

**Transformation of Services**

**needs**

**Transformation of Leadership**

## The Blueprint for Transformation



W.E  
Deming

# The Blueprint for Transformation



# The Blueprint for Transformation

## Leadership v Management ?

– the Case for

**Both!**

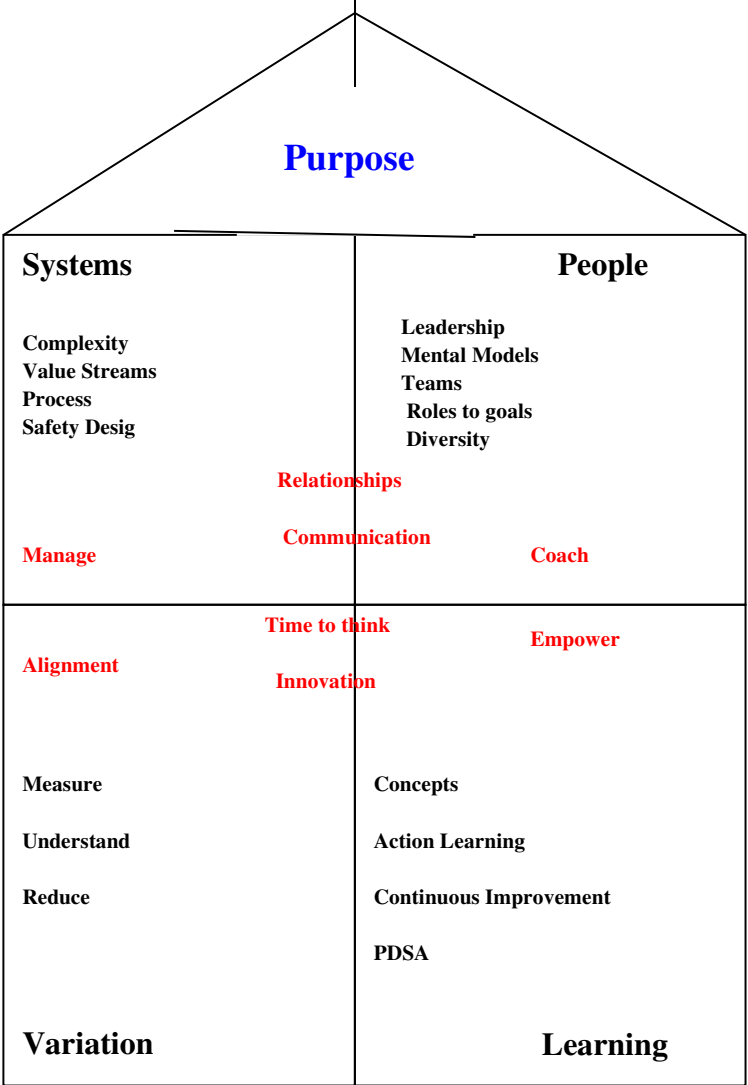
**Manage the System    And ..... Lead the  
People**

‘94% of problems are system (process)  
problems

6% of problems are to do with the  
individual’

# The Blueprint for Transformation

*True  
North'*

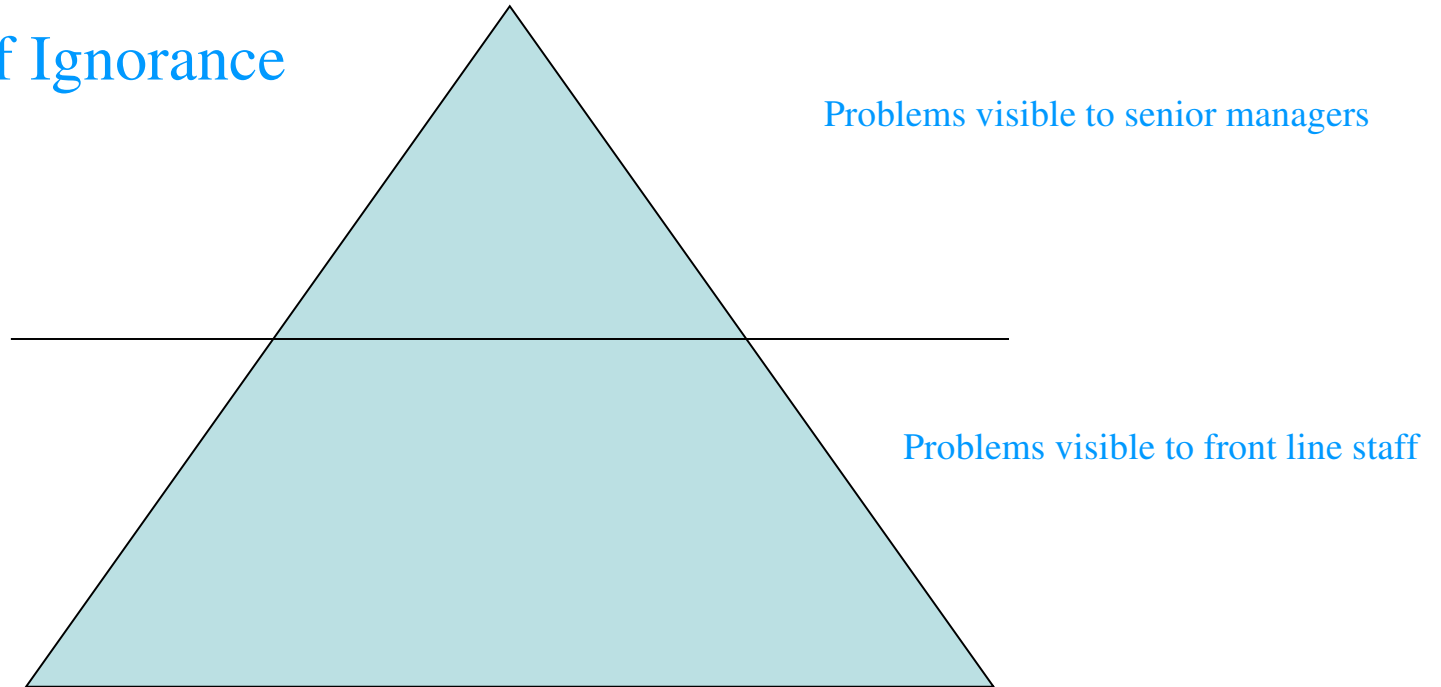


# The Purpose

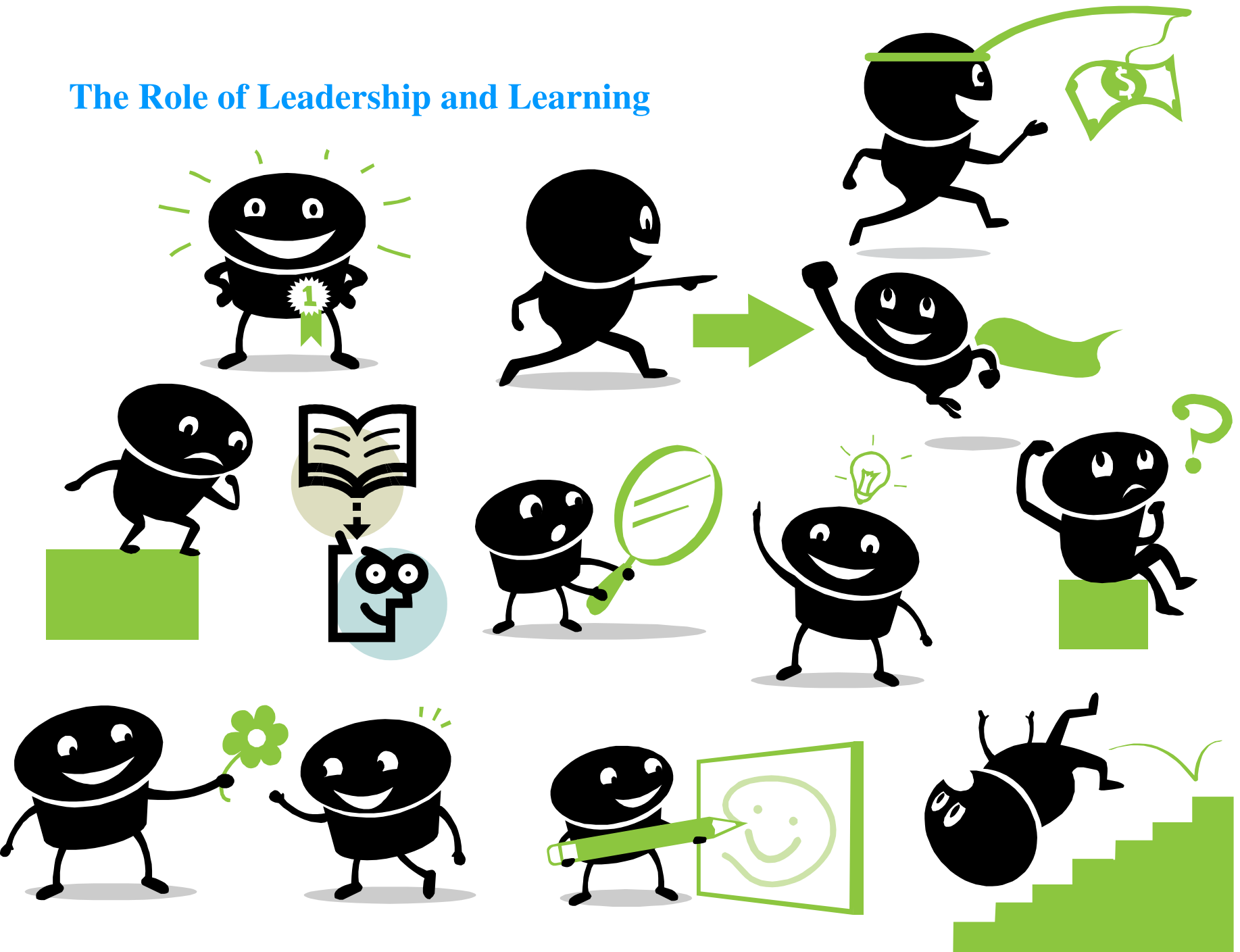


# The Role of Leadership and Learning

## The Iceberg of Ignorance



## The Role of Leadership and Learning



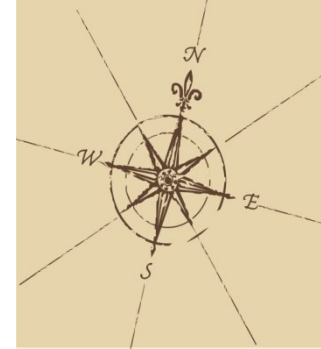
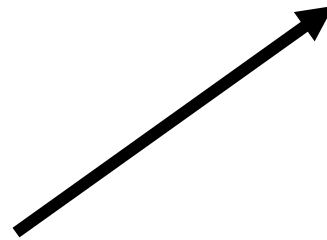


Servant Leaders!!

‘How do I help you remove the barriers to excellent patient care?’



# Understanding and Managing the System



*‘A collection of elements (and people) interacting and working on the system and processes to achieve a common aim – improving services for the customer*

*The sum of the whole being greater than the sum of the parts’*

## Different Tribes!!!!



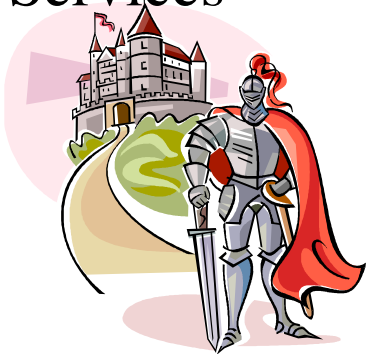
Corporate  
Services



Children's Services



Clinical  
Governance



Social Care

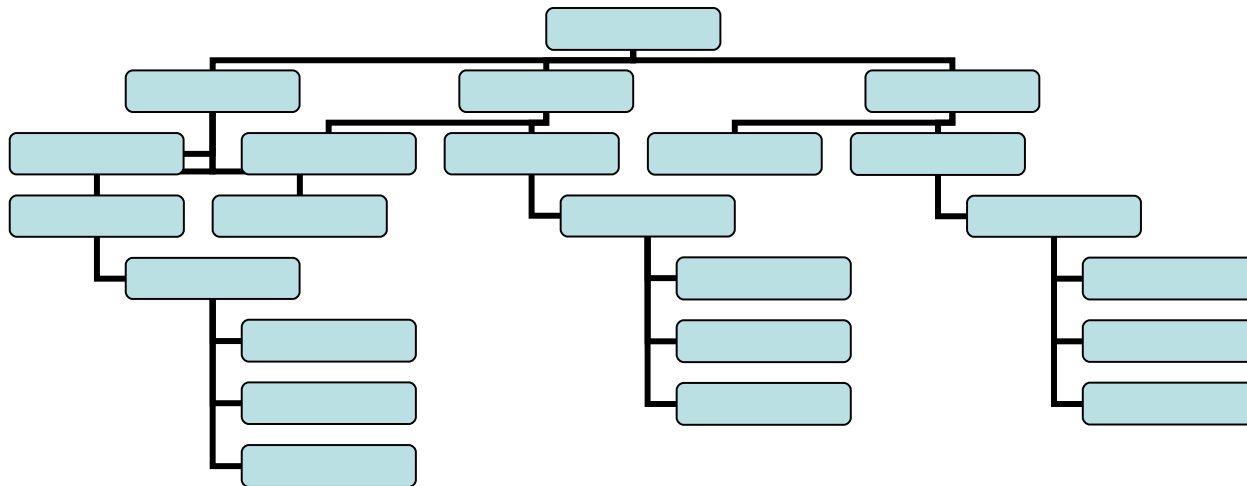


Secondary Care



Acute  
Hospitals

## Add to that....the Hierarchy!

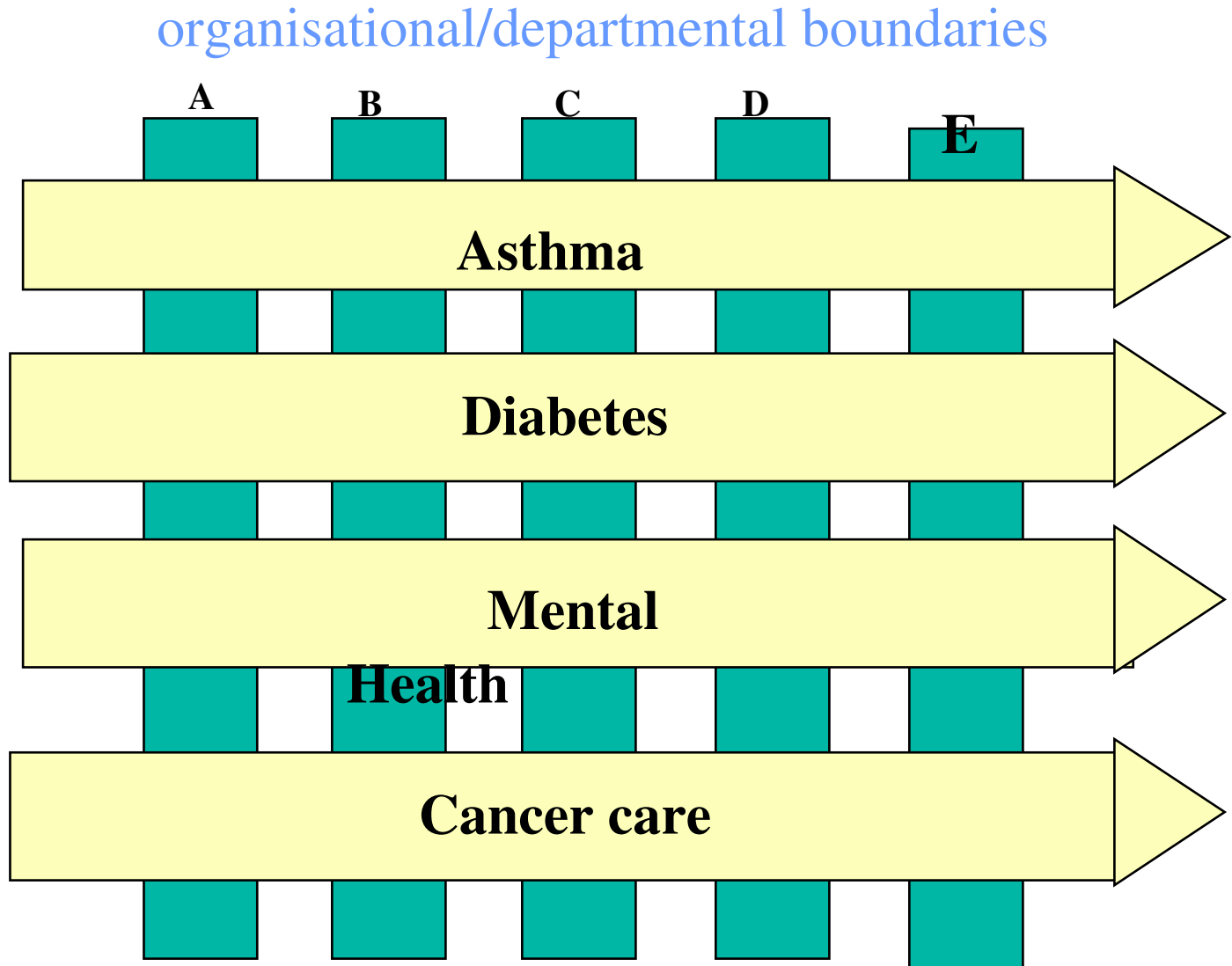


## An Industrial Model in a Knowledge Worker/ Relationship Age

known as the ‘*tree of blame*’

# All this Driving Variation; Waste and Potential for Error!!

- 30 - 70% of work doesn't add value for patient
- up to 50% of process steps involve a "handoff", leading to error, duplication or delay
- no one is accountable for the service user "end to end" experience
- job roles tend to be narrow and fragmented
- Who listens to the voice of service users and carers



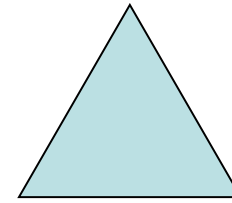


**Each bus holds 73 passengers**

# What management model do you have in your mind?

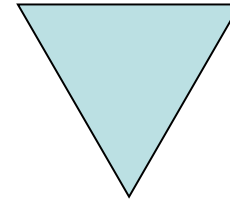
❖ That of Command  
and  
Control

Vision 1920



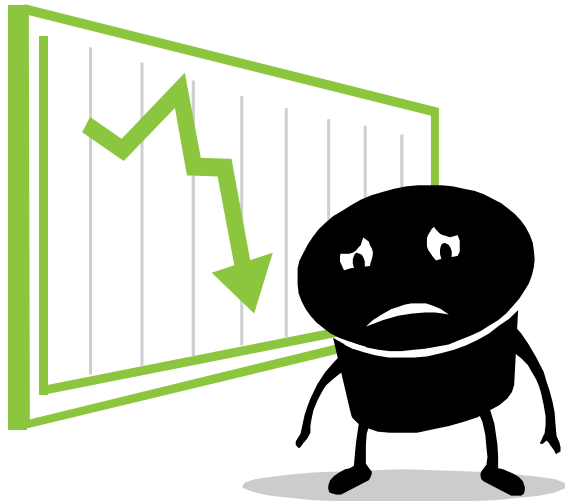
❖ Or that of Coordinate and  
Cultivate

Vision 2000



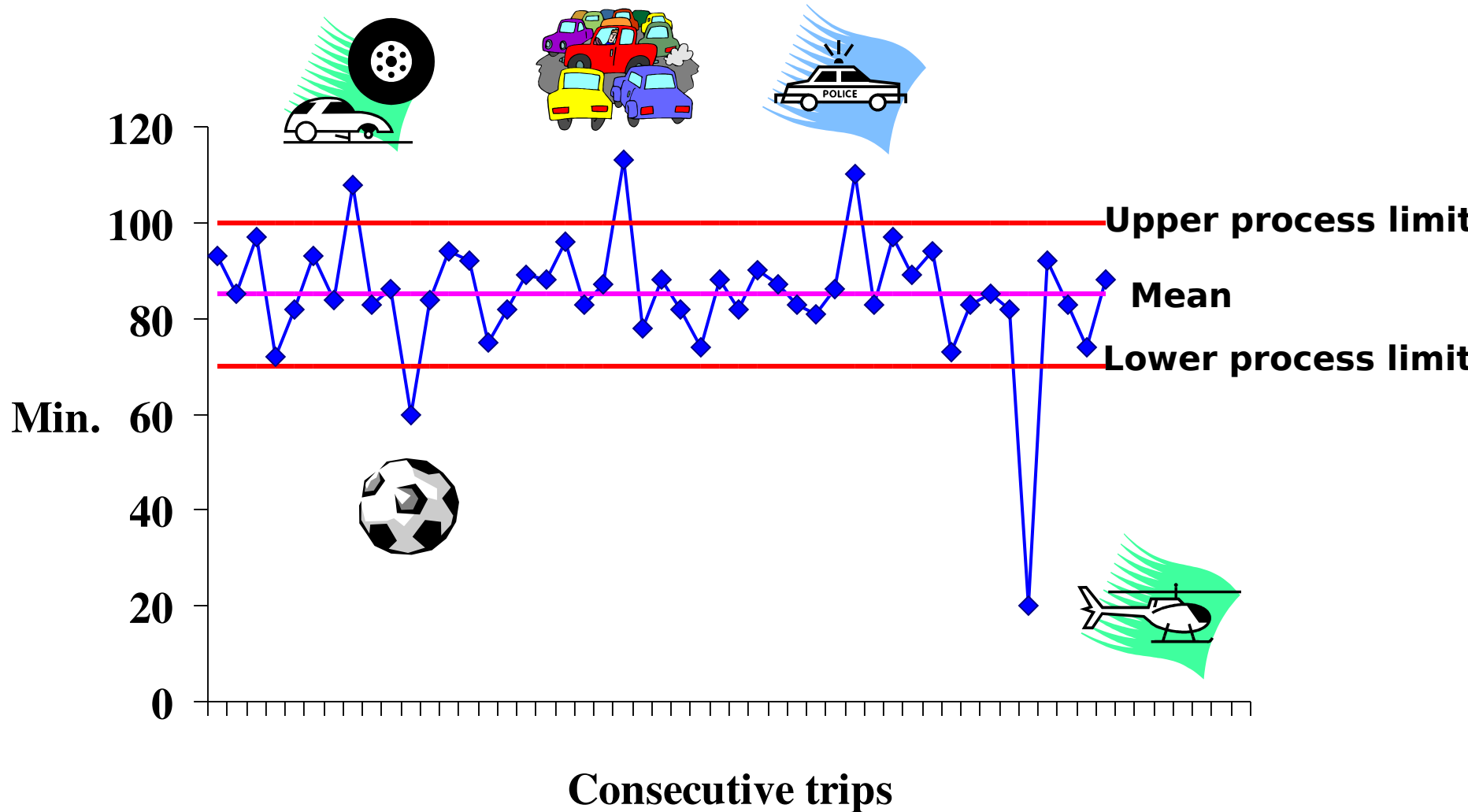
**Coordination** focuses on activities that need to be done  
**Cultivation** focuses on the people doing these activities

## Understanding Variation and its Impact on Service Delivery





## Angie's trips to Leicester



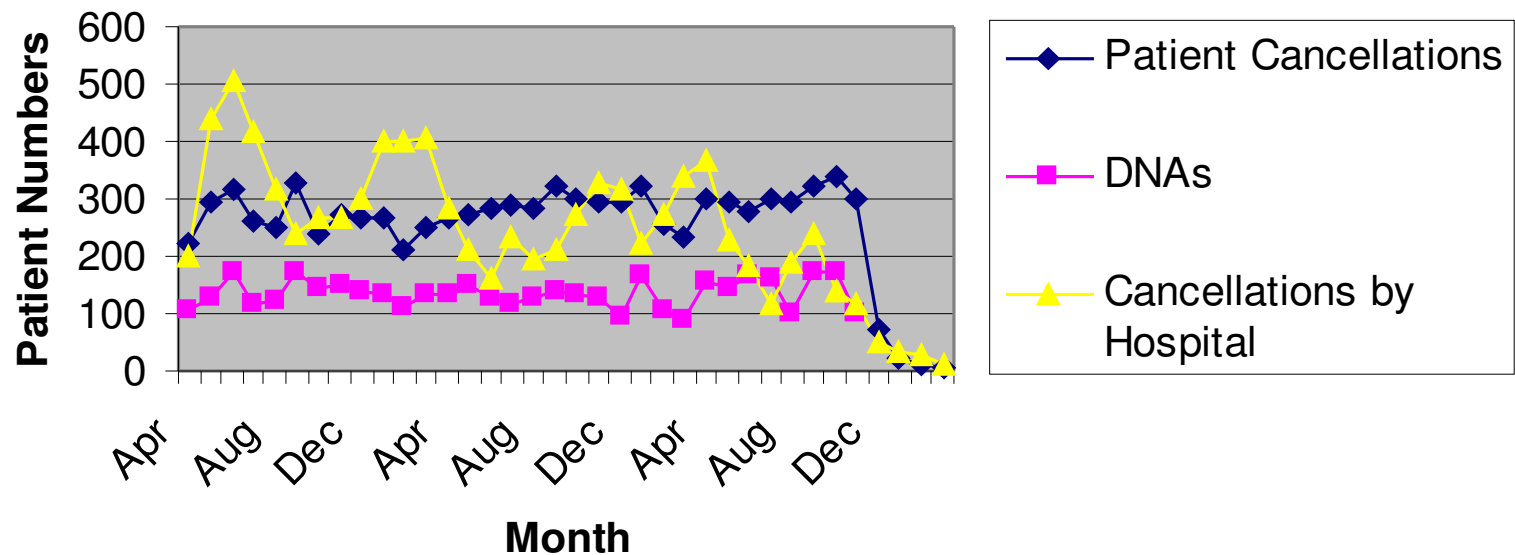
# What is this meant to show/prove?

## Activities summary from the monthly measures : Mar'02-

Pilot sites	Patients within the scope of the project treated this month		Patients in scope of the project treated this month under an agreed Care Pathway		Time* from referral to first definitive treatment (days)		Maximum wait* for 1st specialist appointment		Average wait* for 1st specialist appointment		Booked appointments through new clinics		Booked admissions through new clinics		Number of Patient Discovery Interviews		Team self-assessment
	Mar '02	change from last month	Mar '02	change from last month	Mar '02	change from last month	Mar '02	change from last month	Mar '02	change from last month	Mar '02	change from last month	Mar '02	change from last month	Mar '02	change from last month	
	-	0	-	0	184	-17	-	-140	45	-2	278	54	14	4	-	0	-
	8	-1	8	8	741	434	175	-7	123	-4	0	0	0	0	0	-1	2
	-	0	-	0	-	-8	-	-70	-	-30	-	0	-	0	-	0	-
	97	22	17	11	-	-16	84	0	57	-4	17	2	7	7	0	0	4
	37	-19	12	6	41	-65	84	0	82	22	0	0	0	0	0	0	-
	-	-38	-	0	-	-669	-	-182	-	-123	-	0	-	-48	-	0	-
	15	0	15	0	294	-34	245	14	84	0	0	0	0	-87	0	0	3
	366	24	291	3	395	48	55	10	39	-8	0	-379	0	0	0	0	4
	-	-46	0	-46	282	-52	235	64	119	0	1217	46	0	0	0	0	4
	15	2	3	3	-	0	97	-8	23	1	699	238	6	0	-	0	3
	29	-4	9	3	369	53	226	-49	186	37	0	0	0	0	8	8	2
	18	10	14	9	200	-40	32	1	30	2	0	0	39	2	0	0	-
	175	-77	38	-88	172	-1	137	11	45	5	0	0	18	3	0	0	-
	25	8	25	8	1	-1	98	-14	77	14	123	-3	62	-6	14	4	3
	-	0	-	0	-	0	-	-618	-	-106	-	0	-	0	-	0	-
	30	12	15	5	318	0	89	-155	209	43	0	0	0	0	0	0	3
	11	-3	0	0	400	90	214	-47	210	13	0	0	0	0	0	0	-
	-	0	-	0	-	-416	-	-297	-	-91	-	0	0	-29	9	-9	4
	12	2	12	2	210	113	306	-250	114	43	0	0	0	0	0	0	-
	-	-4	-	-4	204	57	222	-445	192	99	0	0	0	0	0	0	-
	3	0	3	0	226	-81	322	-195	195	104	0	0	0	0	0	0	-

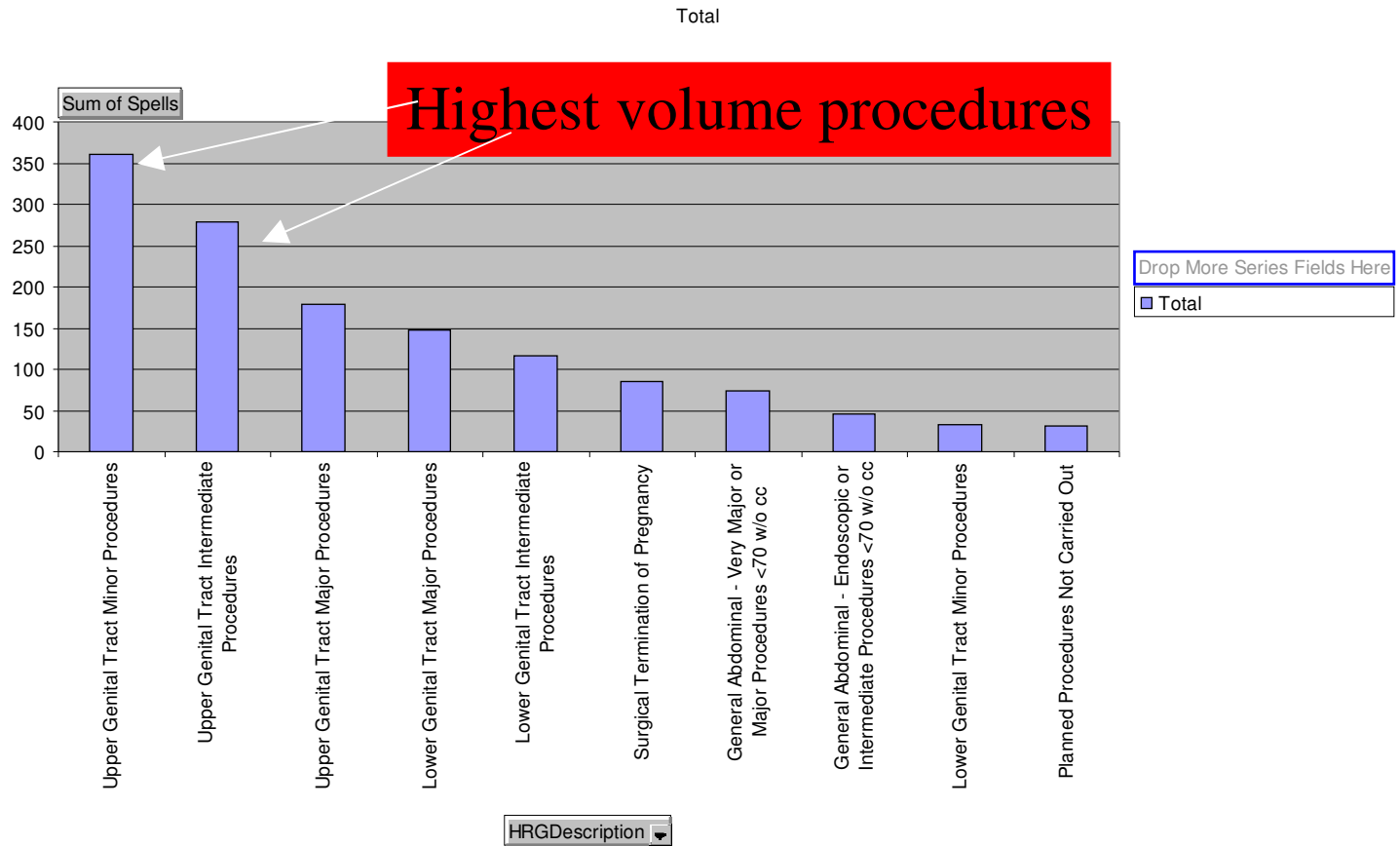
# Use data for Improvement

**Gynaecology Outpatient Appt Analysis including Ward Attenders Apr 2006 - Nov 2008**

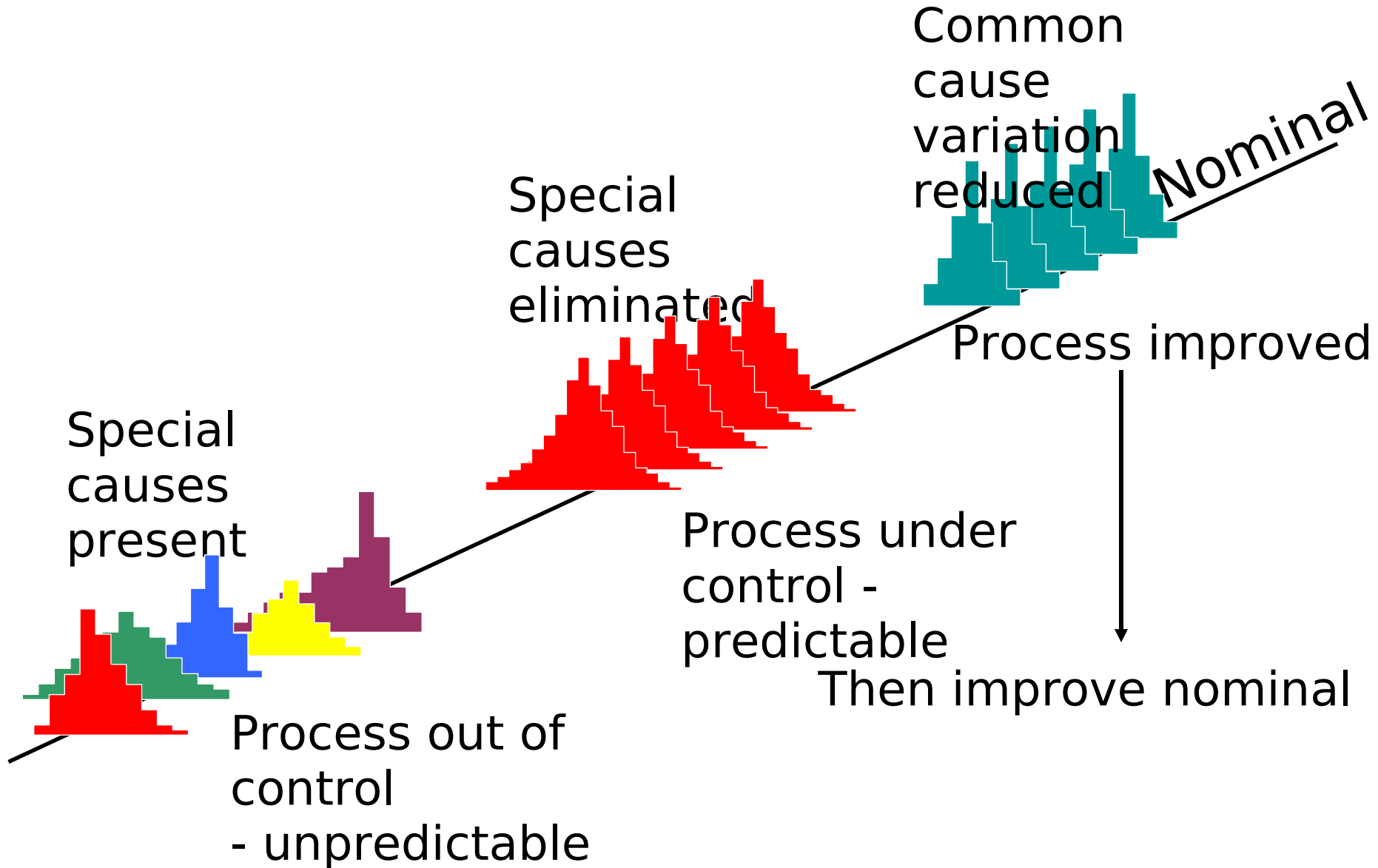


# Completed Spells April 2008-Sept 2008

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# Process Improvement



## Dashboard Information



## Convert non value adding time to value adding time to improve productivity

Number of nurses per Trust = 800

Length of a shift = 480 minutes

Typically, 50 % of time is value adding = 240 mins per shift

50 % of time is non value adding = 240 min per shift

(searching for things, unnecessary movement, chasing results, redoing things)

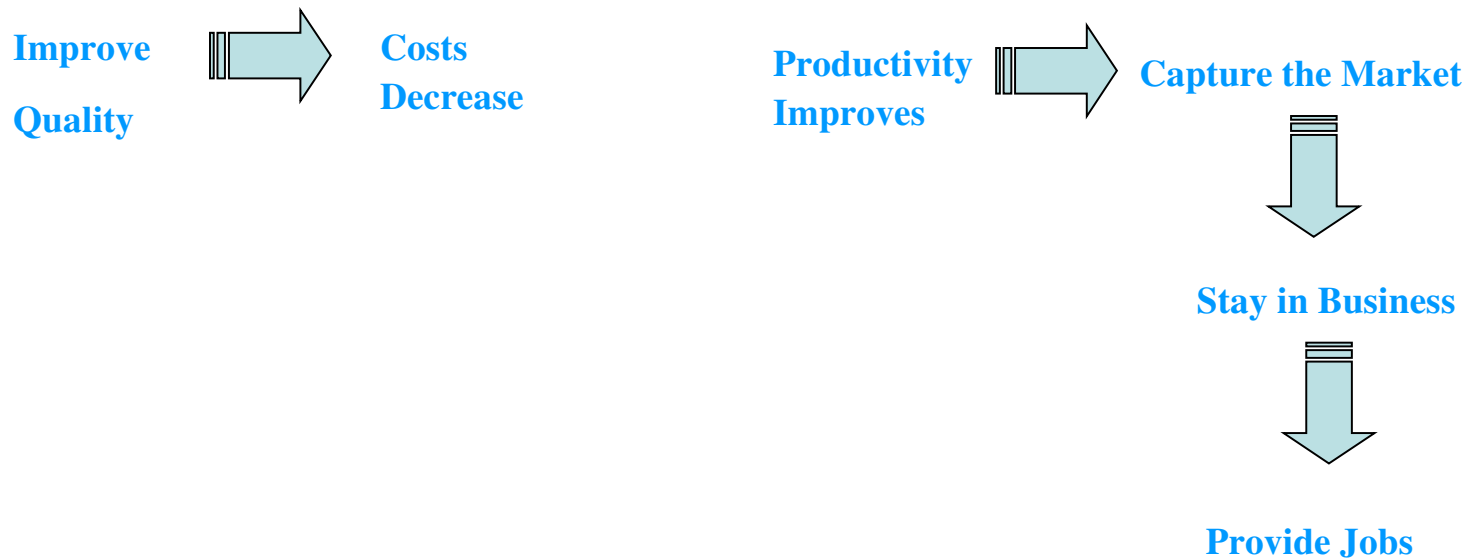
Now, if we can convert 10% of non value adding time to value adding time  
= 24mins extra value adding time

# This is the equivalent to 38 extra nurses

(23 mins \* 800 nurses = 18400 extra value adding minutes)

# Deming's Chain Reaction

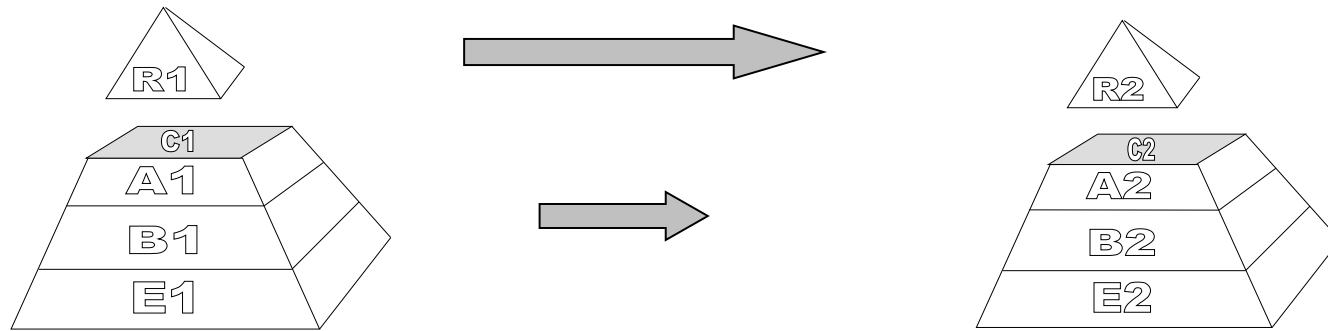
In 1950 Dr W E Deming used the diagram below to describe to his students the benefits of building quality into the system



*The organisation that seeks to decrease costs, improve quality  
– without first building quality into the systems- is gambling long term  
survival for – at best – short term gains.*



# Creating the Environment for Transformation



Results Pyramid- Roger Connors: Tom Smith

## Lean is based on 5 key principles:

Adopt a LEAN Approach...

**Value** - Understand what the ‘service user’ perceives as value.

**Value Stream** – How ‘value’ is created and delivered to the service user.

**Flow**- Smooth the journey, remove all barriers and interruptions to deliver ‘value’.

**Pull** – Linked to the value stream processes and is triggered on demand from the service user.

**Perfection** – Continuous improvement

**Lean goals include**

**Doing work on time**

**Identify problems  
(defects and backlog)  
before it's too late**

**Learn by doing**

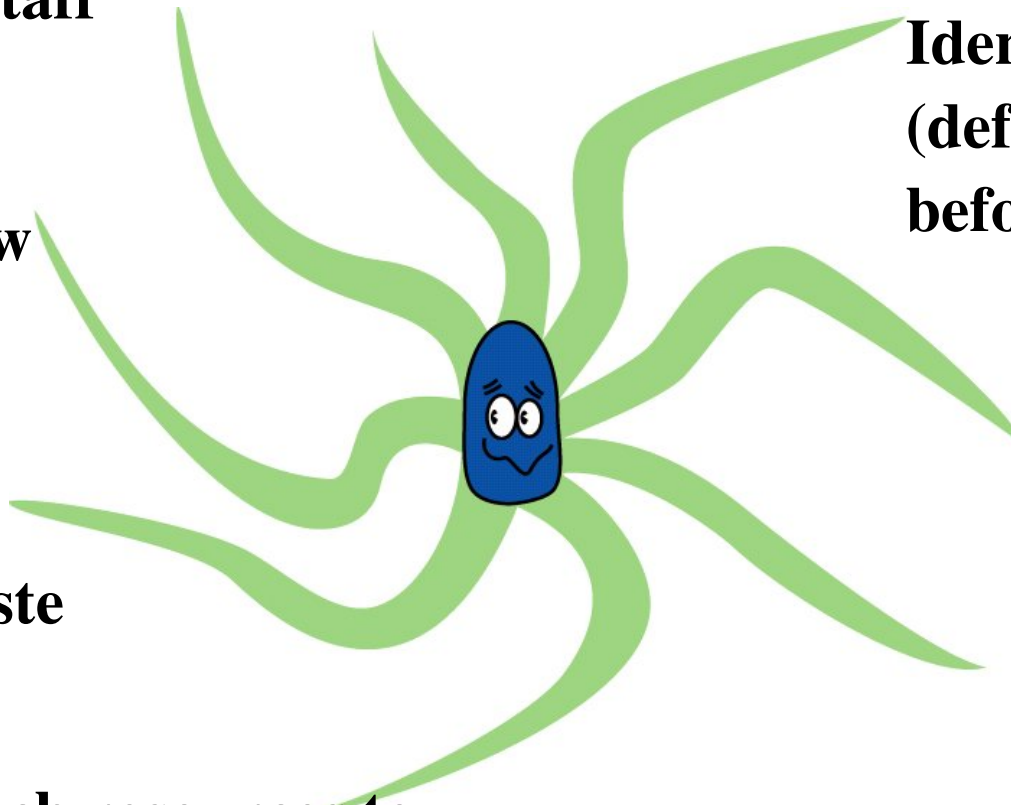
**Right first time,  
every time**

**Match resources to  
meet demand**

**Empowered staff**

**Improved flow**

**Eliminate waste**



A large, solid blue triangle is centered on a white background. Inside the triangle, the text "Paris In the the spring" is written in a white, serif font, arranged in three lines.

Paris  
In the  
the spring

# To Err is Human – Design for Safety

**Preoccupation with failure** – all potential problems or errors identified/analysed

**Reluctance to Simplify Interpretations**- nothing taken for granted. Checks happen in multiple ways.

**Sensitivity to operations** – all observe ops, have continuous communication

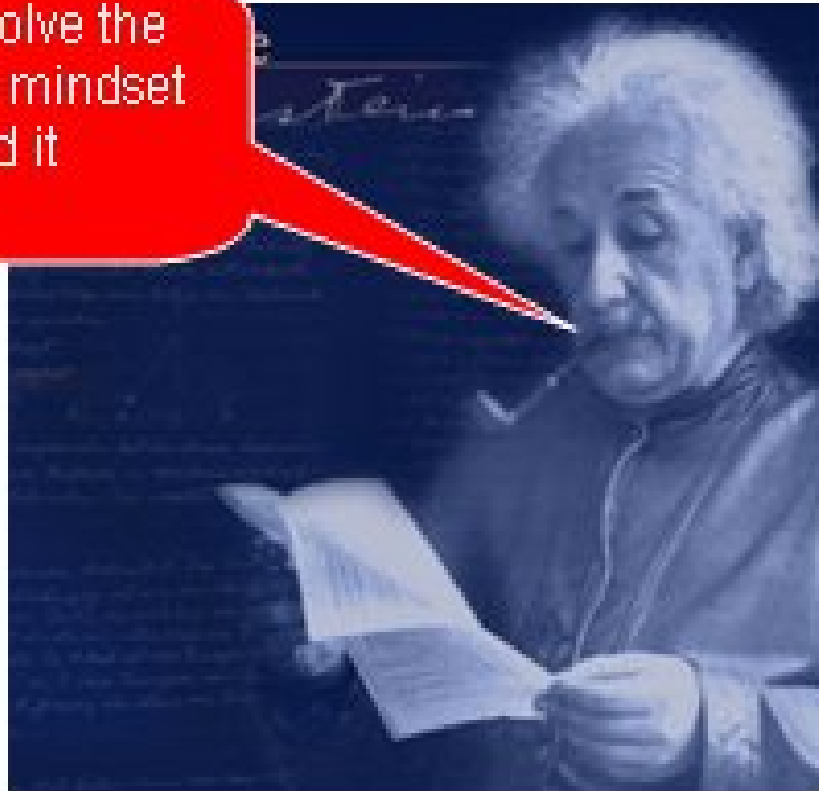
**Commitment to resilience** - the ability/agility to respond to the unexpected.

**Deference to expertise** – decisions are made away from formal authority toward expertise and experience

**Karl Weick's** five key organisational operating principles required to create an organisational infrastructure for reliability.

## Remember

You will never solve the  
problem with the mindset  
that created it



# Creating the Environment for Transformation

**Leaders need to be:**

**and**

✓ Consistent  
communicate!!

Communicate; communicate;

✓ Give Clarity

✓ Show Empathy

Manage relationships

✓ Give Support

✓ Be Authentic

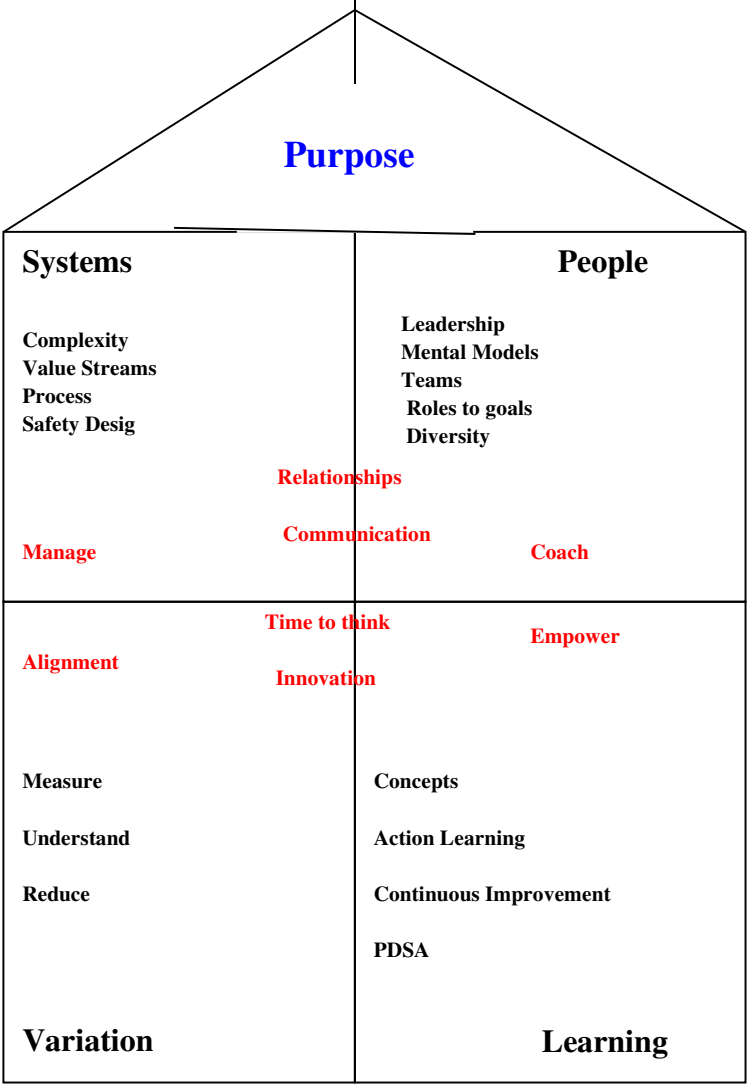
Manage Transition

✓ Coach

✓ Be Persistent

# Revisit the Blueprint for Transformation

*‘True North’*





## **Action Planning and Next Steps.....**

**For Me.....**

**For my team.....**

**For my organisation.....**