

# Every ward is a 'Nut Island'?

## Preventing good health-care teams 'going bad'

*This article explores how Levy's 'Nut Island effect' can be used to help identify health-care teams at risk of becoming isolated, disenchanted and separated physically and psychologically from senior management. Such isolation can lead to disastrous effects.*

### Background and context

The NHS is one of the largest employers in the world, and is the biggest in Europe, with over 1.3 million staff (NHS Jobs, 2015). Its size alone means that it is a highly complex, multi-layered organization comprising thousands of semi-autonomous components. These units (wards, departments, clinics, theatres) are staffed by highly skilled, dedicated professionals who often feel a physical and psychological separation from senior management, with managers often being seen as on the 'dark side' (Spurgeon et al, 2011). Couple this with many senior managers being distracted from paying attention to the realities of day-to-day care by financial concerns and performance management and a constellation of circumstances arises which can lead to the 'Nut Island effect' (Levy, 2001).

The Nut Island effect 'begins with a homogeneous, deeply committed team working in isolation that can be physical, psychological or both. Pitted against this team are senior supervisors, who are usually separated from the team by several layers of management' (Levy, 2001). Levy describes the Nut Island effect based on a sewage plant on Nut Island which managed the sewage outflow into Boston harbour. The

crew that managed the plant were a hard-working, tight-knit group of men with high trust in one another and shared ways of working and values. They worked largely out of sight and mind of the commissioners of the Massachusetts Water Authority who were responsible for the plant, but who had under-funded it for many years. The crew struggled to maintain the ageing machinery but developed creative ways of patching things up and disguising flaws and deficiencies (such as water test results) so that on the surface things appeared to be running smoothly. In 1976, the ageing engines gave out and untreated sewage flowed into the harbour for 4 days. But rather than bring management and the team closer together, instead the team turned inwards, avoided contact with management at any cost, battled on themselves and manipulated or ignored evidence that contradicted their view that things were running well.

This set of circumstances is a type of organizational pathology which helps explain how 'good people' end up doing the 'wrong thing'. This article uses the Nut Island effect to explore how the NHS and its component organizations might recognize the circumstances and risks and put preventive measures in place.

### 'Five steps to failure'

Levy (2001) describes five predictable stages which lead to the Nut Island effect and four interlinked preventive steps. This article takes each in turn and considers how these may apply in health-care situations.

### 'Management... assigns a vital, behind-the-scenes task to a team and gives that team a great deal of autonomy.'

The 'provision of high quality care' is one of the NHS Constitution's (Department of Health, 2011) seven guiding principles.

This care is delegated to clinical and ward managers by senior managers with often little direction or strategy provided to those working on the 'shop floor'. This partly reflects the autonomy of professionals to provide clinical care according to their professional judgement. However, basic care can fail to be delivered with time and service pressures, and although senior managers may assume that the care provided is excellent, this assumption is not always substantiated or actively ensured.

This was one reason for the regular and fundamental failures of care described within the Andrews report (Andrews and Butler, 2014), an independent review into patient care and safety at Abertawe Bro Morgannwg University Health Board. These failures included patients routinely not receiving their medication and nurses 'instruct[ing] a continent patient to ... defecate in their bed onto a continence pad' (Andrews and Butler, 2014). Clearly this is unacceptable.

It could be easy to blame individual health workers but poor planning and lack of oversight from senior management regarding tasks normally 'taken for granted' may lie at the root of the problem. There is a fine line between delegation and perceived (or actual) abandonment of staff. Both the Andrews (Andrews and Butler, 2014) and Francis (2013) reports into failings at the Mid Staffordshire Foundation Trust cite poor staffing levels and a lack of planning for staff absences as directly correlated to poor care. This is exacerbated by a disconnect between senior management and frontline clinical staff, for example Francis (2013) describes how a senior nursing manager was unaware of numerous incident reports regarding low staffing levels.

There is clearly a role for improved communication between clinical staff and

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senior management and a place for external monitoring and regulation. Many medical procedures adhere to strict guidance, which is then audited to assure compliance or recommend improvements. However, essential basic care is not subject to the same levels of scrutiny and poor care can therefore 'slip through the net'. National Institute for Health and Care Excellence (2014) guidelines on 'safe staffing for nursing in adult inpatient wards' may go some way to addressing this problem. The Andrews report (Andrews and Butler, 2014) called for more regular inspections of clinical care by directors and senior clinical members, anticipating this would increase standards. Ultimately, it is the responsibility of the senior management team to ensure that standards of care meet both external and internal standards.

### **The self-sufficiency of the team is taken for granted and calls for help are ignored**

The second stage of failure in the Nut Island effect describes management ignoring requests for help or warnings of impending trouble. The Francis report (2013) noted that concerns raised by nursing staff repeatedly went unresolved by Trust management. This was emphasized in the follow up Freedom to Speak Up Review (Francis, 2015) in which clinical staff reported that raising concerns with senior management is futile, as nothing would be done. In hospitals, one example of the Nut Island effect may arise through senior management ignoring repeated requests for assistance in finding nurses to cover unfilled shifts. This consequently leaves senior nurses with the responsibility of finding their own replacements. While this can lead to resentment by those left to manage with low staffing levels, it may also have the unintended consequence of fostering a dangerous culture of self-sufficiency.

This second stage exemplifies a larger problem regarding 'whistleblowing', in which an individual or group raises a concern internally or takes the concern externally, e.g. via the mass media or regulatory bodies. Whistleblowing is described as a negative experience in which the whistleblower is left feeling isolated, ignored and victimised (Francis, 2015). The lived experience contradicts the UK regulatory guid-

ance which states that doctors have a duty to speak out when they see adverse events (General Medical Council, 2012).

The Nut Island effect also describes senior management taking the team's self-sufficiency for granted. Medical teams often function in this way. If the workload is high, or team members are absent, doctors will often start their shift early, or stay late, to ensure the work is complete and that patient safety is not compromised. Anecdotally, there have been occasions where evening shifts are not covered, and the doctors have not been allowed to leave until cover is arranged or a locum is found. Often somebody will volunteer, solving the problem that day but continuing to perpetuate the impression of a self-sufficient team, with the added consequence that often 'today's favour becomes tomorrow's obligation'. The NHS relies on this sense of obligation to provide sometimes even routine patient care.

### **'Heroic outcasts'**

Health workers generally feel a strong duty of care towards their patients and struggle when the provision of basic aspects of care seems at odds with demands from senior management, whose priorities seem to revolve around headline figures, such as mortality rates, and budgetary constraints. This engenders a sense of isolation among frontline staff, who may be driven to uncomfortable lengths to meet targets set from 'above'. These targets are often introduced with the best of intentions, but can result in unintended consequences.

One example is the introduction of the maximum 4-hour target for patients attending emergency departments to be seen, assessed, treated and admitted or discharged. Instead of prioritizing each patient's needs, the pressure to meet the 4-hour target may result in rapid referral of patients to other departments. As a consequence, clinical decision and medical assessment units now proliferate, where another doctor and team will, again temporarily, take over care of the patient. This can lead to disrupted care and is especially concerning for patients with dementia, for whom confusion can be worsened by frequent changes in environment and staff.

The Francis report (2013) describes how many of the clinicians working in the Trust 'kept their heads down' rather than

pursue concerns with management, leading to senior managers having a distorted perspective or being unaware of the issues facing frontline staff. Meanwhile, frontline staff toil away to minimize the harm that may come to patients. For example, the added demands on emergency departments have resulted in an increased workload with poor working conditions and unsociable hours (College of Emergency Medicine, 2012). The combination of high workloads and a culture where patient safety and basic care seems not to be prioritized by senior managers, can lead to patient care becoming visibly compromised. Poor care can even become routinized, e.g. the Andrews report described serious problems with the administration of medication and how 'doctors, pharmacists, nurses and managers in Abertawe Bro Morgannwg University knowingly tolerate this hazardous, prohibited and unjustifiable practice' (Andrews and Butler, 2014).

### **Management failures**

The nature of the pressures on ward teams may sometimes lead to behaviours that are misaligned with organizational objectives but help the team to achieve what it sees as its own important goals. One of the consequences of the Nut Island effect is that while teams might be 'heroes, unfortunately they were fighting the wrong war' (Levy, 2001). For example, instead of addressing basic care concerns, teams may become over-controlling of administrative or other areas where they feel they have control, exacerbating an 'us and them' culture. In *Case scenario 1* (a true story), the nurses and doctors start to 'fight' over something of little relevance to the bigger picture.

This problem is further compounded when management fails to help the team to see the wider implications of their actions on the organization as a whole. In recent years there has been a significant focus on patient flow and reducing delays in care which, when implemented well, enhances the safety and reliability of patient care (NHS Institute for Innovation and Improvement, 2008). However, achieving adequate bed occupancy through outlying patients on wards away from their clinical team or moving them frequently risks patient

safety. One study reported an increase in mortality of outlying patients of over 40%, albeit with a number of potential confounding factors (Perimal-Lewis et al, 2013), and another estimated that 13% of handovers contain incorrect information (Robertson et al, 2014). If a team has an insular focus or wards have different practices from others (e.g. the location of equipment and patient notes (*Case scenario 1*), visiting times or protocols), wider patient safety implications exist for the whole organization.

### A disastrous separation

The final stage of the Nut Island effect occurs when senior management and the team are so separated from one another, and from the reality of the situation, that even when issues become glaringly obvious they are not recognized. The team refuses to accept that there are problems and because management hears nothing from the team, they assume nothing is wrong. These behaviours can only be changed by a catastrophic event or crisis, which finally breaks the stalemate.

Long-standing staff members, such as consultants and senior nurses, develop a 'way of doing things' (the 'ward culture') which does not welcome change and can be difficult to challenge (Mee, 2013). The Nut Island effect describes how the team believed 'they are the only ones who understand their work' (Levy, 2001) and who will go to great lengths to retain control. The Andrews report identified that embarrassed staff concealed their failure to provide good quality clinical care until patients and relatives complained. Managers were also at fault, highlighting that the 'culture of care of any hospital is defined by what staff and management seem to regard as acceptable along that spectrum' (Andrews and Butler, 2014).

New staff, particularly junior doctors who frequently rotate through posts every few months, may provide perhaps more objective new 'eyes and ears', spotting things that could be improved as they enter a new environment. However, as a new (and junior) team member, being perceived as criticizing or even suggesting improvements may be met with resistance (*Case scenario 1*). Once they are settled into the environment and familiar with the running of the ward, they may struggle to see problems or failings in patient care, having become part of the team and lost perspective of the bigger picture. Individuals may also feel helpless or disempowered to address issues and, particularly if they are moving on, may just ignore the problem rather than creating trouble. Even when incidents are reported and complaints made, if these are minor or infrequent then it is unlikely that any significant changes will be made (Fox et al, 2009).

Individual medical or surgical teams can also develop these behaviours. They feel separated from other teams and lose sight that the patient's welfare is the priority. Demanding tasks such as arranging urgent scans or making referrals may seem more important and leave little time to administer basic care and seek understanding of the patient's ideas, concerns and expectations. Occasionally, teams may put great effort into referring patients on to other specialties, often exaggerating or misconstruing issues in an attempt to 'sell' the patient. This contributes to a high number of ward transfers and risks losing continuity of care for the patient, but the original team has met their goals.

### Preventive actions

Levy (2001) suggests four steps to help prevent the Nut Island effect happening which require managers to nurture and

encourage high-performing and independent teams while ensuring they remain embedded in and aligned with the organization as a whole.

### Define internal and external performance measures

The first preventive action is to ensure that performance measures and reward structures are aligned with both organizational and external goals and standards. West and Lyubovnikova (2013) suggest that a feature of high performing health-care teams is that they have clear goals. They also identify many health-care teams as 'pseudoteams', i.e. that they appear team-like but have low levels of interdependence, shared objectives and reflexivity. While the Nut Island effect applies to seemingly high-performing teams, managers need to be aware that teams are constantly in flux and that the fluidity of health-care team membership means that some teams' activities can easily slip out of sight (O'Sullivan et al, 2015).

Aligning team functions, activities and outputs with organizational and clinical goals and requiring team leaders to be routinely accountable helps to prevent teams becoming isolated and focussing on the wrong goals. The NHS uses a range of quality assurance measures but it is vital that these are joined up and that data are used to improve health outcomes and patient care. The Francis report (2013) critiqued many external bodies for their lack of communication with one another and the Mid-Staffordshire Trust itself for failing to use data to proactively improve direct patient care. From the board to the ward, clinical governance arrangements, professional or regulatory standards, protocols and measures against government targets all need to be fully aligned.

### Managers must be visible and 'hands-on'

Levy (2001) suggested that senior managers need a visible presence, for example leading 'tours' for employees from other parts of the organization and leading occasions such as recognition ceremonies. This helps leaders to identify problems early and staff feel that they are valued, important and listened to. In some organizations this happens in practice. For example, a Chief Executive welcomes new foundation doc-

### Case scenario 1: 'the way we do things round here'

'I worked with two other junior doctors on a very busy ward. We found the organization of patients' notes diabolical, as they were based on a consultant system which was no longer functioning. We spent a significant amount of time hunting for patient notes and helping other doctors reviewing our patients to find notes they needed. We had informal complaints from other doctors about having to treat our patients without notes, during the night or at weekends. Having time one day (and consent from our consultants) we reorganized the notes to be arranged by bed number; the system used on most other wards in the hospital. We came in the following day to discover the senior nursing staff had put it back the way it was before. We were never really forgiven for trying to change the system. Ironically, the nurses' own notes for patients were arranged by bed number...' (F1 doctor).

tors to the organization, runs question and answer sessions in the doctors' mess several times a year and writes a weekly bulletin on the staff intranet which makes him visible and seem approachable. In the wider NHS, recognition ceremonies exist at all levels, from local 'foundation year one trainee of the year' to the *Health Service Journal's* Clinical Leader awards.

Patient safety walk-rounds (Frankel et al, 2003), now widespread in the NHS, are where a team of mixed managerial and clinical staff, led by a member of senior management, spend time in the clinical environment talking to staff and patients (Patient Safety First, 2009). They provide opportunities for patient care and safety issues to be raised informally and make senior management visible to clinical staff and patients. Performance targets, complaints and compliments are discussed and plans made for improvements and actions which are followed up at the next visit. This type of activity (and others such as the 'friends and family test') will help organizations to achieve recommendations made in the review and Inquiry reports, e.g. strengthened inspection and monitoring by senior clinical staff and directors (Berwick, 2013; Keogh, 2013; Andrews and Butler, 2014).

### Integrate teams within the organization

Third, Levy advises assimilation of employees from all parts of the organization so that good practice is shared and effective systems and processes can be adopted in other areas. Doctors in training undertaking qualifications involving work-based assignments can be helpful here. They will understand the complexity of the organization or system, have time to carry out quality improvement projects and provide ideas for change. Levy also advocates personnel coming together to see 'the big picture'. Schwartz rounds, a form of group reflection where staff from all professions come together to consider the emotional impact of their work, are a good example of sharing practice and dissipating the impact of siloed teams (Goodrich and Levenson, 2012).

### Bring in an external perspective

The final preventative action requires the rotation of outside influences into the team environment (Levy, 2001). Students and

health professionals in training frequently rotate through posts and placements and while they often struggle to make suggestions when they are new to a team, they should be welcomed to do so. Their varied experience and fresh perspectives can provide a stimulus for innovation and improved practice (*Case scenario 2*). Additionally, non-clinical managers should experience the clinical environment just as clinical staff should develop their leadership skills.

## Conclusions

As a consequence of the series of critical reports described here, a range of activities at all levels are starting to be implemented, many of which (e.g. patient safety walk-rounds, national standards for care of frail elderly people and the 'friends and family test') can help to mitigate future occurrences. In addition, the shift away from 'heroic leadership' (The King's Fund, 2011) to 'collective leadership' in the NHS (West et al, 2014) can be assisted through a consideration of the Nut Island effect and putting preventive steps in place. **BJHM**

*Conflict of interest: none.*

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## Case scenario 2: an external perspective

In a large intensive care unit, the fixed consultant body establishes year-long, advanced trainee roles for consistently rotating senior specialist trainees. They provide these trainees with considerable responsibility including the majority of day-to-day organizational elements in the department. With their fresh external perspective, these trainees are encouraged to take ownership of an area, for example quality and safety, and implement targeted change as they see fit. The senior leading body appears respectful of and eager to engage with their team. This creates a positive culture within the department.

At the top level of ward hierarchy, consultants and senior nurses rarely rotate. This problem is compounded because these permanent senior figures are leadership figures and role models for the ward team and set the ward culture and accepted behaviours much more than junior team members (Mee, 2013). This is the perhaps where the ward structure fails in this regard. In order to share best practice, both senior and junior team members need to move around the organization and outside (e.g. through secondment, mentoring or work shadowing). External bodies carrying out inspections, visits and monitoring can also provide opportunities for obtaining fresh perspectives if good relationships are made.

## KEY POINTS

- The Nut Island effect helps to explain how good health-care teams 'go bad' through isolation from senior management and a feeling of being ignored.
- These isolated teams develop a sense of self-sufficiency and their activities become misaligned with organizational goals and targets.
- Preventive steps include establishing performance measures, visible, hands-on management; integration with other parts of the organization and exposure to other teams and groups.

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# Clinical Leadership made easy: Integrating theory and practice

Edited by Judy McKimm  
and Helen O'Sullivan

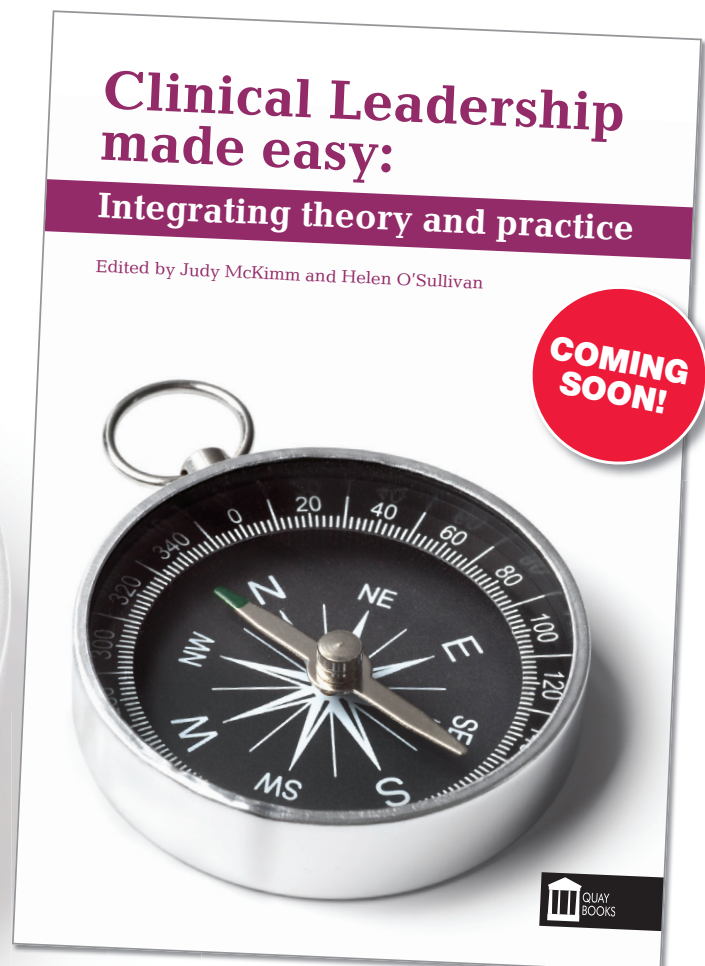
Foreword by Peter Lees

This book is designed to provide core theory and case scenarios predominantly around clinical and educational leadership for doctors, nurses and other health professionals. It includes other aspects of leadership in health professions, including leading research initiatives and leadership of professional groups and specialities. It takes an international perspective, drawing on contemporary best practice in health professions' leadership.

This book brings together the generic aspects of leadership (and strategic management) theory relating to clinical and educational contexts, while setting these within frameworks and case studies relating to a range of professional groups.

This book is primarily aimed at hospital and community based clinical teachers, supervisors, mentors, preceptors, trainees and students who have a teaching or training role: doctors, nurses, midwives, allied health professionals. It will also be useful for educational developers and those responsible for faculty and professional development of clinical teachers.

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