of reorganisation that is rarely given sufficient weight: organisations carry memory.

Organisational knowledge does not exist only in policies, databases and procedure manuals. Much of it is held by people. It is accumulated through experience, relationships and familiarity with the way a system actually works. Someone knows why a particular arrangement was created because they remember the problem that preceded it. Another person knows which colleague in a neighbouring organisation can resolve something quickly. A manager understands the history behind a difficult relationship between two services. A clinician remembers an earlier attempt to introduce a change and understands why it failed.

Much of this knowledge is informal and therefore almost impossible to record completely. When experienced people leave during a reorganisation, the organisation may lose something it does not realise it possesses until it is gone.

This issue has become increasingly relevant as the NHS has moved through repeated cycles of structural change. Each individual reorganisation may be capable of being justified on its own terms, but the cumulative effect deserves much greater attention. Staff have to learn new systems, rebuild relationships, understand new responsibilities and discover where decisions are now made. At the same time, the service itself must continue to operate.

There is an assumption hidden within much restructuring that the organisation can absorb this disruption while continuing to function much

as before. Sometimes it can, but there is a cost. People spend time preparing for new structures, applying for posts, attending consultation meetings, learning new systems and worrying about their future. Experienced staff may decide to leave rather than go through another period of uncertainty. Those who remain inherit new responsibilities while still trying to maintain existing services. It is hardly surprising that morale, trust and organisational capacity can suffer.

This does not mean that change should be avoided because staff find it difficult. There are occasions when organisations must change substantially and when difficult decisions cannot be postponed. It does mean, however, that the human and organisational consequences of restructuring should form part of the judgement about whether the change is worthwhile. They are not peripheral matters to be dealt with after the structural decision has been made.

A Staff Perspective

A staff perspective offered while this book was being developed was particularly helpful because it brought the experience of restructuring from within the service into the argument.

The central concern expressed was that repeated restructuring can gradually dismantle organisational knowledge and skill while offering too little evidence that lessons have been learned from previous programmes of change. The observation was not an argument against change in itself. It was a challenge to the way change is sometimes conceived and implemented.

As the contributor put it:

“The central challenge of restructuring lies not simply in the change itself, but in the motivation for it and the extent to which it is informed by evidence.”

If the reason for the restructure is not clear, the new structure may do little more than disturb the organisation while leaving the underlying issues the restructuring was designed to solve to simply being transferred.

The same staff perspective drew attention to the effects of continual uncertainty upon the workforce. Organisational knowledge can be lost, capacity reduced and morale damaged long before the full consequences of a reorganisation can be measured. People may be required to continue delivering services while uncertain about their own role, their colleagues or the future shape of their organisation. The way leaders behave during that period therefore matters greatly.

One of the points made in this feedback concerned the manner in which staff sometimes discover that major organisational change is taking place. When people affected by a decision first learn of it through the media or informal networks rather than directly through their own organisation, the issue extends beyond communication technique. It conveys something about the relationship between the organisation and its staff. One staff perspective states;

“Major organisational change should be communicated directly, honestly and with sufficient support to preserve trust, dignity and workforce engagement.”

This seems to me to be an important Organisation Development principle. **The way an organisation undertakes change is itself an expression of its culture.**

If people are told that a reorganisation is intended to improve openness while the process itself feels secretive, the contradiction will be noticed. If leaders say that staff are valued but communicate life-changing decisions impersonally or at the last possible moment, the behaviour will carry more weight than the words. If an organisation claims to value participation but staff experience major decisions as something done to them, the process reinforces precisely the culture the organisation may claim it wishes to change.

There was another aspect of this staff perspective that deserves particular attention. A contributor to this chapter strongly argued that evidence for change should not be restricted to performance figures, financial data or national policy requirements. Patient experience and staff experience are also forms of evidence.

In the words of one contributor:

“We need change to be evidence based and one of the most effective ways to ensure the evidence stands up to rigour is to ask the people who use our services.”

I would go further and suggest that this should happen before the solution has been determined. Too often involvement means presenting people with a proposed change and asking them for their views. That may have some value, but it is not the same as involving them in understanding the problem. If patients and frontline staff are brought into the diagnostic process earlier, they may see things that those designing the organisation cannot see.

That returns us to the argument made in the previous chapter about following the patient. If we want to understand whether an organisational structure works, one of the most revealing things we can do is follow the

person who has to travel through it. The points at which patients become confused, have to repeat information, wait unnecessarily or find that nobody appears to hold responsibility tell us something important about the way the organisation is functioning.

The same principle applies to staff. Those working closest to the patient often know where systems are failing long before that failure appears in formal performance information. The problem is not usually an absence of knowledge somewhere within the organisation. The difficulty is whether that knowledge travels, whether it is taken seriously and whether people have sufficient influence to act upon it.

The final question raised through this staff perspective is perhaps the most uncomfortable:

“Why are we continually trying to do the same thing without learning?”

That question reaches well beyond one programme of NHS restructuring. It raises the possibility that continual reorganisation can itself become evidence of a failure to learn. If a structural intervention does not produce the expected improvement, the appropriate response should be to understand why. Instead, organisations can move relatively quickly towards the next structural solution without spending enough time examining what happened to the last one.

What did the organisation expect to improve? What actually improved? What was lost? What unintended consequences emerged? What did staff and patients experience differently? Which assumptions turned out to be wrong?

These are not questions designed to prevent future change. They are questions that should make future change more intelligent.

Mergers and organisational identity

Mergers provide a particularly clear illustration of the difference between formal structural change and genuine organisational development. Two organisations can legally become one on a particular date. Financial systems can be combined, a single Board appointed and a new name introduced. From a regulatory and administrative perspective, the merger has happened.

The people within those organisations may experience something very different.

Every organisation develops its own history, stories and assumptions about itself. Staff remember periods of success, difficult episodes and influential leaders. Professional groups establish ways of working that gradually become

taken for granted. Relationships develop across departments and with outside organisations. People become attached not simply to a name or logo, but to what they believe their organisation represents.

A merger disturbs that identity. Questions that appear relatively minor from outside may carry considerable symbolic importance within the organisation. Which headquarters will remain? Whose systems will be adopted? Which members of the executive team will retain their positions? Which organisation's language, traditions or policies will predominate?

These questions are partly practical, but they are also about power and status. If one organisation consistently provides the Chief Executive, the management systems, the headquarters and most of the senior posts, staff from the other organisation will reasonably conclude that they have been taken over, whatever language was used to describe the merger.

This is why merging structures is easier than merging organisations.

A successful merger requires deliberate attention to identity and relationships. It means recognising what is valued in both organisations and being willing to create something new rather than simply imposing the practices of one upon the other. That process takes time. If it is neglected, the old organisations may continue to exist psychologically for many years beneath the new name.

Hierarchy, authority and knowledge

Hierarchy is another feature of organisations that is sometimes criticised too easily. The NHS could not operate without clear authority and accountability. Decisions have to be made, responsibilities defined and professional standards maintained. In complex clinical environments there are situations where uncertainty about who has authority would itself be dangerous.

The problem is not the existence of hierarchy but the assumptions that can develop around it.

In particular, greater authority can become confused with greater knowledge.

Senior managers necessarily work at some distance from the everyday experience of patients and frontline staff. That distance is unavoidable and can even be useful because senior roles require a broader view of the organisation. However, it also means that those with the authority to make major decisions may have less direct knowledge of the particular circumstances affected by those decisions.

A healthy organisation recognises this and creates ways for knowledge to travel. Senior leaders remain curious. They seek out different perspectives.

Managers are prepared to carry uncomfortable information upwards. Frontline staff believe that raising a concern is worthwhile because something will happen as a result.

An unhealthy hierarchy behaves differently. Information becomes increasingly polished as it travels upwards. People learn what senior colleagues want to hear. Difficult messages are softened. Managers become reluctant to raise concerns for fear of being regarded as negative or disloyal. Eventually those at the top of the organisation can find themselves making decisions on the basis of a version of reality that bears only partial resemblance to the experience of those delivering or receiving the service.

The importance of this can again be seen in Thirlwall. One of the deepest lessons is that information existing somewhere within an organisation is not enough. The organisation has to recognise its significance, connect it with other information and ensure that it reaches people able and willing to respond. Formal reporting arrangements are therefore only part of the answer. The culture surrounding those arrangements determines whether they work.

This also takes us towards the discussion in Chapter 7 about the shadow side of organisations. Speaking up is often treated as if the primary problem is persuading individuals to have sufficient courage to raise concerns. Courage certainly matters, but it cannot carry the whole burden. If people repeatedly raise concerns and discover that nothing happens, the organisation teaches them – ‘what’s the point?’. If those raising difficult issues suffer personally while those who ignore them experience no consequence, the organisation teaches them to keep quiet.

Psychological safety is therefore not created by telling people that they are free to speak. It develops through what happens after they speak.

Leadership at every level.

Our traditional understanding of hierarchy also contributes to an unhelpful distinction between leaders and everyone else. The word *leader* is frequently used as though it refers primarily to people occupying senior positions. This can unintentionally encourage those elsewhere in the organisation to regard leadership as somebody else’s responsibility.

One comment in the anonymous staff feedback brought this home to me particularly strongly. Having reflected critically on the behaviour of leaders, the contributor suddenly recognised that they had been “othering” leadership and remarked that they did not think of themselves as a leader.

Yet elsewhere in the same reflections was their account of challenging senior clinicians and managers during a serious safeguarding investigation and

using the voice and experience of patients to bring uncomfortable information into view.

It would be difficult to find a clearer example of leadership.

That does not mean everybody should attempt to exercise the authority of senior managers. It means that leadership and hierarchical position are not identical. Leadership occurs when people take responsibility for improving something that matters, when they question an accepted practice, draw attention to risk, help colleagues understand a problem or create the conditions in which others can contribute.

An organisation that depends entirely upon its senior leaders to identify every problem and initiate every improvement will never be sufficiently responsive or able to sustain improvement. The people closest to the work continually see things that those further away cannot see. The organisational task is to create a structure and culture in which that knowledge can influence what happens.

We will return to this more fully in Chapter 8 because leadership at every level is fundamental to continuous improvement. It is introduced here because structure can either enable that leadership or suppress it. A hierarchy that clarifies responsibility while encouraging initiative can be extremely effective. One that concentrates both authority and permission to think at the top eventually weakens the organisation.

Structure must serve the work

The implication of all this is not that the NHS should stop reorganising. Structures do become outdated. Responsibilities can become unnecessarily complicated. Layers of management can accumulate. Functions may be duplicated and organisational boundaries can obstruct rather than assist care. Sometimes significant structural change is necessary.

The question is how we know that structure is actually the problem.

This takes us back to organisational diagnosis. Before deciding upon a merger, abolition, transfer of responsibility or removal of a management layer, we need to understand what is preventing the organisation from achieving its purpose. Is the difficulty genuinely structural, or is it primarily about relationships, culture, resources, skills, leadership, information or behaviour? If several of these factors are involved, as they usually are, how will changing the structure influence them?

There is a danger in starting with the solution. “We need fewer layers”, “we need to merge these services”, “we need to centralise this function” or “we need to move decision-making closer to the frontline” may all ultimately

prove sensible, but each is a proposed solution to an assumed or unknown problem rather than a diagnosis.

The first question remains: what is happening here?

That is why the discussion in Chapter 3 about diagnosis is so important. Organisational change should begin with curiosity rather than certainty.

So its important to ask whether we are capable of changing intelligently.

That requires us to acknowledge what previous reorganisations achieved and what they did not. It requires leaders to recognise the cost of uncertainty and the value of organisational knowledge. It requires patients and frontline staff to be involved in understanding problems before solutions are settled. It requires structures that provide accountability without assuming that wisdom travels only downwards from the top. Above all, it requires an organisation willing to learn from its own experience.

The staff question quoted earlier remains a useful one: why would we continue doing the same thing if experience tells us it does not work?

There will never be a perfect NHS structure. No arrangement can remove every boundary, eliminate every tension or anticipate every future demand. Structures are temporary solutions to changing organisational problems. Their value lies not in their elegance on paper but in whether they help people provide better care.

The real test, therefore, is not whether a new organisation chart looks simpler than the old one. It is whether information travels more effectively, whether responsibility is clearer, whether people can work across boundaries more easily, whether staff are able to exercise judgement, whether patients experience greater continuity and whether the organisation becomes better at noticing when something is going wrong.

If those things improve, structural change may have served its purpose. If they do not, changing the boxes has achieved very little.

This is what takes us beyond reorganisation. The structure matters, but the organisation is what happens between the boxes.

Connectedness — Bringing People, Performance and Quality Together

As organisations become larger and more complex, specialist knowledge is needed. Human Resources develops expertise in employment, recruitment and workforce matters. Finance looks after money. Clinical governance develops systems concerned with quality and safety. Digital teams deal with information and technology. Improvement teams develop expertise in methods of change. Education and development functions concentrate on learning. Patient experience teams listen to patients and families.

Each of these functions makes sense in its own right, and it is important to have structure.

The difficulty begins when the boundaries created to organise expertise start to divide responsibility.

It is quite possible to walk through a large organisation and hear people talk about “the HR issue”, “the quality issue”, “the digital problem” or “the governance people”, as though these things belong somewhere else. A policy may be beautifully written in one office yet barely recognised on the ward or in the clinic where it is supposed to influence behaviour. A leadership programme may receive excellent evaluations while making little discernible difference to the way those leaders subsequently manage their teams. Patient experience data may be carefully collected, analysed and presented to a committee without significantly altering the experience of the next patient coming through the door.

Everyone can be working hard. Every department can be producing what has been asked of it. Yet somehow the pieces do not join together.

This chapter is about those connections.

Connectedness

I have explored connectedness in more detail in *The Healthy Organisation* (MWA Publications) but the principle is particularly important in Organisation Development. An organisation is not simply a collection of functions. It is a network of relationships, decisions, processes and consequences in which something happening in one part can eventually be felt somewhere quite different.

In healthcare, the ultimate test of many of those connections is the experience of the patient.

This does not mean that every employee has direct contact with patients. Clearly they do not. It means that we should be able to trace the contribution of their work through the organisation to its ultimate purpose.

When I wrote the original version of this chapter, I suggested a question that a Chief Executive might ask:

“Do I understand the connection between the way I make decisions, communicate and manage my team and the way care is ultimately given to patients?”

I still think it is a good question, although there is no reason to restrict it to Chief Executives.

A finance manager making a decision about resources, an HR adviser helping to recruit a ward manager, an IT specialist changing an electronic record, an estates manager responding to a heating failure and a domestic assistant cleaning a patient's room are doing very different jobs. Yet each can affect the conditions in which care is provided.

Connectedness means being able to see those relationships and act accordingly.

It is also an antidote to one of the persistent weaknesses of large organisations: the tendency to improve things separately.

Previously I have identified several organisational activities that I frequently saw being developed apart from one another: HR strategy and OD, clinical governance and culture change, appraisal and career development, research and strategic review, performance management and organisational improvement. In reality they are concerned with each other and significantly connected so why develop them separately?

Consider leadership development. An organisation may invest considerable money in developing its leaders. Participants attend programmes, discuss values, learn about coaching and practise giving feedback. They leave enthusiastic and complete positive evaluation forms.

Then they return to an organisation where they experience leadership that undervalues their development, so they revert to type.

The formal development programme may have lasted several days. The organisational environment influences behaviour every day.

Or consider recruitment. An organisation publishes values describing kindness, openness and respect. Its People function designs a thoughtful recruitment process around those values. The successful applicant arrives in a

department where new staff are barely welcomed, the manager is permanently under pressure and an established colleague quietly tells them, “You’ll soon find out what it’s really like here.”

The recruitment process and the lived culture have become disconnected. Organisation Development asks us to notice these gaps.

The answer is not to create one enormous programme that attempts to encompass everything. That would merely produce another layer of bureaucracy. The aim is to ensure that the important elements work together in the context of total organisational culture change.

Personal Development and Organisational Development

People need opportunities to learn for many reasons, including professional development, curiosity, confidence and personal fulfilment. But an organisation investing in development should also be interested in what happens when the person returns to work.

Completing a course is an activity. What matters organisationally is what the person is subsequently able to do differently or better.

If someone develops greater leadership capability, where will that capability be used? If a clinician learns a better approach, does the surrounding system make it possible to apply? If a manager develops coaching skills but returns to a job in which pressure and organisational expectations leave no time to use them, the organisation may have purchased development without creating much development at all.

The connection should work in both directions. Organisational priorities should help identify the capabilities people need, while the knowledge, ideas and aspirations of staff should influence how the organisation itself develops.

This was one of the ideas behind **Investors in People**, which featured in the original edition. Investors in People still exists, but it no longer has the same prominence within NHS organisational development that it once did. I would not now advocate pursuing an award as though accreditation itself were the solution. The enduring principle is more important: people should be able to understand how their development and contribution connect with the objectives and purpose of the organisation.

The stonemason building the cathedral, whom we met in Chapter 2, understood more than the task immediately in front of him. He could see what his stone contributed to. Connection gives work meaning.

The original edition devoted considerable space to the **European Foundation for Quality Management — EFQM — model**. At the time it provided a

useful way of looking across an organisation rather than concentrating on isolated improvement initiatives. Its areas included leadership, strategy, people, partnerships and resources, processes, and different kinds of organisational results.

I would no longer advocate the detailed EFQM model as the principal framework for NHS OD, but I would certainly not discard the thinking behind it.

At heart, the model asked whether the different elements of organisational life made sense together. Does leadership support the organisation's purpose? Are strategy and resources pointing in the same direction? Are people being developed to deliver what the organisation is trying to achieve? Do partnerships genuinely work? Are processes designed around those who use them? What are patients and staff experiencing, what results are being achieved, and what is the organisation learning from all of this?

Those questions remain remarkably current.

Today's NHS has different frameworks and tools, but they face exactly the same danger as their predecessors. They will achieve their purpose only if people understand how they connect and take ownership of what they are trying to achieve.

Three contemporary approaches are particularly relevant.

NHS IMPACT

NHS IMPACT — Improving Patient Care Together provides a shared approach to continuous improvement. Its components bring together purpose and vision, people and culture, leadership behaviours, improvement capability and the embedding of improvement within management systems and processes.

What interests me is not simply the existence of another framework. It is the insistence that these elements should be considered together i.e. Connectedness.

Shared purpose takes us back to Chapter 2. Understanding what needs improving requires the diagnostic thinking explored in Chapter 3. Improvement capability becomes useful when people can examine and redesign the processes considered in Chapter 4. Whether they have sufficient authority and appropriate structures to make those changes takes us towards Chapter 5.

The danger would be for NHS IMPACT to become regarded as the responsibility of an Improvement Team. Such a team may provide expertise,

coaching and facilitation, but improvement ultimately has to happen where work is being done. A central team cannot continuously improve thousands of individual interactions and processes on everyone else's behalf.

The NHS Oversight Framework

The NHS Oversight Framework performs a different function. It brings together measures concerned with areas such as access, quality, productivity, people and finance, alongside assessment of organisational capability.

This can provide a useful view of organisational performance, but again the principle of connectedness matters.

A Board presented with a deteriorating indicator has been given a signal. It has not yet been given an explanation.

The natural reaction to a red indicator is to ask who owns it, why performance has deteriorated and when it will return to green. Those questions have their place, but Chapter 3 established an important distinction: **a metric is a signal, not a diagnosis**.

The more useful organisational conversation begins when the signal is followed into the organisation. A deteriorating result may eventually take us into workforce, process design, leadership, resources, information or relationships between organisations. Quite often it takes us into several of them at once.

Oversight becomes most useful when it stimulates understanding and action rather than simply compliance.

The Model Health System

The **Model Health System** provides another window, enabling NHS organisations and systems to compare aspects of quality, productivity and performance and to identify variation that may deserve investigation.

Used intelligently, comparison can be enormously useful.

Suppose the data suggests that a comparable service elsewhere achieves better outcomes with fewer resources. The important response is not simply to conclude that they are better and we must copy them.

The comparison tells us where to look and who we could learn from.

Their patient population may be different. Their staffing pattern may differ from ours. They may organise the pathway differently or make better use of

technology. Their professional relationships may enable decisions to be made more quickly. What looks like a productivity difference may even partly reflect differences in data definition or recording. However, they may be working in a different way that may be able to be transferred elsewhere. Sharing best practice is an important aspect of OD internally and externally.

There is also a connection between these contemporary approaches. Performance and benchmarking information can help an organisation **see**. Oversight can help it recognise where further attention may be required. NHS IMPACT can help build the capability to improve. Organisation Development connects all of these with purpose, people, leadership, culture, relationships and the way work is actually done.

Clinical Governance — Everyone's Business

Clinical governance was an important part of the original book and remains so today.

When clinical governance became prominent within the NHS, I frequently encountered confusion about what it meant. Some people associated it primarily with audit, research, professional standards or the work of particular committees. Non-clinical staff could quite reasonably hear the word *clinical* and conclude that it had little to do with them.

My proposition was different. As a Hospital Director with oversight responsibility for Clinical Governance, I stressed the importance of Clinical governance been everybody's concern.

A patient's experience is directly or indirectly affected by everybody working within the healthcare system.

That does not mean everybody carries clinical responsibility. Clearly, they do not. It means that many people outside clinical roles help create the environment in which safe and effective clinical care takes place.

Think again about the patient journey described in Chapter 4. A doctor may make the clinical decision, but the quality of what happens afterwards may depend upon whether the investigation is requested correctly, information reaches the next professional, an accurate medication record is available, staffing is sufficient, equipment works, the ward is clean and someone notices that the patient does not understand what is happening.

The patient does not experience those things as separate organisational functions. They experience care.

This is why I remain uncomfortable when clinical governance is treated as a specialist process that somehow sits alongside ordinary organisational life.

Clinical governance should be visible in the way people learn from mistakes, how openly concerns are raised, whether patients are listened to, how evidence influences practice, how professional competence is developed, how processes are designed and how leaders respond when something goes wrong.

The original chapter described clinical governance as everyone's business: crossing service boundaries, involving patients, supporting professional development, using evidence and creating an open culture of continuous learning. Those principles have aged well.

The strongest form of clinical governance is therefore not simply a governance system.

It is embedded in the culture — part of *the way we do things around here*.

There is an organisational trap here that extends far beyond clinical governance.

An important issue is recognised. A specialist team is created to deal with it. That team quite properly develops expertise, policies, systems and terminology. Gradually, however, everybody else begins to assume that the specialist team **owns** the issue.

The very act of creating expertise can unintentionally remove ownership from the rest of the organisation.

A Quality Team cannot personally create quality throughout a hospital. An OD team cannot create the culture on everybody else's behalf. A Patient Experience Team cannot make every interaction compassionate. A Digital Team cannot determine whether every system helps rather than hinders the work. An Equality team cannot make every manager behave inclusively, and an Improvement Team cannot continuously improve everybody else's work for them.

Specialist functions should provide expertise, not relieve everyone else of responsibility.

Sometimes the easiest way to understand connectedness is to follow a very ordinary event.

Imagine a domestic assistant cleaning beside a patient's bed and noticing that the patient has hardly touched the water within reach. The domestic assistant is not responsible for assessing hydration or making clinical decisions.

But what happens next matters.

In an organisation where roles are interpreted rigidly, the response may be, *That's nursing's responsibility*. In a more connected organisation the response may simply be, *someone needs to know*.

Clinical governance did not begin when somebody completed a form.

It began when somebody noticed something relevant to the patient's care and understood that it mattered enough to say so.

The organisational question is whether we create an environment in which people recognise those connections and feel able to act upon them.

The same thinking should apply to performance management.

There is a danger in separating organisational performance from individual performance. The organisation has its dashboards, strategic objectives and Board reports; the individual has an appraisal, objectives and a development plan. One conversation happens in the Boardroom and another in a manager's office.

Connectedness asks whether those conversations have anything meaningful to do with each other.

If reducing inequalities is an organisational priority, people need to understand where their work can influence it. If patient flow is a major problem, teams need to know what part of the pathway they can affect and what support they need from others. If staff experience is deteriorating, managers need more than the organisation's aggregate survey score: they need help understanding what is happening in their own working environment. If digital transformation is strategically important, people require both the skills and the opportunity to redesign work using the new technology rather than simply having new systems imposed upon old processes.

The purpose is not to cascade every corporate target mechanically into every individual's objectives. That can produce a forest of meaningless measures in which people can barely see the organisational purpose.

Lightening the Shadows — Making the Undiscussable Discussable

Imagine sitting in a meeting where almost everyone in the room knows there is a problem.

The figures on the screen are reassuring. The formal report says that improvement is continuing. Around the table people nod. Questions are asked, answers are given and the agenda moves on. Yet one person knows that staff are becoming frightened to raise concerns. Another knows that incidents are being under-reported. Someone else knows that an influential colleague behaves in ways that would not be tolerated from anyone less senior. Several people privately doubt the optimistic interpretation being presented, but none is quite prepared to say so.

The meeting ends.

In the corridor afterwards, the conversation changes. What could not be said inside the meeting is suddenly discussed freely. People exchange knowing looks. Someone mutters that “nothing will change while so-and-so is in charge”. Another says they tried raising it once and will not make that mistake again.

The problem has not disappeared.

It has moved into the **Shadow Side**.

When I first wrote about the Shadow Side in 2003, I described it as those parts of organisational life that are hidden, covert, undiscussable or so deeply embedded that they have become taken for granted or institutionalised. They are the things that rarely appear on meeting agendas, in policy documents or in official communications, but nevertheless exert considerable influence on what an organisation actually does.

I remain convinced that understanding this hidden organisation is one of the most important contributions Organisation Development can make.

The Shadow Side is not inherently sinister. Every organisation has one because every organisation contains informal relationships, assumptions, loyalties, anxieties, power and conversations that sit alongside its formal structures. Much of this is simply part of being human.

It is the joke everyone recognises but nobody would make in front of the Chief Executive. It is the consultant whom colleagues privately describe as

impossible but whom nobody challenges because of reputation or status. It is the manager whose behaviour contradicts the organisation's stated values but whose performance figures provide protection. It is the shortcut staff use because the official procedure is unworkable, the meeting before the meeting where the real decision is shaped, or the informal network that can get something done in an afternoon when the formal system would take three weeks.

Some of this informal life is useful. Indeed, without informal relationships many organisations would struggle to function at all.

The danger begins when significant problems, poor behaviour or uncomfortable truths are repeatedly pushed into the shadows because bringing them into the light feels personally or politically unsafe.

That is when the Shadow Side can become dangerous.

I owe much of my thinking about the Shadow Side to Professor Gerard Egan, a colleague and friend whose book *Working the Shadow Side* remains one of the clearest explorations I know of the realities that organisations often prefer not to discuss. I was also fortunate to work with Chris Argyris, whose work on organisational defensive routines provided another powerful way of understanding how intelligent people and apparently rational organisations can become trapped in patterns that protect them from learning.

Their work helped make explicit something I had repeatedly encountered in practice: **the formal organisation and the lived organisation are not always the same.**

An organisation may formally value respect and openness while its everyday behaviour rewards silence and deference. It may describe its decisions as evidence-based while everybody knows that certain influential people usually get their preferred outcome. It may have excellent policies for addressing bullying, discrimination or poor practice while quietly tolerating the behaviour of a powerful individual because "that's just what they're like".

That discrepancy between **said policy and done policy** was one of the central Shadow Side ideas in the original edition.

The Questions We Often Avoid

The original book contained a number of deliberately uncomfortable questions. I would retain their substance because the issues have not disappeared, although they are perhaps more useful considered together than fired at people one after another.

We need to be curious about which values actually dominate organisational life rather than simply those displayed on the website. We need to understand what standards of behaviour are genuinely tolerated and whether professional status, social background, familiarity, personality or influence affect whose voice receives attention. We should be prepared to examine prejudice, dominant leadership styles, unresolved conflict and the organisational cost of arrogance, intimidation or incompetence when these occur in somebody powerful.

Every organisation also contains social groups and special networks. Some become productive communities; others become tribes. There are people who formally possess authority but surprisingly little influence, and others whose position on an organisational chart gives no indication of their real power. Decisions may be made in formal meetings but shaped long before those meetings begin. Systems may be routinely bypassed because experienced people know that the formal route does not work.

These are not questions designed to expose villains.

They are attempts to understand **how the organisation really works**.

The Shadow Side becomes destructive when we stop being curious about these realities and they become part of the culture. They then hide and distract from dysfunctional and often expensive and wasteful practice.

Today I would describe part of this territory using the language of psychological safety: whether people believe they can ask questions, admit mistakes, raise concerns, disagree with authority and offer unwelcome information without disproportionate personal risk. Psychological safety matters because it affects whether people will speak freely and honestly, but the Shadow Side asks a question that comes even earlier: are we capable of seeing and thinking about what the organisation would rather not contemplate

An anonymous staff reflection offered during the development of this book sharpened this point for me: "To talk about the untalkable, you have to have the capacity to think it." In a serious safeguarding investigation, the contributor described how becoming comfortable with an accepted explanation had made it harder to imagine that something much more troubling might be happening. The breakthrough came only when people were prepared to think the unthinkable, test it against the evidence and allow the patient voice to challenge professional reassurance. That requires courage, but courage to speak is useful only when an organisation is also capable of hearing what is said.

A psychologically safe organisation is therefore not simply a pleasant place where people feel comfortable. It is an organisation capable of noticing what does not fit, considering explanations it would rather reject, and hearing something it would rather not hear. In that sense the path towards making

the undiscussable discussable begins one step earlier: first we have to be willing to see it and think it.

When the Shadows Become Dangerous

The NHS has had repeated and painful reminders of what can happen when concerns are not heard early enough.

I do not suggest that the Shadow Side alone caused any particular scandal. Serious failures usually have multiple clinical, operational, regulatory and leadership causes. But independent investigations repeatedly describe organisational conditions that are recognisably Shadow Side conditions: concerns that were difficult to raise, professional divisions, repeated warning signals that did not prompt sufficient action, false reassurance, defensive behaviour and an inability to discuss honestly what was happening.

Maternity Services — When Escalation Becomes Unsafe

The Ockenden Review into maternity services at Shrewsbury and Telford found significant failures in governance and leadership, delays in escalation and a damaging “them and us” culture between midwifery and obstetric staff. It also identified a lack of psychological safety that limited the service’s ability to make positive changes. Mistakes were repeated and lessons were not learned.

Consider what that can mean in everyday clinical practice. A midwife sees something that worries her and clinically believes escalation is required. But escalation is never only a technical act; it takes place within a relationship and a culture. If previous challenges have been dismissed, hierarchy has become intimidating or people have learned that raising concerns earns them a reputation for being difficult, the threshold for speaking becomes higher.

The question in someone’s mind can gradually shift from *Is this concern serious enough to escalate?* to *What will happen to me if I escalate it?*

At that point the Shadow Side has entered the clinical pathway.

The East Kent maternity investigation was tellingly entitled *Reading the Signals*. It too described organisational problems that went well beyond individual clinical practice and emphasised the need for the NHS to become better at recognising poor performance, working with a common purpose and responding to challenge with honesty.

“Reading the signals” is an excellent phrase because it takes us back to the organisational antennae discussed in Chapter 3. However, in this case the signals are not usually external – they can be captured in a phrase, a look, an absence, emotion, avoidance, silence, missed reports, and many other subtle

signs that can create an atmosphere contributing to the growing shadows effecting a culture.

The question is whether the organisation is capable of noticing them, and offering enquiry as to what lies beneath the shadow.

Edenfield — When the Board Hears a Different Organisation

The independent review following the abuse exposed at the Edenfield Centre within Greater Manchester Mental Health NHS Foundation Trust provides another disturbing example.

Staff described reaching a point where raising concerns appeared futile. The review reported low incident reporting in some areas and problems with the way information about performance travelled upwards. At senior levels the picture could become opaque and unduly positive, reducing the Board's ability to interrogate what was actually happening. Some staff simply stopped raising concerns.

That is almost a literal description of a Shadow Side becoming organisationally invisible.

Governance processes can continue to exist. Reports still travel upwards, meetings still take place and the Board still receives information. Yet the picture reaching the top can become increasingly disconnected from the experience of people doing the work.

This is one of the most dangerous forms of organisational defensiveness because an organisation can begin to believe its own reassurance.

Nobody necessarily sits down and decides to deceive the Board. Information can be softened, interpreted, filtered and made more presentable as it travels upwards. A difficult story becomes an amber indicator. The amber indicator becomes an improving trend. A worried member of staff becomes someone who “needs more support”.

The organisation remains busy managing information while gradually losing contact with what the information was originally trying to say.

Emergency Pressure and the Importance of Transparency

The COVID-19 pandemic created a very different context, but the procurement of personal protective equipment provides another useful organisational lesson.

Government was operating under exceptional pressure. Vast quantities of PPE had to be acquired rapidly in an international market in which demand

greatly exceeded supply. Normal timescales were impossible and urgency was genuine.

Nevertheless, subsequent National Audit Office examination identified shortcomings in documentation and transparency around aspects of procurement, including how some suppliers were selected and how potential conflicts of interest were considered. It also examined the operation of a high-priority route through which potential suppliers could be referred.

The lesson is not that emergency action should be prevented by bureaucracy. It is almost the opposite.

The greater the pressure to act rapidly, the greater the need for important decisions to remain visible, explainable and reviewable.

Under pressure, shortcuts multiply. Informal influence becomes more powerful, normal challenge may feel inconvenient and people may understandably decide that some questions must wait because action is urgent.

Exceptional arrangements can themselves create risks if they move too far into the shadows. Transparency is not simply an administrative burden. It is one of the ways an organisation protects itself from its own blind spots.

The Ladder of Inference — How Facts Become Stories

Not everything in the Shadow Side begins with fear or power. Sometimes it begins with the way an individual makes sense of incomplete information.

The **Ladder of Inference**, associated particularly with the work of Chris Argyris, remains one of the most useful ways of understanding how quickly we can move from something we observe to something we become convinced is true.

The process can happen almost instantaneously. We observe an event, notice particular aspects of it, give those observations meaning, make assumptions and draw conclusions. We then begin behaving as though our conclusion were itself the observable fact.

In my original example, an organisation facing overspending introduced a recruitment freeze while a senior office completed the recruitment of a post that had already been advertised. From that observable event it would be easy to move rapidly towards a conclusion: senior management are hypocrites who operate one rule for themselves and another for everybody else.

Perhaps that conclusion is correct. Perhaps it is not.

The important thing is knowing which rung of the ladder we are standing on.

This has become even more relevant in a world of rapid digital communication. A short email can be interpreted as dismissive. A name omitted from a meeting invitation becomes deliberate exclusion. A delayed reply becomes evidence that somebody does not care. A decision made elsewhere becomes proof that “they had already decided before consulting us”.

We begin telling ourselves a story, and then we begin telling other people. Before long the story can acquire more organisational reality than the original event.

Coming back down the ladder requires discipline. What did I actually observe? What do I know rather than assume? What meaning have I attached to it, and what evidence would cause me to think differently? Is there a question I should ask before reaching a conclusion?

This is where careful listening and plain speaking, discussed earlier in the book, meet organisational learning.

Single-Loop and Double-Loop Learning

A second Argyris concept worth retaining is the distinction between **single-loop and double-loop learning**.

Single-loop learning asks what went wrong and what needs to change so that it does not happen again. A procedure may be revised, a form changed or staff given additional training. Sometimes that is entirely appropriate.

Double-loop learning goes further. It asks what created the conditions in which the problem became reality in the first place.

Rather than stopping at *Why was the procedure not followed?* we might ask why people had come to regard the procedure as unworkable. Instead of merely reminding staff to speak up, we might examine what happened previously when somebody did. If warning signals were repeatedly discounted, we need to understand why. If poor behaviour was tolerated, what protected it? If senior leaders received false reassurance, what happened to the information on its journey upwards? (one of the simplest and most powerful techniques in examining the root cause of an incident is to use the Why, Why, Why techniques described in *Making Business Work*, MWA Publications)

The original chapter argued that deep double-loop reviews are too often triggered only after events have become catastrophic and external

investigation is unavoidable. I drew partly on my experience working with the airline industry, where the relationship between safety and an open learning culture was much more explicitly understood.

That comparison still matters.

Healthcare is another environment in which decisions can have life-and-death consequences. The quality of those decisions depends not only upon individual competence but upon the learning environment surrounding multidisciplinary teams.

If an incident results only in another instruction telling staff to “be more careful”, we may have learned very little. If it helps us understand why capable people operating within an apparently safe system repeatedly failed to recognise or act upon a risk, organisational learning has begun.

The Conversation We Have — and the One We Do Not Have

Perhaps the most interactive of the Argyris tools is the **left-hand/right-hand-column exercise**.

Most of us have experienced the situation. A meeting begins with a sincere invitation to be open and honest. The discussion proceeds politely. We say something carefully phrased, somebody responds and we nod. Then the meeting ends.

Almost before reaching the door, we realise that we did not say what we were actually thinking. Nor we suspect, did anybody else.

The exercise asks us to reconstruct a difficult interaction. In one column we record what was actually said. In the other we record what we were thinking but chose not to say. With skilled facilitation, the gap between those columns can then be explored: the assumptions, fears, judgements and calculations that sat behind the conversation.

The purpose is emphatically not to encourage people to say every thought that enters their head. That would be neither wise nor kind. Some thoughts should remain unspoken.

The useful question is:

What useful truth am I withholding, and why? What assumptions am I making to lead me to respond or not? What was behind my statement?

I may fear conflict or distrust the other person. I may be uncertain of my evidence. My instinctive language may be accusatory rather than constructive.

I may be protecting my own status, or perhaps experience has taught me that this particular subject is simply not discussable here.

Once we understand the barrier, we have a better chance of finding language that is both honest and useful. Making something discussable is a skill. It is not the same as making it confrontational.

The Chair or facilitator has an important role in creating the conditions for this kind of honesty. Once there is a reasonable expectation of psychological safety, carefully chosen questions can help people move beyond rehearsed positions: what was behind that statement, what led you to act in that way, what were you not saying, what did you fear might happen, and what response did you imagine you would receive? The purpose is not interrogation. It is to help people examine the assumptions, emotions and calculations that shaped what they said or did, so that the real issue can enter the conversation without becoming an accusation.

Plain Speaking Requires Careful Listening

This brings us back to the distinction introduced in Chapter 2.

An organisation that values plain speaking but does not listen can become brutal. An organisation that values listening but avoids plain speaking can become politely dysfunctional.

Healthy organisations need both.

Consider the statement: *"I am concerned that our staffing level is unsafe."* Saying it may require courage. Hearing it without immediately becoming defensive requires maturity. Examining the evidence together requires professionalism. Acting if the concern proves justified requires organisational capability.

That sequence is what turns speaking up into learning. If any part breaks down, the issue may return to the shadows.

Formal organisational charts tell us where authority is supposed to sit. They do not necessarily tell us where influence actually sits.

In the original chapter I argued that formal meetings and policy-making structures account for only part of organisational decision-making. Influence also occurs through corridor conversations, informal meetings, friendships, professional networks and relationships that will never appear on a governance diagram.

That is neither surprising nor necessarily unhealthy. Human beings form relationships. People ask trusted colleagues what they think. Leaders test ideas

privately before presenting them publicly. Clinicians contact colleagues whose judgement they respect.

The Shadow Side question is not whether informal influence exists. It is whether we understand its effect.

Some people have ready access to decision-makers while others rarely enter the informal conversation. A relatively junior person may possess considerable influence because of expertise, relationships or reputation. Someone with considerable formal authority may discover that their title provides surprisingly little ability to persuade others.

Informal decision-making forums are a reality of organisational life. They cannot be abolished by pretending that all influence occurs in formal meetings, but they can be understood. Over the years I have encountered senior colleagues whose real weekly sense-making happened over a Friday drink after work, managers who travelled together and used the journey to exchange rumours and shape decisions, overseas colleagues whose regular social gatherings became an important place for interpreting events, and senior people whose golf circle carried more influence than the formal structure suggested. None of these arrangements is automatically improper. The risk arises when access to the informal network determines whose information is heard, whose career is discussed or which decision has effectively been made before the official meeting begins. Stakeholder analysis is one practical way of bringing some of this hidden social system into view.

Stakeholder Analysis — Mapping Influence as Well as Structure

Begin with a change you want to make, perhaps redesigning a service, introducing a new clinical pathway, altering a structure or solving a persistent problem. Identify those directly involved, but do not stop there. Consider who else could significantly influence success or failure, who controls important resources, who possesses professional credibility and where particularly strong or difficult relationships exist.

This will help to understand the social system through which change will have to travel. It begins to inform a communication and influencing strategy to increase the chance of the change to be successful.

A beautifully rational proposal can fail because its sponsor never spoke to the person whose cooperation was essential. A difficult proposal can succeed because somebody understood where the concerns genuinely lay and took time to build trust before asking for agreement.

Used with a team, stakeholder analysis can be particularly revealing because different people hold different pieces of the organisational map in their heads. One person knows that two senior clinicians have not spoken properly for months. Another knows that an apparently sceptical manager is actually

supportive but fears the effect on their staff. Somebody else knows that a patient group excluded from previous discussions is likely to challenge the proposal publicly.

Put those fragments together and the organisation becomes more visible.

When Workarounds Enter the Shadows

One part of the hidden organisation deserves particular attention: the workaround.

We encountered this in Chapter 4. When an official process does not work, good people often invent another way. They keep a personal spreadsheet, telephone somebody they know, bypass an unreliable referral process or make a handwritten note because two digital systems do not communicate.

In the short term this can be sensible and sometimes essential.

The danger comes when the workaround becomes so normal that nobody remembers the system itself is broken. Worse still, senior leaders may see acceptable performance and conclude that the formal process is working perfectly well when in fact it is not and maybe wasting time and resources.

The workaround belongs in the light, not because staff should be punished for using it but because it tells us something valuable about the organisation. If people continually have to workaround a process to achieve its purpose, the process itself deserves attention.

The workarounds themselves are often very ordinary. A manager telephones a bed manager or consultant they know personally to move a patient through a blocked system. A department brings forward repairs because somebody has a good relationship with the estates manager. A meeting suddenly attracts attendance because the organiser invokes the Chief Executive's interest, even though the Chief Executive may know nothing about it. Wheelchairs are hidden in departmental stores because staff do not trust the formal supply system; linen and other supplies are kept back because previous deliveries have been unreliable. Each workaround may solve an immediate problem, but collectively they can conceal a system that is not working as intended and create unfairness for people without access to the same informal routes and importantly cost the organisation in time, resources and finance.

What Leaders Do With Bad News

Perhaps one of the clearest tests of an organisation's relationship with its Shadow Side is what happens when somebody brings bad news.

The response need not be dramatic to have an effect. A raised eyebrow, a weary sigh, an irritated question or the abrupt change of subject can be enough. So can the reputation of a leader who “doesn’t like surprises”.

Compare two possible responses to an unwelcome concern.

One begins, *“Tell me more.”*

The other begins, *“Why wasn’t this dealt with before it reached me?”*

There may eventually be a legitimate need to ask the second question. But if it is the first response, the person delivering the message learns something about the risk involved in bringing bad news.

One defensive response from somebody powerful can affect what reaches them for months. Eventually a leader can become surrounded by reassurance while genuinely believing they have created an open culture.

This is why openness cannot simply be announced. It has to be **experienced**.

Lightening the Shadows

The aim of OD is not to eliminate the Shadow Side. That would be impossible. Human beings will continue to have informal relationships, private thoughts, political instincts, assumptions and anxieties. There will always be conversations outside formal meetings.

The aim is to prevent important organisational reality from becoming permanently trapped there.

Lightening the shadows means creating conditions in which a significant concern can move from *“Everybody knows but is afraid to say anything”* to *“Can we talk about this?”*

That movement requires skill and the appropriate response will depend upon the situation. Sometimes an issue needs better data. Sometimes it requires a facilitated conversation or a leader willing to acknowledge their own contribution to the problem. A person may need protection before they can speak safely. An organisation may simply need somebody to give a long-recognised problem a name. At other times it must acknowledge that behaviour tolerated for years is no longer acceptable.

Transparency is sometimes misunderstood as exposing everything and everyone. That is not what I mean.

A transparent organisation is one in which important information can move to where it is needed; decisions can be explained; concerns can be raised; mistakes can be examined; assumptions can be challenged; and discrepancies between stated values and actual behaviour can be acknowledged. It also needs accountability.

A non-blame culture does not mean a no-accountability culture. Human error, poor system design, reckless behaviour and deliberate misconduct are not the same things, and a learning organisation needs to be capable of distinguishing between them.

If people believe that every mistake will be punished, they learn to hide mistakes. If they believe that nothing will ever be challenged, harmful behaviour can become normalised.

The objective is neither fear nor permissiveness. It is **fairness, openness and learning**.

From Scandal to Everyday Practice

It is tempting to read reports such as Ockenden, East Kent or Edenfield and regard them as exceptional failures in organisations very different from our own. That would be a mistake.

The conditions described in major inquiries usually begin in much smaller and more familiar ways. A concern is dismissed. One professional group stops listening properly to another. An incident is explained away. A respected person becomes difficult to challenge. A staff-survey result is privately recognised but publicly rationalised. A patient complaint is dismissed as unreasonable because it conflicts with the organisation's preferred view of itself. A Board is repeatedly reassured because the headline data remains broadly positive. None of these means that a scandal is developing.

Each, however, presents an opportunity to learn before events become more serious. The Shadow Side is therefore not primarily a chapter about disasters. It is a chapter about **prevention**.

I remember facilitating a team-development event for staff from a psychiatric forensic unit. The atmosphere was informal and relaxed until I overheard several participants laughing about the way a patient had been restrained and managed. I asked whether this was really how things were done in the unit. At first the question was laughed off, but eventually one person said, quietly and bravely, that it was – and that it was not right. What followed was a much more searching conversation about standards of care. A core group had worked together for a long time and behaviours that would have looked unacceptable to an outsider had gradually become normal to them. Nobody had arrived one morning and decided to lower standards; familiarity had simply made the behaviour harder to see. That is one of the

reasons the Shadow Side matters. Sometimes the first task is not persuading people to speak about what is wrong but helping them see that what has become normal may itself need questioning.

A Practical Shadow-Side Conversation

A leadership team, ward, department or OD practitioner can begin exploring its own Shadow Side without an elaborate diagnostic instrument.

Three areas are worth considering:

What do we discuss easily?

What do we discuss only outside the room?

What do we hardly discuss at all?

The third question may initially produce silence. Stay with it.

Listen for the joke that contains a truth or the phrase “*Well, everyone knows...*”. Notice when somebody begins speaking and then stops, which subjects generate nervous laughter, or whether people glance towards the most senior person before answering.

None of these observations proves dysfunction. They are signals worth approaching with curiosity rather than accusation.

Then bring in the discipline of the Ladder of Inference. What do we actually know? What have we assumed? What would we need to understand better? Is there a useful truth here that we have not yet found a constructive way to discuss? Use left and right-hand column technique to ease out the undiscussable – all of this needs careful facilitation and groundrules but the skills and style of leadership are ones every health service Chief executive can possess and thus modelling culture whereby shadows are few and light.

A More Conscious Organisation

The subtitle of the original chapter described the aspiration as becoming a **conscious, open and wise organisation**. I still like that.

A conscious organisation notices not only what it is doing but how it is behaving while doing it. An open organisation does not automatically interpret disagreement as disloyalty. A wise organisation understands that uncomfortable information may sometimes be more valuable than reassuring information.

The recent history of the NHS provides painful evidence of what can happen when concerns remain unheard, professional divisions become entrenched and the picture seen by leaders becomes more reassuring than the experience lived by staff and patients. The answer, however, is not simply another policy instructing people to speak up. Policies matter. Culture determines whether people use them.

The deeper OD task is to create an environment in which important things can become discussable **early**, while there is still time to learn and improve. That requires leaders willing to hear unwelcome messages, staff capable of challenging professionally, systems that make concerns visible and relationships strong enough to tolerate honest conversations.

It requires us to notice when we have climbed too quickly up the Ladder of Inference and to use double-loop learning when merely correcting the latest incident will not be enough. It requires attention to both the conversation we are having and the one we are avoiding.

Above all, it requires enough organisational humility to accept that what we say about ourselves may not always be what other people experience.

The Shadow Side will always exist. The question is how dark we allow it to become.

Making the undiscussable discussable — carefully, honestly and at the service of learning — is how we begin to let in the light.

Leading Continuous Improvement — The Facilitative Leader with Vision

A member of staff walks into a manager's office with a problem.

The first manager listens for a few minutes and says, "Leave it with me. I'll sort it out."

The second listens just as carefully but responds differently. "Show me what is happening. What do you think is causing it? What are you trying to achieve? Who else needs to be involved? And what do you need from me?"

Both managers may be trying to help, but they are doing two very different things.

The first takes responsibility for solving the problem. That may be entirely appropriate if the matter is urgent, serious or beyond the employee's authority. But if it becomes the leader's habitual response, something else begins to happen. Problems travel upwards. The manager becomes increasingly busy solving them, while those closest to the work become increasingly dependent upon someone else for solutions. The senior manager spends most of their time managing downwards rather than across or up. Dependency becomes the norm and initiative is stifled.

The second manager is trying to build the person's ability to understand and improve the work themselves. Accountability has not disappeared and the problem still matters, but ownership is not immediately taken away. Instead, the problem becomes an opportunity to develop capability.

That distinction lies at the heart of what I mean by **facilitative leadership**.

When I first wrote this chapter, I argued that if continuous improvement was ever to become part of the culture — simply *the way we do things around here* — then the values of learning had to be visible in the behaviour of leaders at every level. I also argued that leadership was one of the factors most capable of making or breaking the development of an improving organisation. I would make the same argument today.

Methods, data, structures and improvement tools all matter, but people learn what the organisation truly values by watching what leaders do, particularly when circumstances become difficult. I have worked with leaders whose everyday behaviour conveyed messages they did not consciously intend. One Chief Executive chaired a regular Monday meeting and, when asked what time it would finish, replied that it would end when he said it ended. Another routinely told staff never to bring a problem without a solution. A third

walked the corridors with such a stern and distant manner that staff interpreted his behaviour as a wish not to be approached. Each believed they were demonstrating strength or efficiency; each was also shaping a culture in which status, self-protection or reluctance to bring bad news could flourish. Coaching helped them see that leadership is communicated as much through small habitual behaviours as through formal statements of values.

What Do We Believe About People?

Leadership behaviour is significantly influenced by the assumptions and beliefs we hold.

If I believe that most employees avoid responsibility unless closely controlled, I am likely to create systems of supervision, approval and monitoring that reflect that belief. If I assume people cannot be trusted to make sensible decisions, I will make most of the decisions. If mistakes are treated mainly as evidence of incompetence, people will learn to conceal them.

The organisation we create may then appear to prove our assumptions correct. Employees wait to be told what to do, avoid taking risks and send decisions upwards. In this way it is possible that the top team have helped create the behaviour and organisational culture they complain about. For a senior team to recognise and own this possibility is a crucial and fundamental step in creating a culture change programme.

In the original edition of this book I wrote that people generally **want to do a good job, are capable of improving what they do and would prefer to enjoy their working lives rather than endure them**. Leaders who genuinely believe this, who listen to staff and try to understand the realities of their working lives, are more likely to create trust, motivation and commitment.

That does not mean everyone is always motivated, competent or cooperative. Anyone who has managed people knows otherwise. Poor performance sometimes has to be confronted. Standards must be maintained and difficult decisions have to be made.

But the dominant assumption still matters because it shapes the environment people work in. Do we start from the belief that people are potentially part of the solution, or from the assumption that they are a problem requiring control? Eventually, those beliefs become visible in leadership behaviour.

Leadership at Every Level

I have used the phrase **leadership at every level** throughout this book because I do not regard leadership only as the privilege of the person whose name appears at the top of an organisational chart.

Formal leaders carry particular responsibilities. A Chief Executive, Medical Director or ward manager cannot simply hand those responsibilities to somebody else. But leadership is also demonstrated whenever someone influences what happens next.

The domestic assistants who questioned the routine replacement of almost-full water jugs demonstrated leadership because they noticed something, questioned whether it made sense and initiated a conversation that improved patient care. The nurse who raises a concern when remaining silent would be easier demonstrates leadership. So does the receptionist who notices that confused patients repeatedly telephone about the same letter and suggests rewriting it, or the clinician who actively invites a junior colleague to challenge their reasoning.

A manager who is prepared to say at a Board meeting, “I don’t think the picture we are presenting reflects what staff are actually experiencing,” is demonstrating leadership too.

The authority is different. The responsibility is different. The willingness to influence improvement is the common thread.

My original wording was that anyone who has responsibility for people **or the opportunity to innovate or improve their own work situation** is in a position to demonstrate leadership. I would still defend that proposition.

For leadership at every level to mean anything, however, the organisation has to make room for it. Telling people they are empowered while requiring several layers of approval before they can change a minor process simply creates frustration.

The Facilitative Leader

The word *facilitate* literally means ‘making something easier.’ That is not the same as making everything easy.

A facilitative leader helps people understand problems, think, learn, make decisions and improve the work. They do not necessarily provide the answer themselves.

Sometimes that means asking a useful question instead of giving advice. At other times it means removing a barrier that a team cannot remove alone, giving permission to test an idea, providing resources, bringing the right people together or protecting a team sufficiently for them to experiment and learn.

However, there are times when direction is appropriate. Healthcare creates situations in which an immediate decision is required. A clinical emergency

is not the moment to convene a participative workshop about everyone's preferred way forward. Serious misconduct requires clear action. A major safety threat may demand firm instruction.

Good facilitation is the ability to recognise what the situation requires while retaining a broader intention to develop rather than diminish the capability of other people.

That was the purpose of the leadership spectrum I included in the original edition, drawing on situational leadership thinking. It moved from directing and coaching through supporting to delegating. My argument was not that one style should be used regardless of circumstances, but that leaders should be able to adapt while retaining a predominantly facilitative orientation.

The danger lies in allowing one style to become habitual. The directive leader may end up solving everything. The endlessly consensual leader can avoid difficult decisions. The delegating leader may abandon people who genuinely require support. Even the coaching leader can become irritating if every simple request is answered with another question.

What Staff Told Me They Valued

During my time as an internal OD consultant with British Telecom, and as part of my Master's research, I wanted to understand leadership from the perspective of those experiencing it.

Rather than beginning with another theoretical model, I asked staff what behaviours they valued in leaders when they were being asked to cope with change and innovation.

Using personal construct techniques, a remarkably coherent picture emerged.

The highest-rated behaviour was not charisma, strategic brilliance or decisiveness. People valued leaders who **knew what their staff were capable of, encouraged them and took seriously their feelings and aspirations.**

They also valued strength of purpose. They wanted leaders prepared to deal directly with difficult issues rather than avoid them. They valued managers who worked hard, saw themselves as part of the team, remained approachable and dependable, listened properly and showed genuine interest in other points of view.

They wanted leaders who acted rather than endlessly discussed, but who were also prepared to explain decisions and listen to arguments before making them. They valued delegation when it came with trust rather than abandonment, and they wanted managers who asked for ideas and were prepared to change their minds when presented with a better argument.

They also valued leaders who could see beyond the immediate task — people who understood the wider organisation and could connect the work of the team with something larger.

Looking back at those findings more than twenty years later, I am struck less by what has dated than by what has not.

The language of leadership may have changed. We have discussed transformational leadership, compassionate leadership, inclusive leadership, collective leadership and systems leadership, among many other formulations.

Yet people still appear to want something recognisably human from those who lead them.

They want to be noticed, listened to and taken seriously. They want clarity and enough explanation to understand decisions that affect them. They want leaders who have the courage to tackle important matters, who can be trusted, and who have some sense of where the organisation is going.

One finding from that research has stayed with me particularly strongly: *people valued leaders who knew their abilities, encouraged them and took an interest in their aspirations.*

It sounds almost embarrassingly obvious. Yet many employees have experienced development primarily through a formal appraisal process. Sometimes it happens annually, sometimes twice a year, and sometimes — despite policies saying otherwise — barely at all.

I have met people who dreaded appraisal because it felt less like a developmental conversation than an annual judgement. The paperwork was completed, objectives entered into a system, training needs identified and everyone returned to work.

A genuine developmental conversation can be much simpler and more useful. A manager may say, “I’ve noticed you’re particularly good at this. Is it something you enjoy? Where would you like to develop? Is there something you’re capable of that we are not making use of?”

That conversation does not require a form, nor does it need to wait eleven months for the next appraisal cycle. The facilitative leader develops people in the course of ordinary work.

The second most valued behaviour in my research was **strength of purpose and willingness to tackle important issues head-on, however difficult.**

Listening is not leadership if nothing ever follows. Involving people does not mean endlessly postponing a decision until everyone agrees. Coaching is not a substitute for confronting unacceptable behaviour.

A facilitative leader may listen widely, encourage challenge and remain open to persuasion, but eventually somebody may still need to say, “This is the decision,” or “This behaviour cannot continue,” or “We have heard the arguments, but we cannot afford to keep doing this.”

The best leaders I have known have been able to create room for disagreement while retaining a clear sense of what ultimately matters.

A leader can make an excellent presentation about organisational values and destroy the message five minutes later by the way they speak to someone.

Staff watch what leaders pay attention to, what they ask about, what they praise and what they tolerate.

If a Trust says staff wellbeing matters but senior leaders routinely send non-urgent emails through the night and expect immediate replies, people notice. If openness is one of the stated values but leaders react angrily when challenged, people notice that too. If patient-centred care is proclaimed while operational meetings concentrate solely on targets and finance, the omission itself becomes a message.

The real leadership communication system is not simply newsletters, presentations or briefings. It is behaviour.

Vision therefore has to be communicated with conviction, but it also has to be **acted out**. The leader who wants an improving organisation has to demonstrate curiosity about improvement. The leader who wants openness has to tolerate difficult information. The leader who wants staff to take responsibility must occasionally resist taking that responsibility back from them. And the leader who talks about learning has to be capable of acknowledging that they were wrong and be prepared to demonstrate acting on their own development.

The Shadow Side explored in the previous chapter provides one of the clearest tests of leadership behaviour.

Imagine a member of staff saying to a senior leader, “I don’t think the report you are receiving reflects what is actually happening.” Everything that follows matters.

The leader could become defensive, personalise the concern or dismiss it as anecdotal. Or they could become curious and say, “Tell me what you are seeing.” The difference may appear small. Organisationally, it is enormous.

People learn whether speaking up is genuinely valued by what happens when they speak. One poor response from someone with authority can travel remarkably quickly through an organisation.

I once worked with a Board that regarded inviting staff to present improvement projects as a form of recognition. After watching one visibly nervous team being questioned in a style that felt more like interrogation than interest, I asked the Board to consider the experience from the other side of the table. If an invitation intended as a reward leaves people feeling diminished, the message that travels back through the organisation will be very different from the one the Board thought it was sending. The question for the Board was simple: how did they want people to experience them?

The facilitative leader contributes directly to psychological safety. They do not promise that every concern will prove justified or that every suggestion will be accepted. They create confidence that concerns can be explored seriously without the act of raising them becoming the problem.

Continuous Improvement Is a Leadership Practice

The NHS now has a formal improvement approach in **NHS IMPACT — Improving Patient Care Together**, and what interests me particularly is how closely its leadership principles reflect the approach I was advocating more than twenty years ago.

Its emphasis on shared purpose, people and culture, leadership behaviour, improvement capability and embedding improvement into management systems reinforces a central point: continuous improvement cannot be delegated to an Improvement Team while everyday management behaviour remains unchanged.

If every problem still travels upward for permission, there is no continuous improvement culture. If improvement only happens inside formally designated projects, the organisation has not yet made improvement part of ordinary work. If staff can suggest ideas but need several layers of approval before they can test anything, ownership remains theoretical.

Improvement becomes cultural when people routinely notice something that could work better, feel able to investigate it, have access to appropriate methods and support, test a change sensibly, learn from what happens and share what they have learned. Leadership creates the conditions in which that becomes normal.

Leaders Need to Go Where the Work Is

One danger of seniority is distance. As responsibilities grow, leaders spend more time in meetings, reviewing information and discussing performance. Their picture of the organisation becomes increasingly mediated through reports, dashboards and other people's summaries. Those things are necessary, but they are not sufficient. Some organisational knowledge has to be experienced.

A leader needs occasionally to walk through the department, sit with the team, watch how a patient moves through a service and listen to how work is actually discussed at handover. They need to ask people what makes their work unnecessarily difficult, what they are compensating for and what they would improve if they had the authority and support to do so.

Perhaps the most useful question a senior leader can sometimes ask is:

“What do you think I don't know?”

That question matters because it reverses the usual flow of authority. It signals that the leader expects the people closest to the work to possess knowledge that may not yet have reached them.

This is not leadership by wandering around for appearance's sake. The leader has to listen in a way that makes the visit worth having. If every visit produces a new list of instructions, staff soon learn to hide problems before the next one.

I once worked with a senior leader who very rarely left what staff jokingly called the “corridor of power”. On one occasion he visited a ward to see a new piece of equipment. The rumour spread quickly that the ward must be in serious trouble for the boss to appear in person. Nothing he had said created that interpretation; his previous distance had done it for him. Visibility cannot be manufactured occasionally. It becomes credible when it is part of the normal relationship between leaders and the people doing the work.

Creating Capability Rather Than Dependency

There is a simple way of judging whether facilitative leadership is working.

Over time, is the team becoming **more capable of solving its own problems or more dependent upon the leader?**

A strong leader can sometimes become indispensable for the wrong reasons. Everything runs through them. They know every detail. People trust their judgement and wait for their decision. The leader feels needed. Then the leader leaves and suddenly nobody is quite sure what to do.

One of the leader's responsibilities is to develop capability that survives their absence. A good ward manager should leave behind people who are more confident in making appropriate decisions. A good Chief Executive should help create an executive team capable of leading rather than simply following. The same principle guided my own consultancy: my objective in every contract was to make myself redundant as quickly and effectively as possible by leaving the organisation better able to sustain its own development and continue improving without me.

There is another reason facilitative leadership matters so much in today's NHS.

Many of the problems that most need solving cannot be commanded through a single hierarchy. A Chief Executive cannot simply order another organisation to share their priorities because the idea seems sensible. Leadership becomes relational. People need to develop shared purpose, understand different pressures, negotiate, persuade and create sufficient trust to act together.

One of the paradoxes of leadership is knowing when your presence helps and when it gets in the way.

There are moments when people need to see the leader clearly at the front: during crisis, when values are under threat, when a difficult decision needs owning or when organisational anxiety requires visible direction, when motivation or celebration and recognition is required. At other times the leader's most useful act may be to step back.

Let somebody else chair the meeting. Allow the person closest to the work to present the solution. Ask the question and tolerate the silence rather than answering it yourself. Give the team enough room to discover that they can solve something without you.

A Contemporary Test of Leadership

I would not recommend another long leadership checklist. A more revealing exercise may simply be to observe an ordinary management meeting.

Notice what happens when someone raises a problem. Does the manager immediately provide the answer, or do they help people explore what is causing it? Can the most senior person be challenged? Does the discussion stay connected to what the team can actually influence? What happens emotionally when somebody admits a mistake? Are patients discussed as human beings or mainly as activity and numbers?

Notice too who speaks most, who speaks least and who appears to have learned that contributing is not worth the effort.

When the meeting ends, ask whether people leave with greater clarity and ownership or simply with another set of instructions.

Leadership culture is often visible in a single hour if we pay attention to the right things. The NHS senior executive/manager/clinician all need to be equipped with these essential chairing skills.

Leading Improvement

I began this chapter with two managers responding differently to the same problem.

There will be times when the first response — *leave it with me* — is exactly what a responsible leader should say.

But an organisation in which everyone continually leaves problems with somebody more senior will eventually become overloaded at the top and underdeveloped below. Continuous improvement requires a different pattern.

The leader listens and helps people understand the problem rather than simply react to it. They connect the issue with wider purpose, create access to information and expertise, bring people together when boundaries are getting in the way and provide enough authority and protection for ideas to be tested safely. They also challenge when standards fall, make decisions when they are needed and acknowledge mistakes when they have made them. And, increasingly, they allow people to discover that they can improve things themselves.

That was the proposition I made in 2003, and it is one I would make even more strongly today.

If continuous improvement is to become part of NHS culture rather than another programme, leadership cannot be something performed only by the people at the top. Senior leaders have a particular responsibility to create the conditions, but the real evidence of success will often be visible much further down the organisation.

Perhaps on a ward, in an outpatient department, in a laboratory or in an office, somebody notices something that could be better and feels sufficiently trusted to say:

“I think we could improve this.” And the person leading them replies: “Tell me what you’re thinking.”

Beyond Change Management — Leading Culture Change

When I was asked to support Alder Hey Children's Hospital, the organisation was living through one of the most difficult periods in its history.

The organ-retention scandal had profoundly damaged public trust in an institution internationally recognised for the care of children. The consequences were not confined to newspaper headlines, government inquiries or Board meetings. They were being experienced personally by people throughout the hospital.

I remember nurses telling me that they were reluctant to display their uniforms when travelling to and from work because of the public anger associated with the Alder Hey name. These were people who had devoted their working lives to caring for sick children, yet the name of the hospital in which many had previously taken enormous pride had become associated nationally with something deeply distressing.

For the families involved, of course, the consequences were incomparably greater. Parents had discovered that organs and tissue from their children had been retained without appropriate consent. Some families subsequently faced the further distress of having returned organs buried. Nothing an Organisation Development programme could do should diminish the seriousness of what had happened or the suffering of those families.

The question for the organisation was how it could acknowledge and learn from that past while enabling thousands of people who were continuing to provide care to create a different future.

Tony Bell OBE was Chief Executive during this extraordinarily difficult period and brought me into Alder Hey to help with the organisational and cultural recovery. I admired Tony for his leadership, particularly from watching how he behaved when leadership was genuinely difficult.

He understood something fundamental about culture change.

You cannot instruct people to become proud again. Nor can a Board agree a new set of values, publish them around the hospital and declare that the culture has changed.

People have to experience something different.

Tony wanted Alder Hey once again to be an organisation in which people could take legitimate pride, but that pride had to be rebuilt through what people achieved together. Staff throughout the organisation therefore became involved in improvement activities, collaborative working and learning.

We called the programme **Excellence through Learning**.

That name mattered. We were not attempting to recreate yesterday's Alder Hey. The organisation had to learn from what had happened and use that learning to become better at everything it did.

Culture change has to be designed in — and then sustained.

Organisational culture is often described as *the way we do things around here*. It is a useful shorthand, but culture goes deeper than routines. Culture is also what people learn to expect.

People learn what happens when someone disagrees with a senior colleague, when something goes wrong or when a patient or relative raises an uncomfortable concern. They learn who is listened to, who makes decisions, what gets rewarded and what gets ignored. They learn whether uncertainty can be admitted, whether departments genuinely cooperate, and whether the organisation really wants to learn.

The written culture and the experienced culture can therefore be very different.

This is why culture change is so difficult. We are not simply changing what people say they believe. We are changing patterns of behaviour, relationships, expectations, systems and experience that may have developed over many years.

For me, the central proposition is now clear: culture changes when leaders change first. That does not mean senior leaders can change culture by themselves, but they have a disproportionate responsibility for creating the conditions in which change becomes credible. They need sufficient self-awareness to understand how their own behaviour affects other people, sufficient openness to learn about themselves, and the capacity to model that learning in ways that make it safer for others to question, speak and lead. Any serious culture-change programme must therefore be bespoke to the organisation and visibly led from the top, while deliberately building leadership and learning at every level.

Culture Change Is a Process, Not an Event

Over the years I have watched organisations announce culture-change programmes with considerable enthusiasm. There is a launch, senior leaders make presentations, values are introduced, workshops take place and posters appear. Sometimes everybody receives a card containing the new values.

For a while the organisation talks about culture.

Then operational pressures intervene. Meetings become less frequent. Leaders move on. Another national initiative arrives. The improvement team acquires different priorities. The posters remain on the walls long after the conversations that produced them have stopped.

The organisation has experienced a **culture-change initiative**.

It has not necessarily experienced culture change.

My experience has led me to think of successful cultural development as a process moving through recognisable phases. The phases should never become a rigid formula because organisations are different, but they help us remember that culture change needs both **design and continuity**.

Diagnosis without action achieves little. Action without involvement creates resistance or compliance. Training without opportunities to apply learning becomes an educational event. Improvement without reinforcement gradually disappears. A programme that never stops to learn can become as rigid as the culture it was intended to change.

There Is No Standard Culture-Change Package

There are useful principles, frameworks and methods, and we should learn from them. But the actual change process has to belong to the organisation.

In 2006 Alder Hey's Excellence through Learning programme received national recognition in the Excellence in Human Resource Management Awards, winning the Organisational Learning category and then the overall award for Excellence in Human Resource Management. Alder Hey's own annual report described the programme as a best-practice model for leading organisational cultural change.

Alder Hey's culture-change process could not simply have been lifted from another hospital. Its history mattered. Its people mattered. Its reputation mattered. Its relationship with children and families mattered. The circumstances that had brought the organisation to that point mattered.

The same was true elsewhere in my NHS work.

At Aintree, the challenge involved bringing Walton and Fazakerley together and developing a unifying identity and culture that became Aintree Hospitals. At the Royal Liverpool, the emphasis included engaging the whole organisation in improvement, gaining medical cooperation and developing a culture capable of supporting the transition towards a new hospital. At Leeds Teaching Hospitals, **Achievement through Cooperation** involved culture change from the top team throughout the organisation, supported by facilitator development and improvement projects across departments.

In Caithness and Sutherland **Quality through Leadership**, the emphasis included top-team development and leadership at every level. Here, geography itself influenced the approach: communication and leadership across a widely dispersed health community mattered, alongside coaching senior managers and developing project managers as facilitators.

Bespoke culture-change programmes can draw on sound principles and established methods, but the process has to be designed around the organisation's particular history, needs, people and purpose. This is not an argument for inventing everything afresh. It is an argument against assuming that a package which worked elsewhere can simply be transplanted into a different organisational culture.

Begin by Understanding What Already Exists

Chapter 3 argued for diagnosis before intervention. Nowhere is that more important than in culture change.

No organisation starts without a culture, and very few cultures are simply good or bad.

A culture that now appears dysfunctional may contain behaviours that once served a useful purpose. Strong professional identities can produce extraordinary expertise and commitment while simultaneously creating boundaries between groups. Fierce departmental loyalty can generate pride while making collaboration difficult. A command-and-control culture may have developed partly because the organisation once faced serious performance problems requiring greater discipline.

Before trying to change a culture, therefore, we need to understand it.

That means looking at what should be preserved as well as what needs strengthening or changing. It means paying attention to what people are proud of and frustrated by, which behaviours are rewarded or tolerated, and what patients and families actually experience. It also means comparing what the organisation says about itself with what people really experience.

The Shadow Side discussed in Chapter 7 is part of that diagnosis. Culture-change programmes that examine only the visible organisation are likely to leave some of the most influential aspects untouched.

Values Have to Run Through the Process

At Alder Hey, values were not intended simply as an outcome of the culture-change programme. They were designed into the way the programme itself operated. This is an important distinction.

If participation matters, the change process itself should be participative. If learning matters, people need opportunities to learn while change is taking place. If openness matters, difficult information cannot be suppressed because it is inconvenient to the programme. If collaboration matters, the whole process cannot be designed within a small corporate group and then cascaded downwards.

The method of changing the culture should demonstrate the culture we are trying to create.

At Alder Hey we developed a set of guiding principles around the word **CHILDREN**. This was not simply a convenient mnemonic. It connected the cultural aspirations directly with the purpose and identity of a children's hospital.

CHILDREN

C — Communicating

Communicating with staff, patients, families and the community using up-to-date, relevant information.

H — Honesty

Honesty and openness in our ways of working.

I — Innovation

Maintaining and building upon Alder Hey's reputation for being at the forefront of paediatric healthcare.

L — Leadership

Everyone taking responsibility for improving the way we work.

D — Developing staff

Helping people reach their full potential.

R — Respect

Respect for children, families and each other.

E — Energy and enthusiasm

Creating a healing, creative and healthy working environment.

N — National pride

The final principle was particularly significant given where the organisation had started.

Pride could not simply be demanded. But it could become possible again.

The CHILDREN principles gave people a way of connecting improvement with what Alder Hey existed to do. More importantly, they could be translated into behaviour. Communication, honesty, innovation, leadership, development and respect were all things people could actually demonstrate in the way they worked.

Start at the Top — But Do Not Stop There

There is an uncomfortable truth about many culture-change programmes: senior leaders identify behaviours they would like everyone else to adopt, staff are then sent on development programmes, and the senior team carries on much as before. Tony Bell understood why that could not work.

As part of *Excellence through Learning*, Tony and his Executive Directors developed **Top Team Standards** against which they explicitly committed themselves to being evaluated.

Those standards included visible leadership through regular contact with staff, partners and community organisations and through visits to service areas. They committed themselves to maintaining a patient focus in what they did and to understanding the working environment and the pressures other people had to manage.

They also undertook to support personal development, self-management, self-regulation and accountability; to manage resources in ways that promoted improvement in health and health services; and to regard the progress of other people and partners as an important measure of their own success. Strong, open and honest working relationships, based on mutual trust and respect, good communication and flexibility in responding to difference, formed another part of the standards. These were demanding expectations.

What gave them additional credibility was that Tony did not exempt himself or his Executive team from the development being undertaken elsewhere. I took Tony and his top team through the facilitator development training programme that he was advocating for others.

That sent a message more powerful than any poster:

We are part of the change too.

Senior leaders have disproportionate influence over organisational culture. People watch them closely. If a Chief Executive talks about openness but cannot tolerate disagreement, the lesson travels quickly. If executives advocate collaboration while fighting territorial battles among themselves, staff notice. If senior leaders expect everyone else to undertake development they consider unnecessary for themselves, people notice that too.

Culture change therefore needs to begin at the top. But it must never remain there.

Facilitators as Carriers of Culture

One approach I have repeatedly used in Organisation Development is to develop people inside the organisation who can facilitate improvement themselves.

There are practical reasons for this. No external consultant can possibly facilitate every conversation or improvement project in a large NHS organisation. But there is a more important reason. It builds internal capability.

People learn how to bring colleagues together, understand problems, manage difficult conversations, examine processes and facilitate improvement. They then take those skills back into their everyday working relationships.

The facilitator therefore becomes more than somebody who runs meetings. They become one of the **carriers of the developing culture**.

This is why training on its own is insufficient. People need real organisational problems on which to use what they are learning.

Improvement Projects Are Also Culture-Change Projects

An improvement project normally has an obvious practical objective. It may aim to reduce delays, improve communication, redesign a pathway, remove duplication or improve the patient experience.

But well-designed improvement projects can achieve something else at the same time. They can change relationships.

A doctor, nurse, receptionist, manager and administrator who have rarely worked together may begin examining a problem jointly. People discover

what happens elsewhere in the process. Assumptions are challenged. Someone who has never previously been asked for an opinion contributes an idea that changes the solution.

The process improvement may be useful. But something else has happened: people have experienced a different way of working.

This is why I regard improvement activity as one of the most powerful potential mechanisms for culture change. Instead of asking people to attend a workshop to discuss collaboration, we give them something worthwhile to collaborate **on**. Instead of lecturing people about empowerment, we give them genuine responsibility for improving their work. Instead of talking endlessly about breaking down silos, we design improvement work that requires people to cross boundaries and break down rigid structures.

Involve the Medical Profession

Any serious attempt at NHS culture change that fails to engage doctors is unlikely to succeed.

This does not mean doctors are uniquely resistant to change. It means that clinical authority, professional autonomy and medical influence form substantial parts of the organisational system.

At the **Royal Liverpool Hospital**, and **Alder Hey** gaining medical cooperation was therefore an important part of preparing the organisational culture for the future hospital. The Medical Directors were actively involved in leading aspects of the culture change programme. Balancing the sensitive influences of management and clinical priorities.

The same principle applies more widely. Culture change cannot belong to management while clinicians observe it from outside. Nor can it belong to clinicians while managers are portrayed simply as bureaucratic obstacles. Nurses, allied health professionals, administrative staff, estates, domestic services, scientists and many others all experience different parts of the organisation. Finding leaders in each department is key to ownership and sustainability.

Ownership Cannot Be Cascaded

The word *cascade* has been used frequently in organisational change.

The Board develops the strategy, passes it to senior managers, who pass it to managers, who eventually pass it to teams. Information can be cascaded.

Ownership cannot.

People are much more likely to own something when they have had a meaningful opportunity to influence it, understand why it matters and connect it with their own work.

That does not mean thousands of employees collectively decide every organisational issue. Leadership still involves choices and decisions. But involvement should be genuine enough to affect what happens.

Pseudo-participation is quickly detected. If everything important has already been decided, we should be honest about that rather than running a workshop designed to give the appearance of involvement.

The Phases Need Sustaining

Culture change also has a time dimension that is easily underestimated.

Initial enthusiasm is relatively easy to create. Sustaining different behaviour is much harder.

As a programme develops, leadership attention has to remain visible. New people need bringing into the process. Facilitators need support. Improvement work needs reviewing. Successful practice needs spreading. Problems need surfacing rather than being interpreted as evidence that the programme is failing.

Organisational systems also need gradually to align with the desired culture.

Eventually, if culture is genuinely changing, the programme itself should become less visible because its principles are becoming embedded in ordinary management and clinical practice.

That is very different from the programme simply fading away.

In summary here are the phases of culture change

The Phases of Sustainable Culture Change

Understand.

Begin by understanding the organisation as it really is, not simply as senior leaders believe it to be. Listen to patients and staff, examine data, observe behaviour, understand the history, identify strengths as well as problems, and pay attention to the Shadow Side. Culture change begins with diagnosis.

Engage.

Bring people into the process early enough for their experience to influence what happens. This includes staff at different levels, clinicians, managers, patients, families and, where appropriate, partner organisations. Engagement

is not asking people to endorse a solution that has already been decided. It is involving them in understanding what needs to change and why.

Design.

Create a change process that reflects the needs of that particular organisation. The process should embody the culture you are trying to create. If openness matters, the process must be open. If involvement matters, people must have genuine influence. If learning matters, the programme itself must be capable of adapting as experience develops.

Develop Capability.

Start at the top – engage the Board in the practicalities, development needs and consequences of a culture change programme.

Do not make the organisation dependent upon a small group of specialists or external consultants. Develop leaders, facilitators and staff throughout the organisation who can help others think, question, improve and manage difficult conversations. Culture becomes sustainable when the organisation develops its own capacity to change.

Act and Improve.

Culture change cannot remain a discussion about values and behaviour. People need opportunities to work together on real organisational problems. Improvement projects, process redesign, service changes and everyday problem-solving give people the experience of working differently, and it is through those experiences that culture begins to shift.

Learn.

Review what is happening. Ask what is working, what is not, what has been unexpected and what needs to change. Listen again to patients and staff. Encourage honest feedback and be prepared to alter the programme itself. A culture-change process that cannot learn will eventually reproduce the very rigidity it was intended to challenge.

Reinforce.

Different behaviours need to be supported by the organisation around them. Leadership practice, recruitment, development, appraisal, governance, performance measures, resource decisions and what senior leaders reward or tolerate should all reinforce the culture the organisation says it wants. Otherwise, the old culture will gradually reassert itself.

Renew.

No culture is finally completed. Leaders change, staff change, pressures change and the environment changes. What worked five years ago may no longer be sufficient. A healthy organisation periodically revisits its purpose, behaviour and assumptions and asks what now needs to develop. Renew, recognise or refresh – momentum of change can be enhanced by recognising and rewarding success.

These phases are not a straight line. An organisation may need to return to understanding when new information emerges, strengthen engagement when ownership weakens or renew the process when circumstances change. In that sense the final phase leads naturally back to the first.

The objective is not to complete a culture-change programme. It is to develop an organisation increasingly capable of understanding, improving and renewing itself.

Culture Change Cannot Depend Upon One Charismatic Leader

Tony Bell's leadership mattered enormously at Alder Hey. But successful culture change cannot ultimately depend upon one individual, however good that leader may be.

If the culture collapses when the Chief Executive leaves, the organisation has not yet embedded the change deeply enough.

The leader's task is therefore paradoxical. They need to provide visible commitment and energy while simultaneously building leadership capability throughout the organisation so that improvement becomes progressively less dependent upon them.

This is another reason Tony's willingness to participate personally in facilitator development mattered. He was not presenting himself as the person who would repair Alder Hey. He was helping develop an organisation increasingly capable of improving itself.

Rebuilding Pride at Alder Hey

I remain cautious about presenting organisational recovery as a simple success story. Culture change is rarely that tidy.

Alder Hey's history could not be erased, nor should it have been. The experience of the families affected by the organ-retention scandal remains part of that history. But organisations also contain thousands of other experiences.

Children continued to receive extraordinary care. Staff continued to develop expertise. Research and innovation continued. Families continued to depend upon the hospital at some of the most frightening moments of their lives.

The task was therefore not to replace an uncomfortable story with a more flattering one. It was to enable the organisation to learn from what had happened while rediscovering what was valuable about itself.

The word **National pride** in CHILDREN was consequently not about institutional vanity. It was about reconnecting people with purpose.

There is an enormous difference between saying "*You should be proud to work here*" and creating experiences through which people begin saying "*I am proud of what we are achieving together.*"

Designing Culture Change in the NHS

Every NHS organisation will need its own process, but experience has left me with some questions I would now ask of any proposed culture-change programme.

A Culture-Change Design Test

Ask	Why it matters
What are we trying to preserve as well as change?	Existing cultures contain strengths as well as problems.
What do patients, families and communities currently experience?	Culture should ultimately be visible in the experience of care.
What do staff currently experience?	Published values cannot substitute for organisational reality.
Have senior leaders examined their own behaviour first?	Leaders cannot credibly require changes they are unwilling to make themselves.
Are the desired values designed into the change process itself?	A participative culture cannot be created through an entirely imposed process.
How will people throughout the organisation genuinely participate?	Ownership requires involvement.
What real work will people improve together?	Culture develops through shared experience, not discussion alone.
How are we developing internal facilitators and improvement capability?	Sustainable change requires capability within the organisation.
Which organisational systems currently reinforce the old culture?	Behaviour follows systems and incentives as well as values.
How will we know whether people's experience is actually changing?	Activity measures do not demonstrate culture change.
What happens when leadership changes?	The culture must eventually become stronger than the programme or its sponsor.
How will we renew rather than merely sustain?	Healthy cultures continue learning rather than becoming a new orthodoxy.

Beyond Change Management

Large programmes need plans, milestones, responsibilities, resources, governance and risk management. A new hospital cannot be built through goodwill. A digital system cannot be implemented without disciplined programme management. Organisational mergers require enormous practical coordination.

But culture cannot be project-managed in quite the same way. We can manage the **processes intended to influence culture**. We cannot command the culture itself to change by a particular date.

Culture emerges from what people repeatedly experience: how leaders behave, how colleagues relate to one another, what happens when something goes wrong, whether patients are genuinely listened to, whether improvement is encouraged, whether learning follows failure, whether organisational boundaries help or hinder work, and whether stated values survive contact with operational pressure.

That is why culture change has to be designed. And why the design has to be sustained. But it is also why the process must eventually belong to the people living within it.

My experience at Alder Hey reinforced this more powerfully than almost anywhere else I have worked. I entered an organisation whose public reputation and internal confidence had been profoundly damaged. I watched a Chief Executive and senior team willing to participate in the same development they were asking others to undertake, and I saw people throughout the hospital becoming involved in improving their own work and working differently with one another.

The Journey Continued

More than twenty years after my work at Alder Hey, I became curious about what, if anything, remained of *Excellence through Learning*. I expected that the title would have disappeared long ago and that any identifiable connection with the work Tony Bell and his team began in those difficult years would now be impossible to trace.

I was therefore surprised — and rather moved — to discover that Alder Hey's own account of its improvement history still identifies **Excellence through Learning, 2002–2007**, as the first of the foundations in what it describes as its *journey to outstanding*. It places that programme at the beginning of a continuing sequence: **Rapid Improvement and Service Transformation from 2007 to 2010**, followed by the development of programme-management capability from 2010 onwards. Later phases included **Listening into Action between 2016 and 2019** and **Inspiring Quality between 2019 and 2020**. Since 2020 the Trust has described a continuing improvement infrastructure involving patient-safety meetings, quality-assurance activity, ward and department accreditation, quality rounds and executive links.

That chronology matters to me because it illustrates something much more important than the survival of a programme name.

Excellence through Learning was never intended to represent the finished culture of Alder Hey. It was an intervention designed for a particular

organisation at a particularly painful point in its history. If it achieved anything worthwhile, the real test was whether Alder Hey could continue developing after the original facilitators, programme structures and eventually the leaders themselves had moved on.

And Alder Hey certainly did move on — quite literally.

When Tony and I were working together, the possibility of a new children's hospital belonged to the future. Construction eventually began in 2013 and, in October 2015, patients moved into **Alder Hey in the Park**, replacing the hospital that had served the organisation for more than a century. The new hospital was officially opened in 2016. Alongside it came the Institute in the Park, bringing research, education and innovation together in a dedicated centre.

Importantly, the new building was not simply an architectural replacement for the old one. Children and young people influenced its design, and the physical environment was deliberately conceived to make the experience of hospital less institutional and more responsive to the needs of children and families. In that sense, the move seems to have carried forward something of the patient and family focus that we had tried to place at the centre of the earlier cultural work.

The organisation also continued to develop its capacity for learning and innovation. By the period surrounding the move to the new hospital, Alder Hey was reporting stronger links between frontline care and Board-level governance, greater participation in risk management, patient shadowing to improve patient- and family-centred care, new clinical models and investment in innovation.

A decade later, in 2026, that innovation infrastructure had itself matured. Alder Hey marked ten years of innovation in the new hospital with examples ranging from point-of-care 3D modelling and remote monitoring for children with cardiac conditions to artificial intelligence and advanced analytics. Significantly, its Youth Forum was involved in shaping innovation so that the voices of children and young people continued to influence what was developed.

There are other contemporary signs of the same underlying philosophy. In 2026 Alder Hey also became the first hospital in the country to fulfil all the commitments associated with **Sophie's Legacy**, an initiative arising from the experience of a child and her family and intended to improve the everyday experience of children and parents in hospital. The Trust described the achievement in terms of listening to families and acting on what mattered to them.

None of this allows me to claim that *Excellence through Learning* caused what Alder Hey subsequently became.

That would be historically naïve and unfair to the many leaders, staff, patients and families who contributed over the following two decades. The hospital changed physically, organisationally and clinically. Different leaders brought different approaches. New national priorities emerged. New generations of staff joined the organisation and many subsequent improvement methods contributed to its journey. But perhaps that is precisely the point.

A successful culture-change programme should not need to preserve itself indefinitely. Its greatest achievement may be that it eventually becomes unnecessary.

The name can disappear. The original steering group can disband. Facilitators can move into different roles and new programmes can develop to meet new circumstances. What matters is whether some of the habits established during the process — involvement, openness, learning, patient focus, collaboration, innovation and confidence to improve — become sufficiently embedded that succeeding generations can reinterpret and renew them.

Looking at Alder Hey's own chronology today, *Excellence through Learning* appears not as an isolated project but as the beginning of a continuing improvement journey. The organisation Tony Bell was helping to rebuild during one of the darkest periods in its history eventually moved into a new hospital, developed substantial research and innovation capability, continued to involve children and families in shaping services, and built successive approaches to quality and improvement on what had gone before.

For me, there is something quietly satisfying in that. Tony did not live to see the full journey, nor could any of us working there at the beginning have known precisely where it would lead. Perhaps culture change is rarely about knowing the destination in that degree of detail.

It is about helping an organisation become more capable of making the next part of the journey for itself.

That, ultimately, may be the best evidence that the culture really did begin to change.

The Learning NHS — Creating an Organisation That Never Stops Learning

A learning organisation is not defined by the size of its education department, the sophistication of its intranet, the number of mandatory courses completed or the volume of information displayed on dashboards. All of those things may contribute to learning, but none of them proves that learning is actually taking place.

When I first wrote this chapter, I began with a simple proposition:

In order for an organisation to learn, it needs to learn how to learn.

I argued then that feedback, review, measurement, innovation, risk-taking and development needed to become part of everyday work at every level, until the search for improvement became as natural as the work itself. I would make that argument even more strongly today.

The NHS operates in an environment of extraordinary complexity and pace. Technology advances, treatments change, expectations rise, population needs alter, financial pressures shift and organisational structures are repeatedly redesigned. New evidence emerges and new risks appear.

An organisation trying merely to keep up will eventually fall behind.

The ability to learn is therefore not an optional organisational virtue. It is part of survival.

Learning Has to Become a Core Process

We normally think of core organisational processes as planning, budgeting, recruitment, clinical care, governance and performance management.

I would add **learning**.

Not learning as an event, but as a continuous organisational process.

Something happens. We notice it, gather information, listen to the experiences of those involved and try to understand what it means. We decide whether something needs to change, make an adjustment and then watch what happens next.

That sounds straightforward, but many organisations interrupt the sequence. They gather information without really discussing it, discuss problems without acting, act without reviewing whether the intervention worked, or investigate incidents without examining the deeper conditions that allowed them to occur. Staff may be asked for feedback without seeing what happened as a result. Patients may be listened to but find that the process remains unchanged.

Looking back across the preceding chapters, I realise that the learning organisation has been present from the beginning.

Organisation Development starts with learning about the organisation before deciding what intervention it needs. Mission, vision and values require us to keep comparing what we actually do with what we say we exist to do. Diagnosis requires organisational antennae that can interpret what patients, staff, data and the external environment are telling us.

Process redesign asks us to follow the patient and learn from what actually happens rather than what the procedure says should happen. Structural review asks whether organisational arrangements genuinely help people work or whether people have simply learned to work around them. Connectedness requires learning to travel across quality, people, clinical governance, performance and improvement rather than remaining trapped within specialist functions.

The Shadow Side asks whether an organisation can learn from uncomfortable information and from matters people are reluctant to discuss. Facilitative leadership creates the conditions in which people can question, experiment and improve. Culture change makes those behaviours sufficiently normal and sufficiently repeated that they survive beyond the programme that first introduced them.

The final test is whether the organisation can continue doing all of this **after the consultant has gone, after the improvement programme has finished, after the Chief Executive has moved on and after the organisational structure has changed again.**

That is the learning organisation.

A Learning Organisation Is a Listening Organisation

One sentence from the original chapter has stayed with me:

A learning organisation is a listening organisation.

Listening sounds passive. It is not.

Good listening requires effort, curiosity and discipline. It means paying attention not only to information that confirms what we already believe but also to information that challenges it.

At organisational level, listening may involve staff surveys, patient feedback, complaints, compliments, incident reports, performance information, research evidence, benchmarking, community intelligence and conversations with partner organisations.

But collecting all of this is not the same as listening. An organisation can produce enormous quantities of information and remain remarkably deaf. The test is whether what we hear changes what we understand and, eventually, what we do.

The NHS is rich in mechanisms for feedback. Patients complete surveys, staff complete surveys, teams undertake audits, Boards receive dashboards, regulators publish findings, complaints are logged, incidents are reported and clinical outcomes are measured.

Digital systems generate more information than ever before. Yet organisations can become so focused on collecting feedback that they overlook the skills required to **receive it**.

That matters because every organisational feedback system ultimately arrives in front of a human being. A member of staff may tell a manager, “I don’t think you realise what this decision has done to the team.” A junior doctor may say to a consultant, “I find it difficult to question you during the ward round.” A patient may say, “You explained everything, but I still didn’t understand what was going to happen to me.” A colleague may say, “When you chair meetings, I don’t think you realise how quickly you dismiss ideas you disagree with.”

In each case information has been offered. Learning has not yet happened. What follows determines whether it will.

One quality I would like to see more strongly developed in a learning organisation is a **hunger for feedback at the service of improvement**.

This is different from being willing to tolerate feedback. It means actively seeking it.

A leader may ask how a meeting went, what they missed, what someone else experienced, whether their behaviour made something harder, or what another person can see that they cannot. Those are not easy questions because we do not control the answers.

They become more important, not less, as people become more senior. Power changes feedback. Colleagues become more cautious. A junior employee may tell peers that a senior manager is intimidating while reassuring that same manager that everything is fine. The leader then receives less accurate information at precisely the point when greater organisational influence makes accurate feedback more important.

This is one of the Shadow Side problems considered earlier in the book. The person most in need of honest feedback can gradually become the person least likely to receive it.

A learning organisation therefore has to build both the expectation and the skill for constructive feedback.

Receiving Feedback Is an Interpersonal Skill

We often teach people how to **give** feedback. Receiving it is at least as important.

The first reaction is often emotional. Even before somebody has finished speaking, we may feel the need to explain ourselves. We search for contextual details that justify what happened, remember evidence that proves the other person wrong or begin questioning whether they are qualified to judge us. That response is human. But defensiveness blocks learning.

Receiving feedback well requires a different sequence. We listen before justifying or explaining, clarify what has actually been said, check that we have understood and separate observation from interpretation. We may ask for an example or try to understand whether the feedback reflects a single event or a recurring pattern.

The person giving feedback may be partly wrong. They may have misunderstood something. Feedback is not automatically truth. But neither should our first task be to prove it false. An individual's perception and experience is real and within their experience there may be a valuable insight to learn from.

A useful response might be, "Let me check that I have understood you," or, "When you say I closed the discussion down, what did I say or do that gave you that impression?"

At that point, feedback begins to become useful information rather than a personal threat.

Listening, Clarifying and Making Sense

Listening is not simply remaining silent until the other person finishes. It involves checking meaning.

Chapter 7's Ladder of Inference is relevant again. We move very quickly from an observation to a conclusion about what it means. The learning task is to come back down the ladder and understand what actually happened. I response to feedback about shutting down a difficult conversation - Perhaps I interrupted several times, kept looking at my phone or pushed the discussion too quickly. Perhaps I was under pressure for a reason the other person could not see.

Clarification allows both people to learn. It also keeps feedback from becoming accusation.

It is easy for an organisation to tell staff they should give honest feedback. The real test is what happens afterwards.

If someone raises a concern and is subsequently labelled difficult, they learn something. I remember as a student nurse questioning the routine of giving patients enemas on a regular basis – shortly after that I was warned that troublemakers do not get very far in this hospital and I was put on a warning. If a junior colleague challenges a senior professional and is humiliated, others learn too. If a staff survey repeatedly identifies the same problem and nothing visible changes, people learn something about the organisation's willingness to listen.

Learning is always happening. The danger is that the organisation learns the wrong lesson. People can learn that speaking is unsafe, that mistakes should be hidden, that challenge is unwelcome and that initiative is more trouble than it is worth.

Those are organisational lessons too. A learning culture therefore depends upon the psychological safety discussed in Chapter 7 and the facilitative leadership described in Chapter 8.

Learning From Patients

Professional information arrives in familiar forms: clinical language, data, audit results and reports. Patient experience may arrive as emotion, frustration, uncertainty or story. That does not make it less valuable.

The patient journey described in Chapter 4 demonstrated this clearly. A performance system may tell us how long someone remained in an emergency department; the patient can tell us what that time **felt like** when

nobody explained what was happening. The record may show that medication was prescribed; the patient can tell us that nobody explained why it had changed. The system may show that an investigation was completed; the patient can tell us that they were asked to undergo it again because the earlier result could not be found.

Those experiences contain information about the system that conventional performance data may miss.

A learning organisation therefore treats patient experience not simply as satisfaction data but as **organisational intelligence**.

Learning From Complaints

Complaints are particularly valuable, and particularly easy to become defensive about.

Some complaints will be unreasonable or contain factual inaccuracies. Others may reflect unavoidable aspects of clinical care. But even a complaint that is not upheld may still contain information about communication, expectations or understanding.

The useful question is not simply whether the organisation was technically correct. It is whether there is anything to learn from the experience being described.

Sometimes the formal response may correctly demonstrate that appropriate procedure was followed, while the patient still experienced the process as confusing, frightening or uncaring.

Both things can be true. Learning organisations are able to tolerate that complexity.

Learning From Success

We have concentrated much of this book on what goes wrong. Learning also requires curiosity about what goes right.

When a team improves patient flow dramatically, when a ward has unusually good staff retention or when a service receives consistently strong patient feedback, the task should not end with congratulations. We need to understand what made the success possible.

Perhaps there was particular leadership behaviour, a better-designed process, stronger relationships, more effective information flow or a different use of professional skills. If we understand the conditions that produced success, we may be able to reproduce or adapt some of them elsewhere.

Failure tends to attract investigation. Success often attracts applause. We should study success with the same discipline. Celebrating it feels good. Understanding it is more useful.

Learning Across Boundaries

The original chapter argued strongly for inter-organisational learning and the active search for best practice elsewhere. That principle is even more relevant now.

No NHS organisation possesses all the answers. Benchmarking can reveal variation, visits can expose different practices, networks can spread ideas and research can identify effective approaches. But copying without understanding is not learning.

An organisation that performs well may have a different patient population, staffing model, geography, technology, leadership culture or resource base.

The important task is to understand the principle that appears to be producing the result and then ask how, or whether, that principle can translate into our own context. That is adaptation rather than imitation.

Knowledge Sharing, Not Just Knowledge Management

The original chapter distinguished knowledge management from **knowledge sharing**. I still think that distinction matters.

The technology has changed beyond recognition since 2003. Information that once required libraries, paper manuals or specific desktop access can now often be available instantly through electronic patient records, online education, shared systems and digital communication. Yet information sitting somewhere in a system is not useful simply because it exists.

Someone has to know that it exists, be able to find it, trust it, understand it and, where appropriate, act upon it. This is exactly what we saw in Chapter 4 when information about the patient did not always travel as smoothly as the patient herself.

The same applies to organisational learning. Knowledge trapped inside one department is not yet organisational knowledge.

The Information-Rich, Learning-Poor Organisation

This is one of the paradoxes of the modern NHS.

We have more information than ever. Dashboards can display hundreds of indicators. Patient feedback can be analysed electronically. Staff surveys can be examined by service and demographic group. The Model Health System allows comparison with peers. Electronic records generate huge quantities of clinical information and artificial intelligence can identify patterns that would previously have been difficult to detect.

Yet an organisation can still be **information-rich and learning-poor**.

Data can accumulate without insight. A red indicator can trigger pressure rather than curiosity. A staff survey can become a routine annual exercise. Thousands of patient comments can be categorised while nobody spends time with the human experience behind them.

Artificial intelligence can identify a pattern while the organisation remains incapable of changing the process responsible for it. Technology accelerates information. It does not guarantee learning.

AI and the Learning Organisation

Artificial intelligence adds another layer of responsibility.

The NHS will increasingly use AI in diagnosis, administration, forecasting, population health, research and service management. That creates enormous possibilities, but it also means organisations themselves have to learn about the technology as they use it.

A learning organisation needs to remain curious about where an AI system performs well and where it does not, which assumptions are embedded in the data, whose experience may be under-represented, and when professional judgement should challenge the output. It also needs to pay attention to unintended consequences: whether technology genuinely removes unnecessary work or simply moves it elsewhere, and whether it improves the patient experience or merely makes an internal process faster.

A learning organisation should never become passive in the presence of sophisticated technology. The more powerful the tool, the stronger the requirement to learn from its use.

The original chapter described a learning climate in which setbacks, mistakes and disappointments are examined openly for what they can teach rather than primarily for whom to blame. I still believe that.

But a learning organisation is not one in which anything goes. Accountability matters. The distinction made in Chapter 7 is important: human error, system failure, reckless behaviour and deliberate misconduct

require different responses. If every mistake is punished, mistakes become hidden. If nothing is challenged, standards deteriorate.

The learning organisation needs enough judgement to distinguish between them. Learning and accountability are sometimes presented as opposites. They are not.

Fair accountability strengthens learning because people are more likely to speak openly when they believe they will be treated according to what actually happened rather than subjected automatically to blame.

The Individual Learner

All of this eventually comes back to the individual. People learn. Teams learn. The organisation becomes capable of retaining, sharing and applying what they learn. That is why personal development and organisational development were connected so strongly in Chapter 6.

A person who regards learning as something provided by an employer may wait for training. A person who regards themselves as having some responsibility for their own learning behaves differently. They remain curious about what they are trying to improve, seek evidence about their current performance, ask others for help in understanding it and reflect on what particular experiences have taught them.

That does not remove organisational responsibility. Employers should provide opportunities, support, time, supervision, coaching and access to learning.

But ownership of learning ultimately has to become personal.

The Learning Team

Between the individual and the organisation sits the team. This may be where much organisational learning either lives or dies.

A team that routinely reviews its work, discusses mistakes, shares useful information and challenges assumptions can become remarkably adaptive. Another team in the same hospital can remain closed, defensive and dependent. Team learning does not always require a formal meeting.

It may happen in a five-minute conversation after something difficult, when colleagues ask what happened, what they missed, whether they would do anything differently next time and what the rest of the team needs to know.

That is learning integrated into work. Repeated often enough, it becomes culture.

Learning at Board Level

Boards also need to behave as learning groups. A Board can receive enormous quantities of assurance without genuinely learning very much. The challenge is not simply whether information is available. It is whether Directors remain curious about it.

A learning Board is interested in where it may be falsely reassured, which assumptions underpin its strategies, what information struggles to reach it and where staff or patients may be experiencing something different from the picture presented in formal reports.

It should also be able to identify decisions it has changed because new information altered its understanding. Those are not signs of weakness. They are signs of adaptability. The dangerous Board is not the one that occasionally discovers it was wrong. It is the one that never does.

Strategy That Learns

The original chapter described strategy as something developed through vision, consultation, internal and external diagnosis and continual feedback rather than as a static plan.

That is increasingly important. A five-year strategy cannot mean five years of pretending nothing has changed.

Direction should remain relatively stable where possible, but the route may need continual adaptation. This is particularly true when technology, workforce pressures, public expectations and organisational structures are changing rapidly. A learning strategy therefore combines conviction with adaptability. The organisation knows what it is trying to achieve. It remains prepared to change how it gets there.

Policy That Learns

Policies are intended to provide guidance, consistency and safety. But experience may reveal that a policy is producing consequences nobody anticipated or no longer reflects the circumstances in which people are working.

In the original chapter I argued that when implementation conflicts with organisational values, that discrepancy should be openly debated and the policy modified where appropriate.

A rigid organisation says, "That is the policy."

A learning organisation is capable of saying, “That is the policy, but the evidence suggests it no longer works as intended. We need to review it.”

Rules should provide safety and consistency. They should not prevent thinking.

The Learning NHS in Practice

What would all of this look like if learning were genuinely embedded?

A patient explains that the discharge information was confusing, and instead of merely apologising, the team examines why it was confusing and improves it. A junior employee questions a process and is taken seriously. A team discusses a near miss without immediately searching for someone to blame. A senior manager receives difficult feedback and asks for an example instead of defending themselves.

A Board sees a green indicator and still wonders whether some groups are having a poorer experience. A service discovers better practice elsewhere and adapts it thoughtfully rather than copying it mechanically. An improvement that failed is treated as information rather than embarrassment. A new technology is evaluated by what it changes for patients and staff rather than simply by whether it was successfully installed.

And after completing a difficult piece of work, somebody asks a deceptively simple question:

“What did we learn?”

None of these actions is spectacular. Together, they create an organisation capable of changing itself.

The Final Conversation

Imagine finishing a meeting.

A colleague remains behind. They look slightly uncomfortable and say:

“Can I give you some feedback?”

For many of us, those words create a reaction before we have heard anything else. Perhaps there is a tightening in the stomach or the beginnings of an explanation forming in the mind.

What have I done now?

That moment contains almost the whole learning organisation in miniature.

I can defend myself, dismiss what is being said or silently conclude that the other person does not understand.

Or I can become curious.

“Of course. Tell me.”

I listen and resist the urge to interrupt. When they have finished, I check that I have understood what they mean. Perhaps I ask for an example or what they think I might have done differently.

I may not agree with everything I hear. That is all right. The point is not obedience to feedback. It is the willingness to learn from it. And eventually there is one more question:

What am I going to do with what I have just learned?

The Learning Organisation Begins with the Learning Individual

When I wrote the first version of this book in 2003, I argued that organisations which failed to learn at least as quickly as their environment changed would stagnate.

The pace of change since then has made that proposition feel almost understated.

The NHS does not need another fashionable definition of the learning organisation. It needs learning to become part of how it functions: learning from patients and staff, from data and experience, from success as well as failure, from research, from other organisations, across professional boundaries, from new technology and, importantly, about ourselves.

If there is one final thread connecting the ten chapters of this book, it is this:

Organisation Development is ultimately about increasing an organisation's capacity to understand itself and improve itself.

No OD consultant can do that indefinitely on its behalf. No framework can guarantee it, no restructuring creates it automatically, and no strategy preserves it once and for all.

It lives in the behaviour of people and in the quality of their conversations. It depends upon the ability to listen without immediately defending, the confidence to make difficult things discussable, the willingness to test

assumptions, the humility to acknowledge that something did not work and the habit of turning what has been learned into something better.

A learning NHS will not ultimately be created by another national programme.

It will be created when learning becomes part of how we lead, how we work, how we listen, how we respond when things go wrong and how we respond when somebody tells us something we would rather not hear.

The learning organisation begins with the learning individual.

And Finally...

I do understand the realities within which people in the NHS are working. Clinical emergencies do not wait for a convenient moment. Wards and departments can be understaffed, demand continues to rise as the population ages, treatments and medicines become more sophisticated and expensive, and organisations are expected to meet increasing expectations while managing financial and workforce pressures that are very real. None of the arguments in this book makes those difficulties disappear.

My argument is that they can be managed more effectively when there is sufficient leadership throughout an organisation that knows how to help people think, learn and improve together. What is needed is a critical mass of people who are constantly looking for better ways of doing the work, prepared to say when something is not right and confident that raising a problem will be treated as an opportunity to understand rather than as an act of disloyalty. In that kind of environment, improvement is not another programme competing for attention. It becomes part of the way people approach the pressures they already face.

Creating such an environment has to begin with those who hold the greatest organisational power. Senior leaders need to understand that what they say, what they do, what they notice and what they choose to ignore eventually reaches much further than the Boardroom. In healthcare there is ultimately a connection between leadership behaviour and the decisions made every day about the safety, dignity and quality of care received by patients. That connection may travel through several layers of an organisation, but it remains.

This requires more than knowing the language of good leadership. It has to come from something deeper: a genuine belief that the purpose of leadership is to make a difference to the people the organisation exists to serve. It also requires sufficient humility to recognise that seniority does not bring all the answers. The task of the leader is often not to dictate the solution but to create the conditions in which the people with the knowledge, experience and responsibility closest to the problem can help discover it.

That is why self-awareness matters. Leaders have to remain capable of asking what effect they themselves are having on the organisation. Are people more

willing to speak when I enter the room, or less? Do I create curiosity or dependency? When somebody brings me uncomfortable information, do I become interested or defensive? Do my actions reinforce the values I talk about, or quietly undermine them? Culture is shaped through thousands of such experiences.

These principles are especially important in healthcare because the consequences can quite literally involve life and death. But they are not confined to the NHS. The same principles of self-awareness, openness, facilitative leadership, trust and organisational learning apply wherever people have to work together to achieve something worthwhile.

There is one final thought that goes beyond the boundaries of individual organisations. The NHS and social care have lived through repeated structural reform, often accompanying changes of government and political priority. I increasingly wonder whether some of that disruption might be avoided if there were greater long-term, cross-party agreement about the fundamental direction of health and social care. Political choices will always remain, as they should in a democracy, but the development of services that people depend upon throughout their lives surely deserves a longer horizon than the electoral cycle.

Such an approach would itself require a different kind of political leadership: open enough to learn, confident enough to listen across traditional boundaries and sufficiently facilitative to recognise that no party, profession or individual possesses all the answers.

Perhaps that brings me back to where this book began.

The NHS will undoubtedly be reorganised again. Structures will change, new pressures will emerge and new solutions will be proposed. But sustainable improvement will depend less upon the next organisation chart than upon the capacity of the people within it to think, speak, listen and learn together.

Culture changes when leaders change first.

And when leaders create the conditions in which others can learn and lead, the organisation begins to acquire the capacity to change itself.

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About Michael Wash

Michael Wash began his professional life in nursing, qualifying as a Registered Mental Nurse and Registered General Nurse before moving into nurse education. He subsequently qualified as RCNT and RNT and gained a Certificate of Education. An increasing interest in what helps people understand themselves, relate to others and change led him into psychology and counselling. He gained a Postgraduate Diploma in Humanistic Psychology and worked with Professor Gerard Egan in delivering counselling training and consultancy.

Those different strands — clinical practice, teaching, psychology and the experience of change — eventually came together in his work in leadership and Organisation Development. While working as a senior manager with British Telecom, where he was involved in culture change, he developed his interest in how large organisations change and why apparently rational change so often meets very human difficulties. He later completed a Master's degree in Business and Economics at the University of Leeds.

For more than three decades Michael has worked with people and organisations undergoing change, as a practitioner, educator, senior manager, consultant and author.

His NHS work has included Organisation Development and major change assignments with some of the country's largest and most complex healthcare organisations. In the late 1990s, as Organisation Development Director in

Leeds, he led *Achievement through Cooperation*, a major culture and organisational improvement programme during the period preceding the creation of Leeds Teaching Hospitals NHS Trust.

His healthcare consultancy included work with Alder Hey Children's Hospital, Aintree, the Royal Liverpool and Broadgreen University Hospitals, Huddersfield Royal Infirmary, and health organisations in Moray and Caithness and Sutherland. His work ranged from Board and senior-team development to culture change, leadership development, process improvement, facilitator development and helping organisations work more effectively across professional and organisational boundaries.

He also designed and facilitated work for the Confederation of Specialist Children's Hospitals UK, bringing specialist children's hospitals together to make sense of major NHS reforms, share good practice and explore the implications of emerging performance, funding and Organisation Development approaches.

At Alder Hey, Michael worked with Chief Executive Tony Bell OBE and others in developing and implementing *Excellence through Learning*. The programme grew from a particularly difficult period in the hospital's history and sought to rebuild confidence, develop leadership throughout the organisation and enable staff themselves to lead improvement. In 2006 the programme received national recognition, winning the Organisational Learning category and then the overall Excellence in Human Resource Management Award.

His work at the Royal Liverpool and Broadgreen University Hospitals was also recognised by the Trust with an award for his contribution to organisational development and improvement.

Michael's experience of healthcare has never been confined to consultancy. He has served as a Non-Executive Director of Selby and York Primary Care Trust during the early years of PCT development and as Chair of the York and Selby Patient and Public Involvement Forum. He later became a Trustee Director of The Retreat in York, with particular responsibility for clinical governance.

Since retiring from large-scale consultancy in 2015, he has remained actively involved in mental-health advocacy and service improvement, and was a founder member forming 'Quaker Voices on Mental Health.'

Writing has run alongside much of his professional life. With Dr Graham Dexter he wrote *Psychiatric Nursing Skills — A Patient-Centred Approach*, reflecting an early concern advocating moving care away from a predominantly task and medical model towards greater attention to the person, relationships and the skills required to help. His later books have explored organisational improvement, leadership and the human experience

of change and include *Making Business Work*, *54 Ways to Work With Change* and *The Healthy Organisation*.

Beyond Reorganisation brings many of those strands together. It is informed by the clinician, teacher, psychologist, manager and Organisation Development practitioner, but also by later experience as a governor, patient advocate and, increasingly, as a patient and relative encountering the NHS from the other side of the system.

That later perspective has brought Michael back to a question that has run through much of his professional life:

How do we create organisations in which leadership at every level helps people learn, speak openly, work across boundaries and act together with a shared sense of purpose?

Related Books by Michael Wash

The Healthy Organisation

A fuller exploration of organisational health, culture, leadership, connectedness and performance. It develops many of the themes touched on in *Beyond Reorganisation* and looks more broadly at how organisations can create the conditions for people and systems to work well together.

54 Ways to Work With Change — Mastering Resistance Within and Around You

A practical exploration of the human side of change: why people resist, what that resistance may be protecting, and how individuals and leaders can work with it more constructively. It complements the NHS focus of *Beyond Reorganisation* by looking more closely at the psychology and behaviour of change.

Making Business Work

A practical guide to improving the way organisations operate, including tools for understanding processes, identifying unnecessary steps and redesigning work. Readers interested in the process-redesign methods discussed in Chapter 4 will find more detail here.

Psychiatric Nursing Skills — A Patient-Centred Approach

Written with Dr Graham Dexter, this earlier work reflects a longstanding concern with placing the person, rather than the task or medical system, at the centre of care. Now being prepared for republication as a free digital edition, it provides some of the roots of the patient-centred thinking that runs through *Beyond Reorganisation*.

Other writing

Michael's writing also extends beyond organisations and healthcare to personal development, wellbeing and the challenges of everyday life, including *Simple Truths* and *Lighter*. He also writes fiction for younger

readers, including *The Fearless Trio* series. Although very different in form and audience, these children's books share a continuing interest and carry messages related to how people understand themselves, face fears and change, work together and find their way through difficult circumstances.

Further information about these books and Michael's other writing can be found at www.mwauk.com.