

Improvement Leaders' Guide

# Leading improvement

**Personal and organisational development**



# Improvement Leaders' Guides

**The ideas and advice in these Improvement Leaders' Guides will provide a foundation for all your improvement work:**

- Improvement knowledge and skills
- Managing the human dimensions of change
- Building and nurturing an improvement culture
- Working with groups
- Evaluating improvement

## **Leading improvement**

**These Improvement Leaders' Guides will give you the basic tools and techniques:**

- Involving patients and carers
- Process mapping, analysis and redesign
- Measurement for improvement
- Matching capacity and demand

**These Improvement Leaders' Guides build on the basic tools and techniques:**

- Working in systems
- Redesigning roles
- Improving flow

You will find all these Improvement Leaders' Guides at [www.institute.nhs.uk/improvementguides](http://www.institute.nhs.uk/improvementguides)

Every single person is enabled, encouraged and capable to work with others to improve their part of the service

Discipline of Improvement in Health and Social Care



---

## Contents

1. What is leadership?	3
2. Is leading improvement different?	5
3. The challenges of leading improvement	8
4. Knowledge and skills of improvement	10
5. Creating a shared vision	12
6. Aligning improvement with the vision	14
7. Building a more receptive context for improvement	16
8. Engaging clinical colleagues	18
9. Encourage and support communities of practice for improvement	20
10. Lessons and experiences from leaders of improvement	22
11. Activities	24



# 1. What is leadership?

Leadership is about setting direction, opening up possibilities, helping people achieve, communication and delivering. It is also about behaviour, what we do as leaders is even more important than what we say.

Sir Nigel Crisp

There are thousands of ways to describe leadership, here are just a few.

Leadership is:

- challenging the process, inspiring a shared vision, enabling others to act and modelling the way (Clark D, 1997)
- transforming followers into leaders themselves (Gill R, 2002)
- creating an environment that supports individual team members in being maximally effective in achieving those outcomes that are valued by users and their supporters (Onyett S, 2002)
- something for the many not the top few (Attwood M, 2003)

A leader of improvement needs to have these leadership skills and more.

You will face challenges in creating a shared vision, challenges developing a supportive culture and challenges engaging others in improvement. This guide has collected together some of the current thinking about the knowledge and skills a leader of improvement may need.

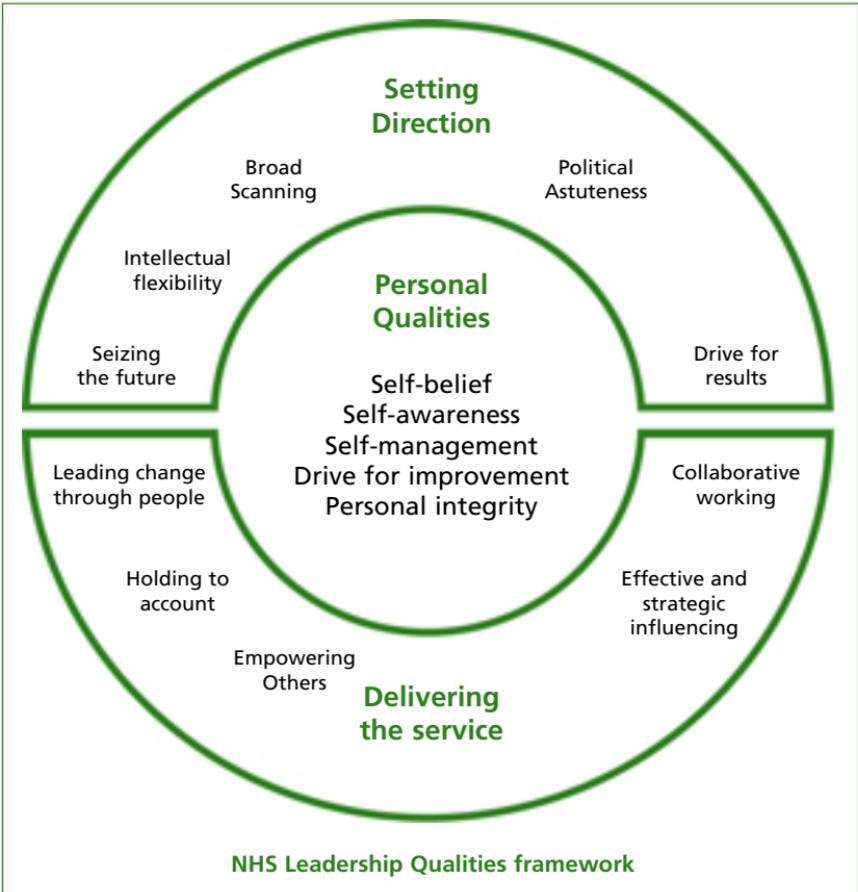
It will help you to be familiar with the different aspects of improvement described in the three groups of Improvement Leaders' Guides:

- **General improvement skills:** introducing a range of basic improvement advice to help you and your colleagues begin to build and learn from improvement in your everyday work
- **Process and systems thinking:** based on the industrial models of processes, systems and flow
- **Personal and organisational:** focusing on the people and culture that make up and organisation and the impact on improvement. This group is about the 'people' side of change

# Leadership Qualities Framework

The key characteristics, attitudes and behaviours expected of leaders in the NHS now and in the future have been pulled together in the **NHS leadership qualities framework**. It describes fifteen qualities, arranged around three clusters: personal qualities, setting direction and delivering the service. You can use this framework to review your own general leadership abilities, with your team or colleagues to establish leadership capability and capacity. You can also use it to focus for personal development, board development, leadership profiling for recruitment and selection, career mapping and succession planning

You can find this framework in full on [www.nhsleadershipqualities.nhs.uk](http://www.nhsleadershipqualities.nhs.uk)



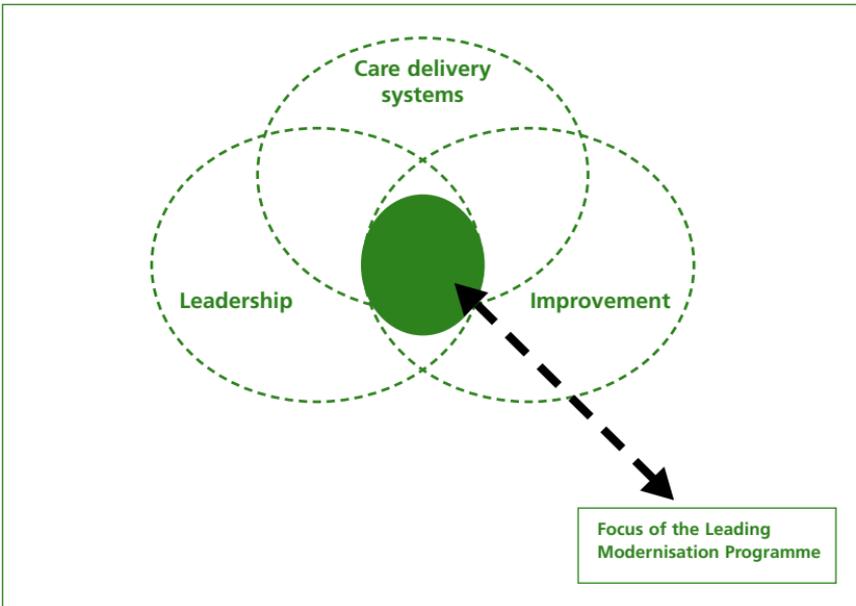


## 2. Is leading improvement different?

The Leading Modernisation framework was developed as a theoretical model for a national programme. It was derived from research that examined the knowledge, skills and capabilities leaders need in order to achieve the most relevant and sustainable improvements. It has three parts:

- **care delivery systems:** the practical realities and future possibilities of how care is experienced by professionals, patients and the public
- **leadership:** the art of getting things done through others
- **improvement:** the study and practice of enhancing the performance of processes and systems at work

This model says that a leader of improvement needs to not only be a good leader but also to excel in delivering excellent care or enable others to do so and promote and support improvement. A leader of improvement needs to work at the intersection of these three domains.



Developed for the Leading Modernisation Programme by Paul Plsek

## Leading Modernisation framework described in more detail

### **A successful leader**

- develops, commits to and communicates clear vision, mission, values, direction and roles
- strategically influences and engages others
- builds relationships
- challenges thinking and encourages flexibility and innovation
- develops, enables and encourages others
- drives for results and improvement
- practices political astuteness
- displays self-awareness
- demonstrates mastery of management skills

### **A successful improvement practitioner**

- sees whole systems and any counter-intuitive linkages within them
- brings in the experiences and voice of patients, carers, and staff
- exposes processes to mapping, analysis and redesign
- applies engineering concepts of flow, capacity, demand and waste-reduction
- encourages flexible, innovative rethinking of processes and systems
- facilitates active local improvement and reflective practice
- sets up measurement to demonstrate impact and gain insight into variation
- works constructively with the human dimension (psychology) of change
- sustains past improvement and drives for continuous improvement
- spreads improvement ideas and knowledge widely and quickly

### **Successful care delivery systems need to**

- deliver evidence-based care in a timely, effective and caring manner
- earn and retain the confidence of the public and politicians
- operationalise a strategic vision of the future, encompassing trends in society, technology, funding, and the workforce
- link systems-design to a values-driven understanding of the experiences of service users
- create seamless-working across boundaries for the benefit of staff and service users
- prioritise and focus limited resources on the key issues and leverage points in the system
- continuously increase capacity to deliver services by improving effectiveness and efficiency
- engage operational staff in active improvement of the systems of care
- develop organisational cultures that are receptive and positive environments for change
- ensure that all central support functions service the requirements of health care delivery

In section 11.2 there is a practical tool to help you assess and measure your progress in the delivery of your improvement initiative. It is based on the Leading Modernisation Framework and can be applied to any improvement activity.

Recently many in health and social care have begun to use the term 'improvement' to describe a range of modernisation initiatives. You might be more familiar with other ways of describing these activities such as change management, quality management, improvement science and service redesign. It doesn't matter what you call it, it's the effect that's important. From now on, in this Improvement Leaders' Guide we will use the term 'improvement' unless it is part of a title.

<b>Change of mindset for a leader of improvement</b>	
<b>From</b>	<b>To</b>
Focus on sorting 'poor performers'	Focus on processes and systems
Select areas for 'remedial action' or reward	Improve the performance of the overall system
Manage volumes of patients	Manage variability in the system
Fire-fight acute problems - treat the symptoms	Deal with the chronic problems that underpin poor performance - treat the disease

**Leading improvement - basically it's all about the leader having a mindset change from one of fire fighting to one of continuous improvement**

Senior Leader of Improvement



### 3. The challenges of leading improvement

The challenges for you, as a leader of improvement, will be related to developing a culture of improvement, encouraging learning and creating support mechanisms and partnerships. You need to create an environment in which:

- improvement, and learning about improvement, are considered to be strategic priorities in their own right
- key planning and operational functions are aligned around improving the way patients' and carers' needs are met
- improvement is a core activity for managers and clinicians with time built in for individuals and teams to learn its principles and practice

There is more about this in the Improvement Leaders' Guide: Building and nurturing an improvement culture [www.institute.nhs.uk/improvementguides](http://www.institute.nhs.uk/improvementguides)

Some of the challenges you are likely to face and the issues they are likely to bring are set out in the table opposite.

<p><b>The challenges</b></p> <p><b>To raise awareness</b> and initial understanding of improvement skills:</p> <ul style="list-style-type: none"> <li>• basic information about improvement including attitudes and behaviours</li> <li>• new and emerging thinking about improvement in healthcare in the UK and across the world</li> </ul>	<p><b>Issues</b></p> <ul style="list-style-type: none"> <li>• how do you encourage others to get involved?</li> <li>• how can you ensure equal emphasis on each of the four domains of the Discipline of Improvement? (section 4)</li> <li>• how can you ensure that you, your department, service or organisation are up to date and keep up to date with the latest improvement thinking?</li> </ul>
<p><b>To synthesise learning</b> considering the current maturity and context of improvement thinking as well as the knowledge and experience in your department, service or organisation</p>	<ul style="list-style-type: none"> <li>• who is responsible for the improvement development and integration of new thinking into your department, service or organisation?</li> <li>• can industry standard products such as six sigma, lean thinking, theory of constraints, etc. be applied in your healthcare environment?</li> </ul>
<p><b>To develop</b> other improvement leaders to be confident, competent, and capable</p>	<ul style="list-style-type: none"> <li>• what is an improvement leader?</li> <li>• what do they need to know?</li> <li>• what kind of support do you and other improvement leaders need to enable you succeed in leading improvement?</li> <li>• how do you engage clinical leaders?</li> <li>• how can Human Resources experts help and support you?</li> </ul>
<p><b>To develop</b> local improvement support networks to best utilise all your improvement resources in your department, service or across your organisation without creating parallel and possibly competing systems</p>	<ul style="list-style-type: none"> <li>• where does improvement sit?</li> <li>• how strong are the links between performance, clinical governance and organisational development?</li> <li>• how can you to create an actual or virtual improvement team?</li> <li>• where are there already improvement skills in your health community to learn from and share experiences and learning with?</li> <li>• what support will your frontline staff want and need?</li> </ul>
<p><b>To create</b> and <b>embed</b> a receptive context for improvement using a philosophy of work based learning, sharing learning and new knowledge to</p> <ul style="list-style-type: none"> <li>• encourage adaptation and adoption</li> <li>• include evaluation and impact of improvement initiatives</li> </ul>	<ul style="list-style-type: none"> <li>• do you have an improvement culture?</li> <li>• do you give enough time and space for reflection and the consolidation of learning?</li> <li>• is there support for effective work based learning?</li> <li>• how can you share your learning within your department, service, organisation and across health and social care?</li> </ul>



## 4. Knowledge and skills of improvement

In order to capture and consolidate the knowledge and skills that are strongly associated with effective improvement, a group of experienced 'improvers' have worked together to define what improvement means to them and what knowledge and skills they used or wished they had. This group involved doctors, nurses, therapists and managers from all parts of health and social care across England. They developed a vision statement for this work:

**Every single person is capable, enabled and encouraged to work with others to improve the service they provide.**

This model of improvement thinking involves four equally important and interrelated parts that can be considered the 'foundation' for all improvement activities. Good sustainable improvement will only be achieved if attention is given to each of the four parts. All the four sections are well researched and we are building a lot of evidence and knowledge from within the NHS that demonstrates their effectiveness and importance.



Discipline of Improvement in Health and Social Care Penny 2002

---

The four parts are described in detail in the Improvement Leaders' Guide: Knowledge and skills [www.institute.nhs.uk/improvementguides](http://www.institute.nhs.uk/improvementguides) but are summarised below:

**Involving users, carers, staff and the public:** This is about using a variety of different and effective techniques to bring in the voices of users, carers, staff and the public. We need to hear and listen to their experiences and needs which should be at the heart of all our improvement work.

**Personal and organisational development:** This is about being able to work constructively with all the people involved: recognising and valuing differences in style and preferences including your own self. It also includes understanding and building a culture that is supportive of sustainable improvement. It involves the use of the principles from psychology and organisational development.

**Process and systems thinking:** This involves all the research and understanding about processes and systems and all the linkages within them. It is about process mapping and analysis and the application of industrial concepts such as capacity and demand, flow and waste reduction. It involves process measurements to gain insights into variation and flexible, innovative redesign of processes and systems.

**Making it a habit: initiating, sustaining and spreading improvement:** This is about building improvement into daily work: making improvement something we don't think about as special but we just get on and do it.

As a leader of improvement it will be helpful for you, yourself, to be familiar with many of these 'tools and techniques' and, importantly, that you encourage and help others who work directly with patients and carers to develop their own skills in these areas. The presence of improvement capability within the community will make it more likely that improvements will be initiated and be successful.

Feel good about not knowing everything. These days there is so much knowledge around that we risk drowning in it. Learning about how things are interconnected is often more useful than learning about the pieces.

Fraser S, Greenhaugh T (2001)



## 5. Creating a shared vision

Leaders of improvement need to set a vision with their colleagues. This can be developed from scratch or adapted from models or frameworks that others have found useful. One such framework used by the UK Pursuing Perfection health and social care communities to drive large system transformation is the following set of aspirations:

- no needless death or disease
- no needless pain
- no feelings of helplessness amongst users and staff
- no unwanted delay
- no waste
- no inequality in service delivery

This vision is built on the following beliefs:

- it is necessary to aim for perfect care because aiming for anything less implies that it is acceptable for some people to receive care that is below the agreed standards
- setting and realising this ambition requires all the leaders involved, e.g. Chief Executives and Directors of Social Care, to re-define their roles both within their organisations and across the communities they serve
- that while ambition and leadership are necessary, they are not sufficient and need to be accompanied by focused improvement activity

You may find the 'no needless framework' appears to be simplistic, however it seems to work. Teams are re-thinking what is possible and reframing them as promises to patients. This change is thought to be triggered by a variety of factors including re-connecting people with the values that brought them into health and social care in the first place, and emphasising the clinical and qualitative aspects of care as well as efficiency and timeliness.

<b>'No needless' framework</b>	<b>Scope</b>	<b>Promise to service users</b>
<b>No needless death or disease</b>	<ul style="list-style-type: none"> <li>• ensure care is safe, reliable and evidence based</li> <li>• detect and treat disease early</li> <li>• act to prevent the causes of ill-health</li> </ul>	We will do everything we can to protect and heal you...
<b>No pain</b>	<ul style="list-style-type: none"> <li>• eliminate errors in care</li> <li>• avoid over-use of unproven interventions</li> <li>• ensure reliability of proven interventions</li> <li>• relieve emotional and physical pain</li> </ul>	We will do everything we can to relieve your pain and suffering...
<b>No feelings of helplessness amongst staff or service users</b>	<ul style="list-style-type: none"> <li>• share information</li> <li>• provide choices</li> <li>• act on preferences</li> <li>• support self-management and independent living</li> <li>• treat every person as the only person</li> <li>• value everyone's contribution</li> <li>• provide the time and skills necessary to support staff to do their jobs well</li> </ul>	We will inform, involve and empower you in your care...
<b>No unwanted delay</b>	<ul style="list-style-type: none"> <li>• ensure there is appropriate and timely access at every part of the pathway</li> <li>• ensure effective flow through the system</li> <li>• ensure coordination across boundaries of care (professional, departmental, organisational)</li> </ul>	We will treat you quickly and appropriately...
<b>No waste</b>	<ul style="list-style-type: none"> <li>• don't waste the time, resources or human spirit of staff or service users</li> </ul>	We will make best use of what we have...
<b>No inequality in service delivery</b>	<ul style="list-style-type: none"> <li>• ensure that all of the above applies to everyone</li> </ul>	...whoever you are...



## 6. Aligning improvement with the vision

### Focusing improvement activity around strategic goals

Improvement won't happen without the energy and enthusiasm of frontline staff. We know that. Yet, if the maximum benefit is to be secured at the system level, these energies need to be aligned with the wider community's strategic aims.

Individual teams are not always best placed to set their work in this wider context. So improvement leaders have a responsibility to support improvement activity as well as the operational priorities and the strategic goals of the system.

You may find that working together and using this matrix is in itself beneficial. Within this framework, individual departments, services or organisations can pursue their own priorities whilst seeking whole systems solutions and collaboration to problems and issues to support the delivery of seamless care.

#### **Strategic aims**

Develop transformational aims that connect with the values that brought people into health and social care in the first place

#### **Measurable goals**

Develop system level, measurable goals that track progress against these aims

#### **National targets**

Show how externally set targets sit within the context of the strategic aims to build ownership to delivery

#### **Improvement work**

Assess current improvement work against the system level goals to ensure that effort is focused in areas of greatest priority

Adapted from Jim Reinerstein and the work of Pursuing Perfection

---

## Case study

### Suggested simple rules for improvement development in an SHA in London

- really listen to the voice of the patients
- establish a sense of urgency
- form powerful coalitions
- create a clear and widely understood vision
- communicate with passion
- empower others to act on the vision
- plan to create short-term improvement and promote what has worked
- consolidate improvement and produce still more changes
- institutionalise new approaches
- understand how we learn



## 7. Building a more receptive context for improvement

### **Harness the energy of clinical teams and create a desire for change**

- address departmental and organisational boundary issues and don't let them get in the way
- positively encourage initiatives and multidisciplinary teams that cross them e.g. clinical networks
- recognise energy: provide resources to support and legitimise time-outs etc.

### **Stop 'doing to' and create ownership**

- focus on what patients and carers need and their experience rather than targets:
  - use the experience of NHS staff as patients and service users
  - ask staff what they would like to do for patients
- create a positive experience with small local initiatives
  - develop some good down to earth examples to use with different groups providing evidence that improvement works
- let departments, services and organisations create their own plans for improvement and then support them

### **Make 'improvement' a normal part of every day work**

- use real words that are understood and avoid jargon wherever possible
- don't separate improvement into separate jobs or departments as it then becomes 'someone else's responsibility'
- create a link between improvement and what it means to staff, patients and carers
- recognise good ideas and give support

### **Build leadership and improvement skills in others**

- model the leadership skills that you want to see in others. Leadership needs to be positive so set the mood and act as a role model yourself
- nurture individuals with a desire to be involved in leading improvement and act as role models to cascade locally
  - don't just focus on clinicians, many other staff are willing to change
  - support team development, not just individuals
- create a network of improvement leaders in health and social care communities
- ensure systematic succession planning of all improvement leaders both managerial and clinical
- train trainers in improvement thinking, tools and techniques
- develop a repository of tried and tested tools and techniques that work

---

## Use the latest improvement thinking to secure early wins

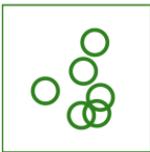
- develop credibility by delivering some early wins
- give attention to the rigorous application of what is already known such as the implementation of the 10 High Impact changes for Service Improvement and Delivery [www.institute.nhs.uk/highimpactchanges](http://www.institute.nhs.uk/highimpactchanges)

### 10 High Impact Changes for Service Improvement and Delivery

We now know quite a lot about what works. Working with thousands of clinical teams across the NHS, the NHS Institute identified a set of the ten best evidence based change principles for service redesign. The headline of each of the change principles is shown below.

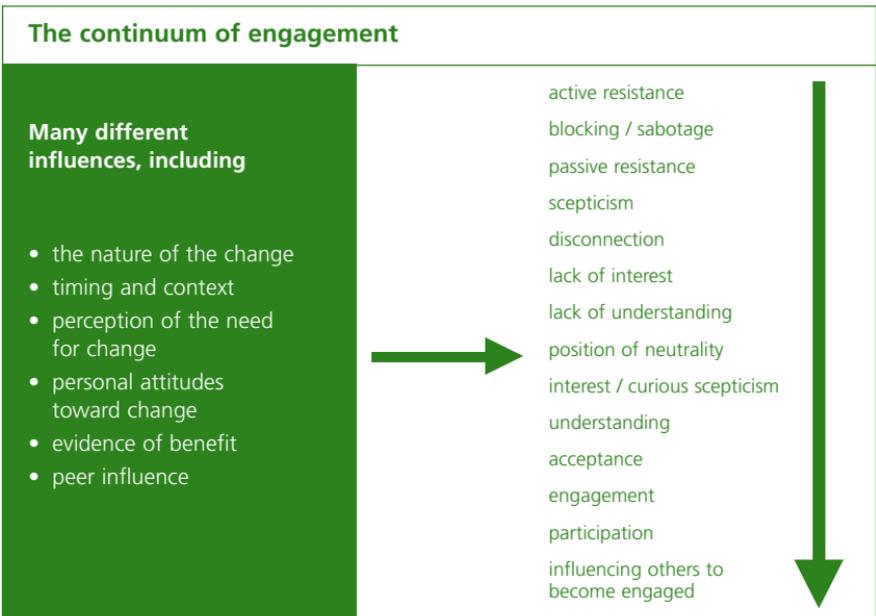
1. Treat day surgery (rather than in-patient surgery) as the norm for elective surgery
2. Improve patient flow across the NHS by improving access to key diagnostic tests
3. Manage variation in patient discharge thereby reducing length of stay
4. Manage variation in the patient admission process
5. Avoid unnecessary follow-ups for patients, providing necessary follow ups in the right care setting
6. Increase the reliability of therapeutic interventions through a 'care bundle' approach
7. Apply a systematic approach to care for people with chronic conditions
8. Improve patient access by reducing the number of queues
9. Optimise patient flow through service bottlenecks using process templates
10. Redesign and extend roles in line with efficient patient pathways to attract and retain an effective workforce

The Improvement Leaders' Guides: Working in systems and Building and nurturing an improvement culture gives more information about building a receptive context to change [www.institute.nhs.uk/improvementguides](http://www.institute.nhs.uk/improvementguides)



## 8. Engaging clinical colleagues

It is vital to engage your colleagues. The degree to which they are engaged will positively affect the success of improvement initiatives. Engagement of either individuals or groups could be described as developing along a range or continuum. The important thing is to analyse the level of support required from each individual and then direct attention towards achieving it. There is a lot more information in the Improvement Leaders' Guides: Managing the human dimensions of change and Building a culture of improvement  
[www.institute.nhs.uk/improvementguides](http://www.institute.nhs.uk/improvementguides)



Reference: Research into Practice: engaging individual staff in service improvement  
[www.modern.nhs.uk/researchintopractice](http://www.modern.nhs.uk/researchintopractice)

Redesigned systems of healthcare delivery almost always require clinicians to change the way they work both at an individual level and collectively within their professional groups. It is therefore vital to engage clinicians in the redesign process ensuring that new ways of working take account of clinicians' priorities.

Plsek 2000

---

## Engaging clinical colleagues

The power of combining the leadership of a clinician with the Chief Executive or Director and project manager has been recognised many times. However, whilst clinical colleagues (nurses, allied health professionals, consultant medical staff, junior doctors and general practitioners) are committed to improving services in principle, present levels of engagement remain relatively low. Clinical engagement is a critical factor in successful improvement initiatives and you should consider the following points that relate specifically to engaging clinical colleagues:

- while engagement of all clinicians is important, consultants can be particularly important both in success and failure
- there are various degrees of engagement and the process through which individuals engage which takes time
- improvement leaders must understand individual clinicians' positions in the adoption process and their individual values and perspectives
- there are important systematic differences in the perspectives of managers and clinicians on some key elements of improvement
- the social context is important, and most individuals are strongly influenced by national or local opinion leaders within their peer group
- to be successful in influencing behaviour, information must be presented in familiar language and format
- a focus on 'better care' as well as 'without delay'

Developed in the Improvement Partnership with Hospitals programme

Clinicians will make varying contributions to your local improvement work, depending on their aptitudes, areas of interest and degree of commitment. However they will definitely need support from other improvement leaders as well as peer support from others in similar roles. Their role is challenging and it is important that they maintain credibility with colleagues.

### What can local clinical leaders do?

#### Influencing

- Direct one to one discussions
- Group presentations
- Personal example
- Challenge unhelpful behaviours

#### Communicating

- Clarity about vision and objectives
- Providing successful examples from early work
- Public speaking to stakeholders



## 9. Encourage and support communities of practice for improvement

A community of practice (CoP) is an informal, knowledge sharing and learning network that you and your organisation can encourage. It differs from a delivery network because membership is optional and the ways of working are informal.

Communities of practice are already a natural part of organisational life but will have no name, no formal membership, and no status. Any community that, you, as a leader, have to deliberately form isn't a community at all: it is a team or a group. A community of practice is an informal, conversational relationship of peers who want to share and learn from each other. Communication may take place in the corridor, by the photocopier, by telephone or email.

Communities of practice tend to be formed by peers who

- do similar tasks
- use similar tools
- face similar decisions
- have similar issues, hopes, problems

It would really be a benefit for you, as a leader of improvement, to be part of a community of practice as they are useful not only for sharing and learning but also they are a great support particularly if you feel isolated in your particular leadership role. They will also help you in developing cross boundary relationships with leaders in other parts of the organisation or community.

There is a lot of emergent thinking about communities of practice on the internet.

The framework below shows how you, as an improvement leader, can offer different forms of support as a community forms and becomes more active.

	Potential CoP	Building a CoP	Active CoP	Adaptive CoP
<b>Description</b>	<ul style="list-style-type: none"> <li>a community is forming</li> </ul>	<ul style="list-style-type: none"> <li>community defines itself and starts to formalise its operating principles</li> </ul>	<ul style="list-style-type: none"> <li>community understands and demonstrates benefits from knowledge management and collaboration</li> <li>community engagement in organisation structure and process</li> </ul>	<ul style="list-style-type: none"> <li>innovation, generation and spread of best practice knowledge across the community</li> <li>community has a defined structure and process and has developed a broad population, health systems focus</li> </ul>
<b>Activity</b>	<ul style="list-style-type: none"> <li>community forms naturally or members are enlisted</li> <li>maintaining connectivity</li> </ul>	<ul style="list-style-type: none"> <li>establishes an identity</li> <li>develops a common language</li> <li>builds organisational support</li> <li>largely passive communication and interaction</li> </ul>	<ul style="list-style-type: none"> <li>community focuses on solving problems and sharing best practice</li> <li>active communication and interaction</li> <li>develops partnerships with key agencies</li> <li>forms of collaborative work groups</li> <li>monitors of outputs</li> </ul>	<ul style="list-style-type: none"> <li>creates new products/ideas</li> <li>adds to existing knowledge</li> <li>responds to emerging issues</li> <li>publishes and reports activity</li> <li>strong partnerships with key agencies</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>identify potential members and facilitate connectivity with group</li> </ul>	<ul style="list-style-type: none"> <li>identify key issues to engage membership</li> <li>develop organisation structure</li> <li>develop skills for community building</li> </ul>	<ul style="list-style-type: none"> <li>development of community agreed standards or measures, problem solving and decision making</li> <li>support collaborative work group</li> </ul>	<ul style="list-style-type: none"> <li>interaction with other communities and interface systems</li> <li>focus on innovation</li> </ul>
<b>Forms of support</b>	<ul style="list-style-type: none"> <li>communication for those who wish to participate e.g. email, list server, teleconferences, online forums, online directories</li> </ul>	<ul style="list-style-type: none"> <li>repository for knowledge e.g. document, library and knowledge management systems</li> </ul>	<ul style="list-style-type: none"> <li>electronic meetings</li> <li>collaboration tools</li> <li>collaborative work teams, forums</li> <li>active knowledge capturing systems</li> </ul>	<ul style="list-style-type: none"> <li>active dissemination strategies and innovative practices</li> <li>broad use of available IT and communication tools</li> <li>local and national forums</li> </ul>

Adapted from The National Institute of Clinical Studies, Australia



## 10. Lessons and experiences from leaders of improvement

**Really understand what is happening** by making sure you have a good overview of your department, service or organisation at all times but choose some aspects of the improvement work to look at more closely. The currency of leadership is attention. Staff will see what you do, what you give attention to, what you talk about or mention, as what you judge to be important. By paying attention you will, as a leader, give credibility and award importance to improvement work: it should be a positive experience for everyone and symbolic, it should not data driven.

**Really listen in order to understand and feel** what patients want, what staff are doing and how they work. Listen deeply and pay attention to what isn't said as much as what is. Get out there, don't just sit at a desk and try to understand what is happening from data.

See things and look for improvements with a **cross-organisational perspective**, not just from your own single department, service or organisation.

Stop saying **'if only they would ...we could'**

Stop saying:

- if only the diagnostic tests were back faster, we could discharge patients faster
- if only the wards got their discharge act together, we could do more operations
- if only the acute Trust would get their admission processes sorted out, we would stop sending so many urgent referrals

Start saying **'we must...'** and work together

---

**Meet in the same room with leaders** of other departments, services or organisations from across the system:

- let people know about the meetings, keep an open door and encourage others to attend
- be productive and work towards agreed actions and useful outcomes and be sure to communicate the results
- spread consistent messages across the system
- speak well of each other

**Reinforce the good improvement initiatives already happening**

- recognise and celebrate that improvement does not have to come from the Chief Executive alone
- create conditions for others to solve problems and avoid creating over dependence

**Try to ensure a balance.** Do not allow business and political drivers of change to override improvement driven by personal, ethical and moral issues.

**Equip leaders for the future.** Don't develop yourself and others for where the healthcare and the leaders' role is now, develop for where healthcare and the leaders' roles are going to be.

**Question:**

What would be the single most important thing we can do to improve healthcare?

**Answer:**

Get as many leaders as you can find who show optimism and confidence

Don Berwick, Institute of Healthcare Improvement USA 2003



## 11. Activities

Use the activities described in this section in the way that best helps you. Start by thinking things through by yourself but then share your thoughts with your colleagues. Compare your thoughts and ideas: learn with and from each other.

### 11.1 Leading a sustainable improvement initiative: ask yourself the following questions

Consider each of these key questions about **leading improvement** in more detail. Work with your colleagues and if you answer 'no', plan what you can do about it.

**[ Y / N ] Am I the right person to lead improvement?**

Consider the context, your skills and influence. If on reading this Improvement Leaders' Guide you feel that you might not have all the skills at the moment, plan what you can do about it

**[ Y / N ] Is there an identified team keen to be involved from the outset?**

Early engagement of key team members is important in the successful spread of new and sustainable practice. Teams who identify a desire to be involved rather than being directed to do so, and who already have an interest in improvement, will really help the improvement process

**[ Y / N ] Is there evidence of co-operative inter-professional working relationships?**

Involvement of the whole team in planning and implementing the service improvements will promote success. This includes the active engagement of all relevant clinical, managerial and clerical staff

**[ Y / N ] Is there a senior clinician willing and keen to be involved from outset?**

The support and involvement of clinical staff e.g. consultants, GPs etc. is seen as central to success. They may or may not take on the overall leadership role, but their participation is key

---

**[ Y / N ] Can dedicated time be allocated for the team to meet regularly and undertake the improvement activities?**

Dedicated time set aside for regular meetings to review current practice, to plan and evaluate service improvements is certainly required

**[ Y / N ] Are any additional demands or changes relating to this service anticipated?**

Many improvement projects have not been sustained or implemented easily owing to unforeseen pressures and competing demands or priorities. These should be minimised if possible or alternatives considered

**[ Y / N ] Will the team identify this as a high priority and will they also recognise the priorities of other services and work towards joint solutions where there is conflict or competing demands?**

Priorities may differ between managers and clinicians and between departments, services or organisations. Recognition of these potentially competing agendas and a commitment to work co-operatively where they exist is required for sustainable change

**[ Y / N ] Will the team integrate this initiative within normal working practice such as incorporating in job descriptions, policies and protocols? Does the team recognise this as a long-term commitment rather than a short-term project?**

Sustainable change needs to be embedded within normal working practice. Short-term thinking by considering improvement as a 'project', with an end point, will cause problems for sustainability

**[ Y / N ] Is there a commitment to, and available resources for, the collection of data relating to the benefits of the improvement?**

To encourage others to adopt new practices and also to ensure sustained improvement, it is important that benefits of the change initiative can be demonstrated. It is therefore essential that there is an understanding of the need to collect and use evidence and data and that there is an effective support/infrastructure in place for this such as IT systems, skilled staff etc.

## 11.2 Are you delivering effective redesign?

### An Assessment Tool developed by South West Peninsular SHA

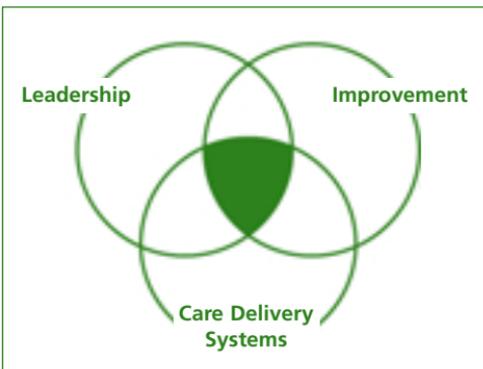
This is an assessment tool to help you to measure your progress in the delivery of your improvement initiative. It can be used for individual improvement projects, or to assess whole community effectiveness of redesign. You can look at your improvement retrospectively for learning, or prospectively to point the way to the development of a successful project or programme. Work by yourself then compare your assessment with colleagues and agree next steps.

This scoring system is based on 3 key parts of the Leading Modernisation Framework (see section 2 for full details):

**Leadership** - the art of getting things done by enabling others to do more than they could or would do otherwise

**Care Delivery Systems** - the practical realities and future possibilities of how care is experienced by professionals, patients and the public

**Improvement** - the study and practice of enhancing the performance of processes and systems of work



Current evidence suggests that it is where these three domains overlap that real transformational change happens. Within these three parts, nine characteristics have been selected for measurement and have significant interdependencies.

#### **First define your Improvement initiative in terms of:**

- Local Health or Social Care Community
- Project title and purpose (brief summary)
- Scale of project: whole community, organisation wide, specialty, pathway, team etc.

#### **Then rate the different characteristics**

A simple linear scale has been devised to assess progress, with each scale ranging from 1, the lowest score, to 7, the highest score indicating maximum achievement of the requisite characteristic.

## Leadership

### 1. Chief Executive commitment

- 1 Chief Executive unaware
- 2 Aware but not involved
- 3 Receives notes/minutes
- 4 Is regularly briefed face to face
- 5 Attends group meetings
- 6 Leads strands of work
- 7 Actively leading and visible at all levels with this work



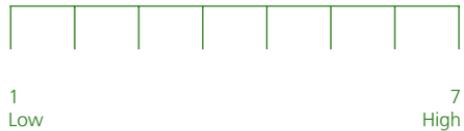
### 2. Project management 'headroom' (and access to improvement support)

- 1 None identified
- 2 Recognised as an issue
- 3 Solutions being sought
- 4 Being picked up in addition to another role
- 5 Part-time resource available
- 6 Resource available and supported
- 7 As above, with line management support, coaching and admin support



### 3. Two way communication strategy in place

- 1 None
- 2 Ad hoc
- 3 Need to communicate regularly identified
- 4 One method of regular communication in situ
- 5 Two different methods in place
- 6 Impact assessment/review
- 7 Robust feedback loop in place with regular understandable updates, delivered in more than one route/method



## Care Delivery System

### 4. Stakeholder participation (whole system)



- |   |  |     |      |
|---|--|-----|------|
| 1 | Uni-organisational/professional group  | 1   | 7    |
| 2 | Stakeholders identified  | Low | High |
| 3 | Stakeholders positively encouraged to participate  |     |      |
| 4 | Stakeholders briefed and understand the system   |     |      |
| 5 | Stakeholders regularly involved in meetings  |     |      |
| 6 | Constructive relationship with stakeholders involved in actions to deliver project/programme |     |      |
| 7 | Building on existing relationships, stakeholders take lead on one or more work strands       |     |      |

### 5. Clinical Leadership



- |   |  |     |      |
|---|--|-----|------|
| 1 | No clinicians involved   | 1   | 7    |
| 2 | Name(s) identified   | Low | High |
| 3 | Have attended one meeting  |     |      |
| 4 | Attends meetings regularly   |     |      |
| 5 | Contributes to project work  |     |      |
| 6 | Leads strands of work  |     |      |
| 7 | Actively leading and visible with clinical and non-clinical interfaces |     |      |

### 6. Interrelationship with other strands of service improvement recognised and synchronised



- |   |  |     |      |
|---|--|-----|------|
| 1 | Overview not considered                              | 1   | 7    |
| 2 | No obvious overlaps                                  | Low | High |
| 3 | Potential overlaps recognised                        |     |      |
| 4 | Overlaps recognised and flagged                      |     |      |
| 5 | Interface between overlaps quantified and understood |     |      |
| 6 | Potential for joint work assessed and agreed         |     |      |
| 7 | Integrated approach evident and operational          |     |      |

## Improvement

### 7. Involving service users, carers and patients

- 1 None/no attempt
- 2 Positive decision made to involve representatives
- 3 Demonstrable action in hand to identify users etc.
- 4 Pre-briefing and support given
- 5 Occasional involvement as required
- 6 Regular 'reference type' involvement
- 7 Full participative involvement in whole project/programme



1  
Low

7  
High

### 8. Matching the understanding of the challenge to appropriate method of redesign

- 1 Not considered or discussed
- 2 Discussed, considered not relevant
- 3 Challenge is understood (including history)
- 4 There is an agreed course of action
- 5 There is full consensus on way ahead
- 6 Redesign lead has skills to match challenge with method
- 7 Nature of the challenge, relevant approach and project lead all in place and agreed



1  
Low

7  
High

### 9. Clear timely measurable reported outcomes

- 1 None
- 2 Programme/project has identified outcomes
- 3 Outcomes reflect the aims
- 4 Outcomes are agreed
- 5 Measures are clear and timely
- 6 Information is available
- 7 Information is collected and reported against outcome measures at regular intervals



1  
Low

7  
High

## Overall summary

Now calculate:

- [     ]     total score for Leadership (questions 1 – 3)
- [     ]     total score for Care Delivery System (questions 4 – 6)
- [     ]     total score for Improvement (questions 7 – 9)

A score of 15-17 in each of the three domains indicates good progress towards transformational change

A total score of 18 or more indicates an excellent chance of achieving transformational change

## 11.3 Transforming your organisation: an alternative way of assessing your progress

There are a variety of things that build towards transforming an organisation into one that embraces improvement. In the table opposite are some for you to assess how far your organisation is towards transformation. Work by yourself, then compare your assessment with colleagues and develop a way forward.

Early stage	Mid-stage	Transformed
<b>Leadership and strategy:</b> Our organisation is a place where...		
The Chief Executive assigns project work	The Chief Executive personally reviews improvement work	The Chief Executive is the 'master teacher' of improvement
Clinical staff have few champions Some are curious, but otherwise largely uninvolved	Clinical staff are engaged on some projects	Clinical staff lead community-wide re-design of care
The Chief Executive and other leaders attend healthcare meetings to get new ideas and learn from others	Designated seekers go outside of healthcare arena for ideas and best performance	All staff seek improvement ideas worldwide
System-level measures are developed and shown to the Board quarterly	There are some system-level improvement measures linked to strategic goals and projects. They are available on request to the community, but a variety of methods makes accountability hard	Strategic goals, system-level and project-level measures are fully transparent
Plans for improvement and strategy are described in two separate documents	Improvement is seen to be part of the business of the organisation	Improvement is the strategy
<b>Process:</b> Our organisation is a place where...		
There are a few isolated improvement projects	There are many improvement projects	Improvement cycles are part of everyone's daily work life and are not thought of as projects
Occasional cycles of improvement are celebrated	There are lots of run charts with cycles of improvement showing steady improvement	There are too many cycles of improvement to count
Improvement projects are focused on the processes of specific disease or departments	Improvement is centred on the systems of the organisation	Improvement crosses many organisations, engages the entire community and interface with many systems simultaneously
<b>Culture, people and patients:</b> Our organisation is a place where...		
There are a few patient representatives	All committees have patient representatives	>50% of all committees have patient majorities
Patients don't know their plan of care	Patients know their plan of care	Patients design and own their plan of care
Improvement initiatives are reactive to problems and need a leader to push them	Improvement is expected by staff but is still reactive. Improvement is demanded by staff, and is part of daily work	Improvement is demanded by staff, and is part of daily work
A few improvement champions	Leaders and managers have improvement skills and are involved in developing others	All teach, all learn

Adapted from Jim Reinerstein and the work of Pursuing Perfection



The Improvement Leaders' Guides have been organised into three groups:

**General improvement skills**

**Process and systems thinking**

**Personal and organisational development**

Each group of guides will give you a range of ideas, tools and techniques for you to choose according to what is best for you, your patients and your organisation. However, they have been designed to be complementary and will be most effective if used collectively, giving you a set of principles for creating the best conditions for improvement in health and social care.

The development of this guide for Improvement Leaders has been a truly collaborative process. We would like to thank everyone who has contributed by sharing their experiences, knowledge and case studies.

Design Team

Jo Bibby, Sarah Garrett, Cathy Green, Catherine Hannaway, Judy Hargadon, Elaine Latham, Lynne Maher, Mike McBride, Annette Neath, Jean Penny, Christina Pond, Hugh Rogers, Jonathan Stead. Also all those who have participated in the work of the Pursuing Perfection Programme and Research into Practice.

To download the PDFs of the guides go to [www.institute.nhs.uk/improvementguides](http://www.institute.nhs.uk/improvementguides)

We have taken all reasonable steps to identify the sources of information and ideas. If you feel that anything is wrong or would like to make comments please contact us at [improvementleadersguides@institute.nhs.uk](mailto:improvementleadersguides@institute.nhs.uk)

The mission of the NHS Institute for Innovation and Improvement is to support the NHS and its workforce in accelerating the delivery of world-class health and healthcare for patients and public by encouraging innovation and developing capability at the frontline.

NHS Institute for Innovation and Improvement  
University of Warwick Campus  
Coventry  
CV4 7AL

Tel: 0800 555 550  
Email: [enquiries@institute.nhs.uk](mailto:enquiries@institute.nhs.uk)

[www.institute.nhs.uk](http://www.institute.nhs.uk)

Gateway ref: 5667

NHSI 0391 N CI/Improvement Leaders' Guides can also be made available on request in braille, on audio-cassette tape, or on disc and in large print.

If you require further copies, quote  
*NHSI 0391 N CI/Improvement Leaders' Guides*

and contact:

Prolog Phase 3  
Bureau Services  
Sherwood Business Park  
Annesley  
Nottingham  
NG15 0YU  
Tel: 0870 066 2071  
Fax: 01623 724 524  
Email: [institute@prolog.uk.com](mailto:institute@prolog.uk.com)

NHSI 0391 N CI  
270955

© **NHS Institute for Innovation and  
Improvement 2005**  
All Rights Reserved